Spring, 2017

Dear Parent/Guardian,

In an effort to maintain the health of your child and prevent transmission of illnesses, it is important for us to have updated medical information on file in the health office. Please complete the required forms and provide the most recent physical form to the health office by the beginning of the school year. Please contact me if your child's health status changes throughout the school year so a current form can be maintained on file.

If your child requires any medications to be administered during school hours, please complete the prescription medication administration form and include physician orders for the school year. Medications must be brought in the original labelled container by the parent or guardian.

Please review the health forms for the 2017-2018 school year and return those applicable to your child by August 15th:

- ☐ RTCPS Medical Information Form (REQUIRED)
- ☐ RTCPS Potassium Iodide Administration Consent Form (REQUIRED)
- ☐ Most recent Physical and Immunizations form* (REQUIRED)
- ☐ RTCPS Authorization for Prescription Medication Administration (if necessary)
- ☐ Licensed Prescriber Order for Prescription Medication (if necessary)

All school generated forms are available at both front offices and online on the family resource link that can be accessed through the main web page at www.risingtide.org.

Please contact us if you have any questions.

Thank you,

Kacie Gaudet   Lisa Biagini RN

Kacie Gaudet, RN, CPNP
(508) 747-2620 x 228
Middle School

Lisa Biagini, RN
(508) 747-1889 x 314
Upper School

*see next page

Immunization Update

Spring, 2017

Dear Parent or Guardian,

The immunization recommendations for the upcoming year have been updated by the Massachusetts Department of Public Health in an effort to decrease disease transmission. As of September 2014, the following immunizations will be **required for all students in grades 7-12**:

- ☐ 2 doses of MMR
- ☐ 2 doses of Varicella or proof of chickenpox illness from a provider
- ☐ A dose of Tdap

Children may be particularly susceptible to transmission in a school environment given the number of close encounters during the day. All updated immunizations must be received **by August 15th, 2017**. If your child has a new medical or religious exemption for these immunizations, a letter must be provided to the school.

For more information regarding pertussis or varicella, you may visit www.cdc.gov or contact your pediatrician.

Please contact us if you have any questions.

Thank you,

Kacie Gaudet, RN, CPNP
(508) 747-2620 x 228
Middle School

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Upper School

*see next page

Rising Tide Charter Public School
Medical Information (page 1)

STUDENT
Name of Child: ______________________ D.O.B.:____________ Grade________

Name of Parent/Guardian 1:______________________________

Home:____________ Cell:____________ Work:____________

Name of Parent/Guardian 2:______________________________

Home:____________ Cell:____________ Work:____________

EMERGENCY CONTACTS

Name: ______________________ Relationship: ____________ Phone: ____________

Name: ______________________ Relationship: ____________ Phone: ____________

INSURANCE
Is the child covered by Medical/Hospital Insurance? ☐ Yes ☐ No
Cardholder's Name:____________________ Plan Name ____________Group No.____________

Does the child have Dental Insurance? ☐ Yes ☐ No
Cardholder's Name: ____________________ Plan Name____________________

If you have no health insurance, Massachusetts has health insurance plans that will provide uninsured children with affordable health care (restrictions may apply). Please contact the school nurse for more information about these programs. All communication will be confidential.

PHYSICIANS
Child's Pediatrician/Physician: ____________________ Phone: ____________ Date of last Physical: ____________
Child's Dentist: ____________________ Phone: ____________

IMMUNIZATIONS & MEDICATIONS
Massachusetts law requires that all children enrolling in public school should be immunized.

- Is your child capable of participation in a full program of school activities, including recess and physical education?
  ☐ Yes ☐ No If no, please explain:______________________________
- Is your child taking any prescribed medications on a daily basis? ☐ Yes ☐ No
  Please list All:______________________________
- **Will your child be taking any medication at school?**** ☐ Yes ☐ No
  Please list All: ______________________________

*****If YES, please complete the RTCPS Authorization for Prescription Medication Administration form and return with both Parent/Guardian and Licensed Prescriber signatures.***

If I cannot be reached in the event of an emergency, I hereby grant permission to school authorities to secure and administer treatment for the above named person. This completed form may be photocopied for use on trips away from school. I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs. I give permission to exchange information with my child's primary care physician for the purpose of referral, diagnosis, and treatment.

Signature of Parent/Guardian:______________________________ **Date:**____________

Please fill out the other side of this document.

Rising Tide Charter Public School
Medical Information (page 2)

I give permission to the school nurse or designated school personnel to give my son/daughter:

- ❑ Oral Tylenol/Acetaminophen or Ibuprofen for fever or discomfort
- ❑ Oral Benadryl/diphenhydramine for non-life threatening allergic reaction
- ❑ Oral TUMS/calcium carbonate for indigestion
- ❑ Topical calamine lotion for mild skin irritation
- ❑ Topical hydrocortisone cream for moderate skin irritation

All above medications are dosed for appropriate age and weight and dispensed only after the assessment of the nurse.

Parent/Guardian signature________________________________ Date__________________

Health Concerns	Check one	If yes, please explain:
Does your child have asthma?	□ Yes □ No	□ Needs inhaler □ Does not need inhaler
Does your child have diabetes?	□ Yes □ No	
Does your child have seizures?	□ Yes □ No	Date of last seizure:
Does your child have ADD/ADHD?	□ Yes □ No	
Does your child have Migraines?	□ Yes □ No	
Does your child have a hearing problem or wear a hearing aid?	□ Yes □ No	□ Left ear □ Right ear
Does your child have a vision problem or wear glasses/contacts?	□ Yes □ No	□ Glasses □ Contacts
Does your child have depression Does your child have anxiety?	□ Yes □ No □ Yes □ No	
Does your child have a chronic illness?	□ Yes □ No	
Was your child born prematurely?	□ Yes □ No	
Has your child ever had surgery?	□ Yes □ No	
Has your child ever been hospitalized?	□ Yes □ No	
Has your child ever had cancer?	□ Yes □ No	
Has your child ever had chickenpox?	□ Yes □ No	Date:
Does your child have allergies?	□ Yes □ No	
Other health concerns?	□ Yes □ No	

Please fill out the other side of this document.

Rising Tide Charter Public School
POTASSIUM IODIDE
Parent/Guardian Informed Consent Form

Reason for Taking Potassium Iodide

In case of an accident at a nuclear power plant or what is known as a radiological emergency, radioactive iodine will be released into the air. This material may be inhaled or ingested and enter the thyroid gland where it can cause cancer and/or disease. Children and infants are the most vulnerable to their occurrence. When taken by pill, potassium iodide (KI) floods the thyroid with non-radioactive iodide and prevents the thyroid from absorbing the radioactive material. Potassium iodide needs to be given before or shortly after exposure to radiation. Potassium iodide works only to prevent the thyroid form absorbing radioactive material.

By signing this document you are allowing a staff member to administer Potassium Iodide to your child for the duration of their stay at Rising Tide if deemed necessary. If you would like to make any changes in this document please contact the school nurse.

Potential Side Effects of Potassium Iodide

It is possible to experience **any or all** of the following side effects when taking Potassium Iodide:

- Upset stomach
- Rash
- Allergic reaction

Risks of Taking Potassium Iodide

Taking Potassium Iodide is safe for most people. Potassium Iodide **should not** be taken if someone:

- Is allergic to iodine
- Has Graves Disease
- Has any other thyroid illness
- Takes thyroid medication

Administration of Potassium Iodide

Potassium Iodide **will only be given**:

- In the case of a radiological emergency
- If it is recommended by public health officials
- If a parent /guardian signs a consent form for a child

PLEASE CHECK ONE:

☐ **I consent** to have the school nurse or her designee administer Potassium Iodide
☐ **I do not consent** to have the school nurse or her designee administer Potassium Iodide

Name of Child: ______________________ D.O.B.:____________ Grade________

Parent/Guardian Name: ______________________ Phone #: ____________

Address: ____

Allergies: ____

Parent/Guardian Signature: ______________________________ **Date:** __________

Rising Tide Charter Public School

Authorization for Prescription Medication Administration

Student's Name: ______________________________ DOB: ___________ Grade: _______

Medication Name: ____

Parent/Guardian Name: ____

Address: ____

Home Phone: ____________________ Cell: _________________ Work: ________________

PARENT/GUARDIAN CONSENT:

Please address each of the following:

1. I request and give permission to the school nurse or trained and designated school personnel to administer this medication to my child as prescribed. ☐ Yes ☐ No
2. I give permission for my child to self-administer this medication if the school nurse determines it to be safe and appropriate. I understand that the Medication Self-Administration Plan on the back of this form needs to be completed if I select this option. ☐ Yes ☐ No
3. I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medication administration as she determines necessary for my child's health and safety. ☐ Yes ☐ No
4. I understand that in the event of a field trip the medication administration plan may need to be adjusted. ☐ Yes ☐ No
5. I give permission to the school nurse or trained and designated school personnel to administer this medication to my child as prescribed during a field trip. ☐ Yes ☐ No
6. I understand that I may retrieve the medication from the school at any time and that the medication will be destroyed if it is not picked up within one week following the termination of the order of the last day of school. ☐ Yes ☐ No

Parent/Guardian Signature: _________________________________ Date: _____________

LICENSED PRESCRIBER

Diagnosis: ____

Allergies: ____

Medication: _____________________________________ Dosage: _______________________

Route: _____________ Frequency: ______________ Time of administration at school: ________

*Whenever possible, medications should be scheduled at times other than school hours.

Adverse Effects: ____

____

Effective Dates: ____/____/______ to ____/____/____

Consent for self-administration (provided the school nurse determines it is safe and appropriate)

☐ Yes ☐ No

Name of Licensed Prescriber (print): ___________________________ Title: _______________

Signature of Licensed Prescriber: ____________________________ Date: ________________

Rising Tide Charter Public School
Self-Administration Prescription Medication Plan

Please note that self-administration is usually reserved for inhalers, Epi-Pens, glucose monitoring tests, and insulin delivery systems. Once completed and signed, this form may be copied and given to the student for whom self-administration is determined to be appropriate. The original is to be retained by the school nurse in the medication book. The medication is to be entered and recorded in the computerized health record for inclusion in the medication statistics.

Student Name: ______________________ DOB: __________ Grade: _______

Medication to be taken: ____

Route: ______________________ Time: ___________________________

Instructions: ____

____

____

Amount of medication to be carried by the student: ______________________

How will medication be carried by the student?
- ☐ Backpack
- ☐ Pocketbook/purse

Where will replenishing of medication be done?
- ☐ In the Nurse's Office
- ☐ At Home

When should the student go to the Nurse's Office?
- ☐ At the end of each school day
- ☐ At the end of each week
- ☐ When medication orders change

If I have the following side effects/symptoms, I should go to the Nurse's Office:

____

____

____

Student Signature: ___________________________ Date: __________________

Parent/Guardian Signature: ______________________ Date: _______________

Nurse's Signature: ______________________________ Date: _______________

Plan Discontinuation:

Reason: ______________________________ Effective Date: _______________

Authorized by: ____

Signature: ____

MEDICATION ADMINISTRATION PLAN (To be completed by school nurse)

Medication: ________________________ Date ordered: ___________________

Expiration Date: ____________________ Time to be given: _______________

IHCP: Yes/No Refrigerate: Yes/No Order received: Yes/No

Nurse's Signature: ____