Daily Log Revised 2016

Date	Time In	Student Name	Grade	Complaint	Temp	O2 Sat	Medication/Treatment	Parent Called	Check Out	Back to Class	Nurse/ MA Initials
							Totals				

Injury_____Illness_____Meds_____Procedures_____Hygiene_____ BS checks_____Insulin_____O2 Sat_____ UOR/911/ER/Dr. Referral_____

Parent Contacts_____ Staff visits_____

_____ Initial _____ Signature _____ Initial _____ Signature _____ Initial _____ Signature

MEDICATION ADMINISTRATION DAILY RECORD FOR:
(To Be Completed For Each Medication and Dosage Change)

_____ _____
Student Name School Year

Date of Birth: _____ Gender: _____ Grade: _____ Teacher: _____ School: _____

Parent/Guardian: _____ Home Phone: _____ Work Phone: _____

Medication: _____ Dosage: _____ Start Date: _____ Stop Date: _____

Route: _____ Frequency: _____ Time(s) Given During School: _____

Known Allergies: _____

Month/Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
August																															
September																															
October																															
November																															
December																															
January																															
February																															
March																															
April																															
May																															
June																															
July																															

Comments: _____

_____

_____

Initial: _____ Name: _____ Initial: _____ Name: _____

_____ _____ _____ _____

_____ _____ _____ _____

CODES			
A	Absent	O	Out of Medication
D	Early Dismissal	R	Refused
F	Field Trip	W	Withheld Dosage
H	Holiday	X	No School

ALABAMA STATE DEPARTMENT OF EDUCATION

Date Medication Received	Date Medication Returned	Medication	Dosage (puffs, tsp, mg, etc.)	Amount of Medication (pill ct., ml, cc, etc.)	School Personnel's Signature	Guardian's Signature
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Controlled Substance Inventory Form

Alabama Board of Pharmacy/ Alabama State Department of Education
Required: monthly count on ALL DEA Schedule Drugs

Revised June 2017

Student: _____ **School:** _____

Inventory Date	Time of day	Name of Medication	Dosage	Amount of Medication *Include form (pill, liquid, etc.)				School Nurse Signature	Witness Signature *School Nurse or Medication Assistant Preferred
				Beginning number	Inventory added	Number administered	Number remaining		
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Nurses Notes:

Revised 06/2017

(Local Education Agency)

Medication Self-Administration Documentation and/or Medication Authorized to Keep On Person Documentation

Student Name_____ Grade _____

Name of Medication _____ School _____

- ✓ Standardized Medication Authorization is complete with parent and prescriber affirmation signatures authorizing this student to self administer medication and keep his/her medication on person.
- ✓ Students Individual Health Care Plan is complete

_____ Parent/Prescriber Authorization matches prescription label and the label is intact.

_____ Medication is not expired: Product manufacturer expiration date _____

_____ Student has knowledge of medication administration and safety, including information addressed in his/her HCP.

_____ Student demonstrates knowledge, skill and experience of his/her chronic illness and medication. He/She verbalizes potential side effects and adverse reactions including when to contact the school nurse or prescriber.

Parent Prescriber Authorization for Self Administration of Medication:

_____ Student agrees he/she is accountable for safe and appropriate self administration of the authorized medication. He/ She has been informed of legal policies and requirements related to self administration of authorized medication and will not give or share medication with another person.

Parent Prescriber Authorization for Medication to Keep on Person:

_____ Student agrees he/she is accountable for safe and appropriate possession of the authorized medication. He/ She has been informed of legal policies and requirements related to possession of authorized medication and will not give or share medication with another person.

Parent/Guardian Signature _____ **Date:** _____

Student Signature _____ **Date:** _____

Parent Prescriber Authorization request that this student be allowed to possess and/or self-administer his/her own medication. I am reasonably assured that this student will safely and appropriately possess and /or self administer his/her prescribed medication as ordered in the school setting. This student currently demonstrates knowledge, skill and experience of his/her chronic illness and medication.

Nurse Signature: _____ **Date:** _____

Seizure Observation Record

Student Name:				
Date & Time				
Seizure Length				
Pre-Seizure Observation (Briefly list behaviors, triggering events, activities)				
Conscious (yes/no/altered)				
Injuries (briefly describe)				
Muscle Tone/Body Movements	Rigid/clenching			
	Limp			
	Fell down			
	Rocking			
	Wandering around			
	Whole body jerking			
Extremity Movements	(R) arm jerking			
	(L) arm jerking			
	(R) leg jerking			
	(L) leg jerking			
	Random Movement			
Color	Bluish			
	Pale			
	Flushed			
Eyes	Pupils dilated			
	Turned (R or L)			
	Rolled up			
	Staring or blinking (clarify)			
	Closed			
Mouth	Salivating			
	Chewing			
	Lip smacking			
Verbal Sounds (gagging, talking, throat clearing, etc.)				
Breathing (normal, labored, stopped, noisy, etc.)				
Incontinent (urine or feces)				
Post-Seizure Observation	Confused			
	Sleepy/tired			
	Headache			
	Speech slurring			
	Other			
Length to Orientation				
Parents Notified? (time of call)				
EMS Called? (call time & arrival time)				
Observer's Name				

Please put additional notes on back as necessary.

revised 5/2014

ALABAMA STATE DEPARTMENT OF EDUCATION

UNUSUAL OCCURRENCE REPORT

Date of Occurrence:_____/____/_____ School:_____

Time of Occurrence:_____ Principal:_____

STUDENT NAME:_____ **DOB:** ____/____/____ **Grade:**____

Parent's Name:_____ Phone:_____

Address:_____ _____

DESCRIPTION OF UNUSUAL OCCURRENCE

Site of Unusual Occurrence:_____

Description of Occurrence:_____

Action Taken:_____

Condition/Status of Student:_____

Notifications: ☐ **911/Ambulance Time:**_____ **By:**_____ ☐ **Parent Time:**_____ **By:**_____

☐ **Designated School Nurse Time:**_____ **By:**_____ ☐ **Principal Time:**_____ **By:**_____

☐ **Lead Nurse Time:**_____ **By:**_____ ☐ **Poison Control Time:**_____ **By:**_____

☐ **Doctor**_____ **Phone Number:**_____ **Time:**_____ **By:**_____

Signatures:

Person Completing this Form:_____ Date:____/____/_____

Principal:_____ Date:____/____/_____

Witness:_____ Date:____/____/_____

Witness:_____ Date:____/____/_____

Fax this report to the Health Services Department within 24 hours of occurrence. File Unusual Occurrences in school and school year specific file cabinet.

Around the Clock
Healthcare Services
"Staffing...wherever healthcare is provided."

☐ MAIL

☐ PICK UP

Fax: (205) 879-1332
Email: atc2058791332@gmail.com

Timecards Due: Monday by 10 am

CLIENT # _____ **DATE** _____

OFFICE # _____ **CK#** _____

PRINT CLIENT'S NAME

PRINT YOUR NAME

CLASSIFICATION

SOCIAL SECURITY #

TIME IN AND OUT MUST BE ACCURATE AND MATCH CLIENT RECORDS

DAY	DATE	AREA	TIME STARTED	TIME FINISHED	LESS LUNCH	HOURS	MILES	CLIENT APPR'VD
SUN								
MON								
TUE								
WED								
THURS								
FRI								
SAT								
TOTAL MILES					TOTAL HOURS NEAREST 1/4			

ALL PERSONNEL CERTIFY THAT THIS FORM IS TRUE AND ACCURATE
DURING THIS PAY PERIOD, IF YOU SUSTAINED AN ACCIDENT OR INJURY WHILE WOKING ON ASSIGNMENT, PLEASE CHECK "YES" >>>>>>>> YES _____

YOUR SIGNATURE

CLIENT'S AUTHORIZED SIGNATURE

ALABAMA STATE DEPARTMENT OF EDUCATION

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

School Year: _____-_____

STUDENT INFORMATION

Student's Name: _____ **School: _____**

Date of Birth: _____/_____/_____ Age: _____ Grade: _____ Teacher: _____

☐ **No known drug allergies---if drug allergies list: _____** Weight: _____pounds

PRESCRIBER AUTHORIZATION (To be completed by licensed healthcare provider)

Medication Name: _____ **Dosage: _____Route: _____**

Frequency/Time(s) to be given: _____ **Start Date: ___/____/____ Stop Date: ___/___/___**

Reason for taking medication: _____

Potential side effects/contraindications/adverse reactions: _____

Treatment order in the event of an adverse reaction: _____

SPECIAL INSTRUCTIONS:

Is the medication a controlled substance?	Yes ☐	No ☐
Is self- medication permitted and recommended?	Yes ☐	No ☐
If "yes" I hereby affirm this student has been instructed On proper self-administration of the prescribe medication.		
Do you recommend this medication be kept "on person" by student?	Yes ☐	No ☐
Emergency Drug required during Bus Transportation	Yes ☐	No ☐
Cake Icing Gel ONLY for Diabetic Student during Bus Transportation	Yes ☐	No ☐

Printed Name of Licensed Healthcare Provider: _____Phone: ( ) _____-_____ Fax: _____-_____

Signature of Licensed Healthcare Provider: _____ Date: _____

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.

Prescription Medication must be registered with School Nurse or trained Medication Assistants. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be registered with the School Nurse or Trained Medication Assistant, OTC's in the original, unopened and sealed container. Local Education Agency Policy for OTC medication to be followed:

Parent's/Guardian's Signature: _____Date: ___/___/___ Phone: ( ) _____-_____

SELF-ADMINISTRATION AUTHORIZATION

(To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent: _____ Date: ____/____/_____ Phone: ( ) _____-_____

Revised 2019

ALABAMA STATE DEPARTMENT OF EDUCATION

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

School Year: _____-_____

STUDENT INFORMATION

Student's Name: _____ **School: _____**

Date of Birth: _____/_____/_____ Age: _____ Grade: _____ Teacher: _____

☐ **No known drug allergies---if drug allergies list: _____** Weight: _____pounds

OVER THE COUNTER PRESCRIBER AUTHORIZATION

Medication Name: _____ **Dosage: _____Route: _____**

Frequency/Time(s) to be given: _____ **Start Date: ___/____/____ Stop Date: ___/___/___**

PHYSICIAN ORDER REQUIRED by LEA : YES ____ NO_____

Reason for taking medication: _____
Potential side effects/contraindications/adverse reactions: _____
Treatment order in the event of an adverse reaction: _____

SPECIAL INSTRUCTIONS:

Is the medication a controlled substance?	Yes ☐	No ☐
Is self- medication permitted and recommended?	Yes ☐	No ☐
If "yes" I hereby affirm this student has been instructed On proper self-administration of the prescribe medication.		
Do you recommend this medication be kept "on person" by student?	Yes ☐	No ☐

Printed Name of Licensed Healthcare Provider: _____Phone: ( ) _____-_____ Fax: _____-_____

Signature of Licensed Healthcare Provider: _____ Date: _____

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up with the medication.

Prescription Medication must be registered with School Nurse or trained Medication Assistants. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be registered with the School Nurse or Trained Medication Assistant, OTC's in the original, unopened and sealed container. Local Education Agency Policy for OTC medication to be followed:

Parent's/Guardian's Signature: _____Date: ___/___/___ Phone: ( ) _____-_____

SELF-ADMINISTRATION AUTHORIZATION

(To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent: _____ Date: ____/____/_____ Phone: ( ) _____-_____

Revised 5/2016

CONCUSSION
SIGNS AND SYMPTOMS

Checklist

CDC HEADS UP
SAFE BRAIN. STRONGER FUTURE.

Student's Name: _____ Student's Grade: _____ Date/Time of Injury: _____

Where and How Injury Occurred: *(Be sure to include cause and force of the hit or blow to the head.)* _____

_____

Description of Injury: *(Be sure to include information about any loss of consciousness and for how long, memory loss, or seizures following the injury, or previous concussions, if any. See the section on Danger Signs on the back of this form.)* _____

_____

_____

DIRECTIONS:

Use this checklist to monitor students who come to your office with a head injury. Students should be monitored for a minimum of 30 minutes. Check for signs or symptoms when the student first arrives at your office, 15 minutes later, and at the end of 30 minutes.

Students who experience one or more of the signs or symptoms of concussion after a bump, blow, or jolt to the head should be referred to a healthcare professional with experience in evaluating for concussion. For those instances when a parent is coming to take the student to a healthcare professional, observe the student for any new or worsening symptoms right before the student leaves. Send a copy of this checklist with the student for the healthcare professional to review.

To download this checklist in Spanish, please visit cdc.gov/HEADSUP. Para obtener una copia electrónica de esta lista de síntomas en español, por favor visite cdc.gov/HEADSUP.

OBSERVED SIGNS	0 MINUTES	15 MINUTES	30 MINUTES	☐ MINUTES JUST PRIOR TO LEAVING
Appears dazed or stunned				
Is confused about events				
Repeats questions				
Answers questions slowly				
Can't recall events *prior* to the hit, bump, or fall				
Can't recall events *after* the hit, bump, or fall				
Loses consciousness (even briefly)				
Shows behavior or personality changes				
Forgets class schedule or assignments				
PHYSICAL SYMPTOMS				
Headache or "pressure" in head				
Nausea or vomiting				
Balance problems or dizziness				
Fatigue or feeling tired				
Blurry or double vision				
Sensitivity to light				
Sensitivity to noise				
Numbness or tingling				
Does not "feel right"				
COGNITIVE SYMPTOMS				
Difficulty thinking clearly				
Difficulty concentrating				
Difficulty remembering				
Feeling more slowed down than usual				
Feeling sluggish, hazy, foggy, or groggy				
EMOTIONAL SYMPTOMS				
Irritable				
Sad				
More emotional than usual				
Nervous				

→ More

Danger signs:

Be alert for symptoms that worsen over time. The student should be seen in an emergency department right away if she or he has one or more of these danger signs:

- ❑ One pupil (the black part in the middle of the eye) larger than the other
- ❑ Drowsiness or cannot be awakened
- ❑ A headache that gets worse and does not go away
- ❑ Weakness, numbness, or decreased coordination
- ❑ Repeated vomiting or nausea
- ❑ Slurred speech
- ❑ Convulsions or seizures
- ❑ Difficulty recognizing people or places
- ❑ Increasing confusion, restlessness, or agitation
- ❑ Unusual behavior
- ❑ Loss of consciousness (even a brief loss of consciousness should be taken seriously)

Additional information about this checklist:

This checklist is also useful if a student appears to have sustained a head injury outside of school or on a previous school day. In such cases, be sure to ask the student about possible sleep symptoms. Drowsiness, sleeping more or less than usual, or difficulty falling asleep may indicate a concussion.

To maintain confidentiality and ensure privacy, this checklist is intended for use only by appropriate school professionals, healthcare professionals, and the student's parent(s) or guardian(s).

Resolution of injury:

❑ Student returned to class ❑ Student sent home ❑ Student referred to healthcare professional with experience in evaluating for concussion

SIGNATURE OF SCHOOL PROFESSIONAL COMPLETING THIS FORM: _____

TITLE: _____

COMMENTS:

Revised August 2019

To learn more, go to cdc.gov/HEADSUP

CDC HEADS UP
SAFE BRAIN. STRONGER FUTURE.

Revised 2020

How Sick is ‘too sick’ to attend school?

Here are five reasons for keeping a child at home:

FEVER: Temperature of 100 or above. Child should remain fever free without fever-reducing medication for 24 hours.

VOMITING or DIARRHEA: Your child should not attend school if they have vomited in the last 24 hours OR have diarrhea or have had diarrhea in the last 24 hours.

UNDIAGNOSED RASH: Your child should not attend school until rash has been diagnosed and treated for 24 hours.

PINK EYE: This is highly contagious. Your child should be treated for 24 hours before returning to school.

HEAD LICE: Your child should not attend school if live bugs are present. Your child should be treated and have no live bugs prior to returning to school.

Please feel free to call with any concerns! Thank You!

_____

Your School Nurse