SUMNER COUNTY SCHOOLS
PERMISSION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION

Name of Student _____

School _____ **Grade** _____ **Date of Birth** _____

Teacher _____

Medication _____ **Dosage** _____

Purpose of medication _____

Time of day medication is to be given _____

Possible side effects _____

Anticipated number of days to be given at school _____

Is this student competent to self-administer medication with assistance from trained, unlicensed, school personnel (Physician please circle)?	**YES or NO**

_____ _____
Signature of Physician/Provider **Date**

_____ _____
Print Physician/Provider Name **Office Number**

_____
Office Address

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the request to perform this service by any person employed by the Sumner County School System, the undersigned parent or guardian hereby agrees to release the Sumner County School System and its personnel from any legal claim which they now have or may thereafter have arising out of the administration of or failure to administer the medication to the student.

I hereby give my permission for _____ **to take the above medication. I understand that it is my responsibility to furnish this medication. I further understand that my signature gives Sumner County School Nurses permission to disclose and receive medical information regarding this student on a need-to-know basis.**

_____ _____
Signature of Parent/Guardian **Date**

_____ _____ _____
Home # **Work #** **Cell #**

Please refer to the *2014 Tennessee State Guidelines of Health Care Professionals and Health Care Procedures in a School Setting [Tennessee Code Annotated, Section 49-5-415 (a)]* for further clarification on self-administration.

3/2015

SUMNER COUNTY SCHOOLS
PERMISSION FOR ADMINISTRATION OF NON-PRESCRIPTION MEDICATION

Name of Student _____

School _____ **Grade** _____ **Date of Birth** _____

Teacher (Homeroom) _____

Medication _____ **Dosage *Will be given according to package directions***

Purpose of medication _____

Time of day medication is to be given _____

Possible side effects _____

Anticipated number of days to be given at school _____

Name of Physician _____ **Physician's Contact** _____

Alternative Medicines: "herbs, herbal supplements, homeopathic medicines, vitamins, traditional or cultural treatments, salves, nutritional supplements, and other products that are not generally considered part of conventional medicine will not be administered at school. The actions and potential side effects of these products are not readily available to health care providers and cannot be safely administered by school staff."

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the request to perform this service by any person employed by the Sumner County School System, the undersigned parent or guardian hereby agrees to release the Sumner County School System and its personnel from any legal claim which they now have or may thereafter have arising out of the administration of or failure to administer the medication to the student.

I hereby give my permission for _____ **to take the above medication. I understand that it is my responsibility to furnish this medication. I further understand that my signature gives Sumner County School Nurses permission to disclose and receive medical information regarding this student on a need-to-know basis.**

Is your child competent to self-administer medication WITH assistance from trained, unlicensed, school personnel (please circle)?	**YES or NO**

Signature of Parent/Guardian	**Date**

Phone 1	**Phone 2**

Please refer to the *2014 Tennessee State Guidelines of Health Care Professionals and Health Care Procedures in a School Setting [Tennessee Code Annotated, Section 49-5-415 (a)]* for further clarification on self-administration.
5/2016

TN Department of Education

Allergy and Anaphylaxis Emergency Plan

Date of Plan: _____

Student's Name: _____ Date of Birth: _____ Age: ____ Weight: _____ pounds (____ kg)
Student's School System: _____ Student's School: _____
Student has allergy to _____
Student has asthma ☐ Yes (If yes, higher risk for severe reaction) ☐ No
Student has had anaphylaxis ☐ Yes ☐ No
Student has recieved instruction and has permission to self-carry epinephrine and use independently ☐ Yes ☐ No

IMPORTANT REMINDER: Anaphylaxis is a potentially life-threatening, severe allergic reaction. If in doubt, use epinephrine.

For **ANY** of the following **SEVERE SYMPTOMS OR A COMBINATION** of symptoms from different body areas


Shortness of breath, wheezing, or coughing


Pale or bluish skin, weak pulse, fainting or dizziness


Tight or hoarse throat, trouble breathing or swallowing


Swelling of lips or tongue that bothers breathing


Many hives or redness over body


Feeling of "doom," confusion, altered consciousness or agitation


Repetitive vomiting or severe diarrhea

☐ **SPECIAL SITUATION:** If this box is checked, student has an extremely severe allergy to an insect sting or the following food(s): _____. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine.**

↓

1. Inject epinephrine right away!
Note time when epinephrine was given.

2. Call 911.
- Ask for ambulance with epinephrine.
- Tell rescue squad when epinephrine was given.

3. Stay with Student and:
- Call parents and student's healthcare provider.
- If symptoms get worse or continue after 5 minutes, give a second dose of epinephrine.
- Keep student lying on back. If the student vomits or has trouble breathing, keep child lying on his or her side.

4. Give other medicine (if applicable) following epinephrine
- Antihistimine
- Inhaler/bronchodilator if wheezing

MILD SYMPTOMS


Itchy or runny nose, sneezing


Itchy mouth


Mild nausea or discomfort


A few hives, mild itchy skin

MONITOR STUDENT

- Stay with student and watch him or her closely.
- Give antihistamine (if listed below).
- Call parents.

If more than 1 symptom or severe allergy anaphylaxis symptoms develop, use epinephrine.

MEDICATION/DOSES

Epinephrine, intramuscular (list type):
_____

Epinephrine Dose:
☐ 0.1 mg (7.5 kg to less than 13kg)
☐ 0.15 mg (13 kg to less than 25 kg)
☐ 0.3 mg (25kg or more)

Antihistamine, by mouth (list type): _____
Antihistime Dose: _____
Other (e.g., inhaler/bronchodilator if child has asthma):
_____

EMERGENCY CONTACTS

Healthcare Provider: _____
Phone: _____
Parent/Guardian: _____
Phone: _____
Other Emergency Contact Name/Relationship:
_____
Phone: _____

_____ _____ _____ _____
Parent/Guardian Authorization Signature Date Physician/HCP Authorization Signature Date

SUMNER COUNTY SCHOOLS
IHP/SAFETY PLAN: ASTHMA DISORDER
This portion is to be completed by a PARENT/GUARDIAN

Child Information

Name of Child:_____ Date of Birth_____

Child's Age_____ Grade_____ Homeroom Teacher_____

Emergency Information

Emergency Contact: _____ Relationship: _____

Phone 1: _____ Phone 2: _____

Parent/Guardian: _____ Phone 1: _____ Phone 2: _____

Pulmonologist: _____ Phone: _____

Primary Physician: _____ Phone: _____

Date of last ASTHMA ATTACK: _____

Triggers that may bring on an asthma episode:

- ☐ **Respiratory Infection**
- ☐ **Exposure to Cold/Temperature Changes**
- ☐ **Cigarette Smoke**
- ☐ **Odors/Fumes**
- ☐ **Exercise**
- ☐ **Allergic Reaction to:** _____
- ☐ **Other:** _____

Please check the signs/symptoms your child displays during an asthma event:

- ☐ **Shortness of Breath**
- ☐ **Bluish Color to Nails/Skin**
- ☐ **Coughing**
- ☐ **Wheezing**
- ☐ **Anxiety**
- ☐ **Difficulty Talking in Complete Sentences**
- ☐ **Other:** _____

List ALL current medications (Home and School):

Medication	Dosage/Strength	Purpose	Time of Day	School OR Home

My child has the following other chronic illnesses/disabilities: _____

Allergies: _____

Child's Limitation or Special Considerations: _____

It is understood that any medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. I understand that I am responsible for furnishing all medications. The school nurse has permission to communicate with the healthcare provider regarding this medication and plan of care including, but not limited to, orders, clarification of orders, etc. I understand that the health care provider may disclose protected health information in consultation with the school nurses. All information obtained will remain confidential and be available on a need-to-know basis to those individuals who are involved in providing for your child's health and educational needs at school. In consideration of the acceptance of the request to perform this service by any person employed by the Sumner County School System, the undersigned parent or guardian hereby understands and agrees that the Sumner County School System and its personnel shall not be liable for any injury resulting from the reasonable and prudent administration of medication or the reasonable performance of health care procedures, including the administration of medication (T.C.A. § 49-5-415). By signing, parent indicates agreement with the plan of action as described by health care provider.

Student information was requested from the parent with no response. This IHP was developed from the school nurse without input from the parents.

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

BACK PAGE TO BE COMPLETED BY PHYSICIAN

SUMNER COUNTY SCHOOLS
ASTHMA IHP/SAFETY PLAN-PRESCRIPTION MEDICATION ORDERS
This portion is to be completed by the PHYSICIAN

Name of Child: _____ DOB: _____

ASTHMA RISK: Mild _____ Moderate _____ Severe _____

Protocol/Procedure for student having an asthma attack:

1. **Encourage student to remain calm, take slow, deep breaths, and sit upright.**
2. **Allow student to administer prescribed asthma medication (if available).**
3. **Stay with student and monitor response.**
   - **If symptoms decrease within 15 minutes and student is relieved, he/she may return to class.**
   - **If symptoms persist after 15 minutes contact SET/School Nurse, call parent AND PROCEED TO EMERGENCY ACTION PLAN BELOW.**

EMERGENCY ACTION PLAN

1. **If in doubt, activate EMS/Call 911.**
2. **Stay with student and continue to monitor breathing and general condition.**
3. **Allow student to take additional prescribed, rescue medications or doses as ordered (if available).**
4. **SET/School Nurse will assess student, utilize pulse oximeter and provide Oxygen support as needed (when available).**

Emergency Medication(s) to be Administered at School During Acute Asthma Episode

Name of Medication	Strength and Dose to be Given	When to Administer at School	Possible Side Effects of Medication

If peak flow meter used, please specify parameter: _____

For Inhaled Medications (Please check <u>ONE</u> of the following):

_____ **I have instructed this student in the proper way to use their inhaled medications. It is my professional opinion that he/she should be <u>ALLOWED TO CARRY</u> and use their prescribed inhaler.**

_____ **It is my professional opinion that the student <u>SHOULD NOT</u> carry his/her inhaled medications, but should receive assistance with administration by an adult.**

This child has the following chronic illnesses/disabilities: _____

Physician's Signature: _____ **Date:** _____

Physician's Name (Print): _____ **Phone:** _____

FRONT PAGE TO BE COMPLETED BY <u>PARENT</u>

SUMNER COUNTY SCHOOLS
SEIZURE IHP/SAFETY PLAN-PRESCRIPTION MEDICATION ORDERS

This portion is to be completed by a PARENT/GUARDIAN

Child Information

Name of Child:_____ Date of Birth_____

Child's Age_____ Grade_____ Homeroom Teacher_____

Emergency Information

Emergency Contact: _____ Relationship: _____

Phone 1: _____ Phone 2: _____

Parent/Guardian: _____ Phone 1: _____ Phone 2: _____

Neurologist: _____ Phone: _____

Primary Physician: _____ Phone: _____

Triggers that may bring on a seizure:_____

Date of last seizure: _____

Signs and symptoms: (Please circle the symptom(s) that occur in your child.)

1. Aura (symptoms before seizure_____)
2. Generalized convulsions involving entire body
3. Pallor or skin discoloration
4. Labored (noisy) breathing
5. Dilation of pupils
6. Loss of consciousness (may fall to ground)
7. Involuntary loss of urine or feces
8. Staring / blank gaze / day dreaming
9. Other_____

Is your child aware of impending seizure activity? YES NO

PARENT/GUARDIAN: It is critical for school personnel to know about same day use of Diazepam, or other emergency anti-seizure medications prior to school. Diazepam rectal gel (Diastat) is not to be used more than 5 times per month and/or more than once in 5 days.

List ALL current medications:

Medication	Dosage/Strength	Purpose	Day/Schedule	Time of Day

My child has the following other chronic illnesses/disabilities: _____

Allergies:_____

Child's Limitation or Special Considerations:_____

It is understood that any medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. I understand that I am responsible for furnishing all medications. The school nurse has permission to communicate with the healthcare provider regarding this medication and plan of care including, but not limited to, orders, clarification of orders, etc. I understand that the health care provider may disclose protected health information in consultation with the school nurses. All information obtained will remain confidential and be available on a need-to-know basis to those individuals who are involved in providing for your child's health and educational needs at school. In consideration of the acceptance of the request to perform this service by any person employed by the Sumner County School System, the undersigned parent or guardian hereby understands and agrees that the Sumner County School System and its personnel shall not be liable for any injury resulting from the reasonable and prudent administration of medication or the reasonable performance of health care procedures, including the administration of medication (T.C.A. § 49-5-415). By signing, parent indicates agreement with the plan of action as described by health care provider.

☐ Student information was requested from the parent with no response. This IHP was developed by the school nurse without input from the parents.

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Nurse Use Only: DIASTAT LOCATED _____. Only parent, nurse or trained personnel can administer Diastat. If given call 911, document on *Emergency Medication MAR*. If no trained personnel available, call 911.

4/2017

SUMNER COUNTY SCHOOLS
SEIZURE IHP/SAFETY PLAN-PRESCRIPTION MEDICATION ORDERS
This portion is to be completed by the PHYSICIAN

Child's Name: _____ **DOB:** _____

DURING SEIZURE ACTIVITY:

1. STAY WITH THE STUDENT & NOTIFY THE SCHOOL NURSE and/or SET TEAM.
2. Note time at onset of seizure, observe pattern of the seizure and document on the seizure log.
3. If generalized jerking occurs, assist student to the floor (if student is in a wheelchair lock the wheels and allow the student to remain in the chair).
    a. Gently support head, roll student to side position and monitor breathing and pulse.
    b. **DO NOT** restrain student or place anything in the student's mouth.
    c. Protect student by moving items away that may cause injury.
    d. Loosen clothing at neck and waist; remove eyeglasses (if applicable).
4. Have another adult remove other students from the area.
5. **CALL 911 & PARENT IF CHILD EXHIBITS:**
    a. Absence of breathing and/or pulse. (Start CPR for absence of breathing and pulse.)
    b. Seizure of 5 minutes or greater duration.
    c. Two or more consecutive (without a period of consciousness between) seizures which total 5 minutes or greater.
    d. Continued unusually pale or bluish skin/lips or noisy breathing after the seizure has stopped.
    e. If Diastat is ordered and given.
    f. If Diastat is ordered and no trained staff member or school nurse is available at the onset of the seizure.

Emergency & Other Medication(s) to be Administered at School (Including VNS magnet, if applicable)

Name & Purpose of Medication	Strength & Dose to be Given	When to Administer at School/Frequency	Possible Side Effects of Medication

This child has the following chronic illnesses/disabilities: _____

AFTER SEIZURE ACTIVITY:

1. Continue to monitor until the student is alert and oriented.
2. Provide for personal hygiene and privacy, as appropriate. If the student is tired after a seizure allow to rest in a supervised area, as needed.
3. A child recovering from a generalized seizure may manifest abnormal behavior, such as incoherent speech, extreme restlessness, and confusion. This may last from five minutes to several hours.
4. **Notify parent if seizure is different from usual type, 911 is called or child has not reoriented after 30-60 minutes.**

Physician's Signature: _____ **Date:** _____

Physician's Name (Print): _____ **Phone:** _____

Nurse Use Only: DIASTAT LOCATED _____. Only parent, nurse or trained personnel can administer Diastat. If given call 911, document on *Emergency Medication MAR*. If no trained personnel available, call 911.

4/2017

SUMNER COUNTY SCHOOLS
IHP/SAFETY PLAN-CARDIAC DISORDER
This portion is to be completed by the PHYSICIAN/CARDIOLOGIST

Name of Child: _____ DOB: _____

Cardiac Diagnosis: _____ Last Examined: _____

1. **The following may indicate a worsening of this child's cardiac disease (Check all that apply):**
   - _____ Decreased level of consciousness
   - _____ Dizziness
   - _____ Change in color to pale or blue
   - _____ Chest Pain
   - _____ Clammy, cool skin
   - _____ Shortness of breath
   - _____ Fainting
   - _____ Other: _____

2. **Steps that should be taken for a cardiac event are:**
   - Check pulse, respirations & level of consciousness (LOC)
   - If decreased LOC or absence of pulse or respirations
     - Begin CPR
     - Delegate calling 911
     - Delegate call to parent/guardian
     - Delegate call to child's cardiologist or physician

3. **Individual Considerations/Additional Comments:** _____

4. **The following recommendations are based on this child's cardiovascular status. These recommendations should be considered in the context of other medical considerations that are part of his/her general medical evaluation. Our recommendations are (Check one):**

	NO RESTRICTIONS: Includes interscholastic athletics, contact sports, etc…
	MODERATE EXERCISE: Includes PE classes & recreational sports but should avoid activities which require maximum or sustained effort
	LIGHT EXERCISE: Includes nonstrenuous recreational games such as swimming, jogging, bowling, golf; modified gym program
	CHILD DETERMINED: Child must be permitted to determine his/her own level of activity and to stop and rest as needed
	NO PHYSICAL EDUCATION (PE) CLASSES

Physician's Signature: _____ **Date:** _____

Physician's Name (Print): _____ **Phone:** _____

FRONT PAGE TO BE COMPLETED BY PARENT

SUMNER COUNTY SCHOOLS
IHP/SAFETY PLAN: CARDIAC DISORDER
This portion is to be completed by a PARENT/GUARDIAN

Child Information

Name of Child:_____ Date of Birth_____

Child's Age_____ Grade_____ Homeroom Teacher_____

Emergency Information

Emergency Contact: _____ Relationship: _____

Phone 1: _____ Phone 2: _____

Parent/Guardian: _____ Phone 1: _____ Phone 2: _____

Cardiologist: _____ Phone: _____

Primary Physician: _____ Phone: _____

Cardiac Diagnosis: _____

Cardiac Procedures/Surgeries & Dates: _____

_____

School staff will notify parent/guardian if the child experiences the following symptom(s):

*Child feels heart beat "funny" or "too fast"
*Shortness of breath
*Marked change in color around lips/mouth area
*Dizziness
*Other: _____

List ALL current medications (Home & School):

Medication	Dosage/Strength	Purpose	Day/Schedule	Time of Day

My child has the following other chronic illnesses/disabilities: _____

Allergies: _____

Child's Limitation or Special Considerations: _____

_____

It is understood that any medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. I understand that I am responsible for furnishing all medications. The school nurse has permission to communicate with the healthcare provider regarding this medication and plan of care including, but not limited to, orders, clarification of orders, etc. I understand that the health care provider may disclose protected health information in consultation with the school nurses. All information obtained will remain confidential and be available on a need-to-know basis to those individuals who are involved in providing for your child's health and educational needs at school. In consideration of the acceptance of the request to perfo rm this service by any person employed by the Sumner County School System, the undersigned parent or guardian hereby understands and agrees that the Sumner County School System and its personnel shall not be liable for any injury resulting from the reasonable and prudent administration of medication or the reasonable performance of health care procedures, including the administration of medication (T.C.A. § 49-5-415). By signing, parent indicates agreement with the plan of action as described by health care provider.

☐ Student information was requested from the parent with no response. This IHP was developed from the school nurse without input from the parents.

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

SUMNER COUNTY SCHOOLS ADRENAL CRISIS ACTION PLAN AND MEDICATION ORDERS

SCHOOL YEAR: _____ Student has ☐ 504; ☐ IEP

PARENT/GUARDIAN -- complete the top portion of form and sign at the bottom.		TRAINED STAFF
Name:	Date of Birth:	
Grade:	Teacher/Homeroom:	
Parent/Guardian:	Secondary Contact:	
Parent Email:	Secondary Contact Phone:	
Parent Phone:	Other Phone Number:	

HEALTH CARE PROVIDER -- complete all items, SIGN and DATE completed form.

DAILY SCHEDULED ADRENAL MEDICINES FOR SCHOOL DAY – NO CURRENT SYMPTOMS

☐ **Student requires medication daily at school:**

- Medication Name: _____
- Medication Dose: _____
- Medication Route: _____
- Time medication is to be taken at school: _____

☐ **Student does NOT require medication daily at school.**

ORAL STRESS DOSE - FOR MILD SYMPTOMS

☐ **Student may need an ORAL stress dose at school for these symptoms – mark all that apply:**

- ☐ Fever > 100.6
- ☐ Vomiting or diarrhea
- ☐ Broken Bones or Serious Injury
- ☐ Other _____

☐ **No oral stress dose is ordered for this student.**

Oral Stress Dose:

Medication Name: _____

Medication Dose: _____

Next Steps:

- Call Parents (see numbers above).

INJECTABLE STRESS DOSE - FOR SEVERE SYMPTOMS – EMERGENCY SITUATION

☐ **Student may need an INJECTED stress dose at school for these emergency symptoms – mark all that apply:**

- ☐ Looks "bad" (pale, sweaty, breathing rapidly)
- ☐ Weakness
- ☐ Lethargy
- ☐ Unable to respond normally
- ☐ Loss of consciousness
- ☐ Vomiting 30 minutes after oral stress dose is given
- ☐ Other: _____

☐ **No injected stress dose is ordered for this student.**

Emergency Injectable Stress Dose:

Medication Name: _____

Medication Dose: _____

Medication Route: _____

Next Steps:

- Call 911 and School Emergency Team
- Call Parents (see numbers above).

➢ **If trained personnel is unavailable or unable to administer emergency medication call 911 and stay with the student**

Student is capable of carrying his/her own emergency stress dose medication. Must notify school nurse if medication is self-administered. ☐ Yes ☐ No

HEALTH CARE PROVIDER SIGNATURE	PRINT PROVIDER'S NAME	PHONE	DATE

It is understood that any medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. I understand that I am responsible for furnishing all medications. The school nurse has permission to communicate with the healthcare provider regarding this medication and plan of care including, but not limited to, orders, clarification of orders, etc. I understand that the health care provider may disclose protected health information in consultation with the school nurses. All information obtained will remain confidential and be available on a need-to-know basis to those individuals who are involved in providing for your child's health and educational needs at school. In consideration of the acceptance of the request to perform this service by any person employed by the Sumner County School System, the undersigned parent or guardian hereby understands and agrees that the Sumner County School System and its personnel shall not be liable for any injury resulting from the reasonable and prudent administration of medication or the reasonable performance of health care procedures, including the administration of medication. (T.C.A. § 49-5-415)

By signing, parent indicates agreement with the plan of action as described by the health care provider.

PARENT SIGNATURE	DATE	SCHOOL NURSE SIGNATURE	DATE

6/2018

Sumner County School Nurse Program

Send Home-Stay Home Guidelines

The following are some guidelines you may use when deciding whether to keep your child home or to send them to school. The school staff and school nurse will use these guidelines when determining whether your child should be sent home from school. If you are unsure, call your child's healthcare provider.

Fever

Fever is generally defined as a core body temperature of 100.4 F or greater (not 104.). **A reading of 100 F, or greater, with any thermometer is a fever.**

- Your child should be without fever for a full 24 hours, **without fever-reducing medication**, before returning to school. This is because sick children often do not develop fever until the afternoon or evening. If your child has fever, do not give a fever-reducing medication (Tylenol, Advil, etc.) then send them to school.

COVID 19

A respiratory virus that presents with or without symptoms. The symptoms may include new onset fever, chills, sore throat, cough, shortness of breath, stomach symptoms not related to other conditions, loss of taste and/or smell, headache and fatigue. Your student should be evaluated by your health care provider. Please follow your school's guidelines for returning to school after a diagnosis or suspected exposure to COVID 19.

- If your student is under a physician's care for a positive COVID 19 or is presumed positive by a health care provider, they must provide a return to school note, have completed the required quarantine and have decreased signs & symptoms AND be fever free for 24 hours without fever reducing medication.

Vomiting

Your child should be free from vomiting episodes for a FULL 24 hours, prior to returning to school. If vomiting is likely due to diagnosed reflux, or is an anxiety-related symptom, you should observe them for at least 1 hour before sending them to school.

Diarrhea

A child with one episode of mild diarrhea may be able to go to school, but if he/she needs to go to the bathroom more frequently than usual, due to loose stools, they should stay home. Vomiting and diarrheal illnesses are extremely contagious, make sure they wash their hands with soap and water after toileting and before eating. Your child should be free from diarrheal episodes for a full 24 hours prior to returning to school.

Sore Throat

Most sore throats occur due to a mild viral illness and will self-resolve. If a child has **no** fever and does not feel otherwise ill, they may attend school. If the sore throat is accompanied by other symptoms such as headache, stomachache, and/or rash, he/she should see their healthcare provider to rule out strep throat or other contagious illnesses.

Red or Runny Eyes

Bacterial conjunctivitis ("pink eye") is a contagious infection of the lining of the eyeball and eyelid. Symptoms are redness of the white of the eye, swelling of the eye or eyelid, and discharge which is typically cloudy or yellowish-green. If your child wakes up with their eyelid "glued together", with discharge, call your doctor and keep your child home. Careful hand washing is essential with bacterial conjunctivitis. **If it is conjunctivitis they may return to school after they are treated for 24 hours.**

Rashes:

Scabies is a common, very itchy rash caused by a mite burrowing under the skin surface. Small bumps or raised lines are visible on the forearms and hands, and on the trunk and groin area. Often other family members have it as well. Your healthcare provider should see your child if you suspect scabies. **If diagnosed with scabies, upon return to school, your child must bring a note from the doctor as proof of treatment.**

Impetigo is a contagious superficial skin infection which looks like a crusty yellowish scab or sometimes a large blister. It can be seen anywhere on the skin, but is often found around the nostrils and lips. Your healthcare provider should see your child if you suspect impetigo.

Staph Infection/MRSA are commonly seen in school-aged children. Usually it manifests as a pink or red, firm, very sore area. It may or may not have a "head" on it. Your child's healthcare provider should see your child if you suspect a staph infection. **Upon return to school please provide proof of treatment and lesions must be covered.**

Fifth's Disease is a common viral rash which causes bright red cheeks ("slapped cheek disease"), followed by a pink, flat, lacy-appearing rash on the upper arms and tops of the thighs. Most children feel well with Fifth's, and once they develop the rash are no longer contagious. **They may attend school.**

Ringworm is not a worm it's a contagious infection caused by a fungus. Symptoms are small, red, raised, scaly spots that are itchy and grow in a circular pattern. Ringworm can be treated with anti-fungal creams, over the counter, such as Tinactin, Micatin or Lotrimin. **Your child may return once ringworm treatment has been initiated and it must be covered.**

This covers some, not all, conditions that may require your child be sent home. Our goal is to keep your child in school at their optimal health. Please call your school nurse with any questions or concerns.

Thank You,
Sumner County School Nurses