School Nursing Manual

Forms and Samples

May 2009

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RQ = Required S = Sample S* = Sample with Required Elements

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RQ = Required S = Sample S* = Sample with Required Elements

DELAWARE EMERGENCY TREATMENT DATA CARD

Student's Name ________________________________ Birth Date ___________ School District____________________
Last Name First Name M.I.

School_______________________________ Grade________ Homeroom or Teacher_______________ Bus No._____

Home Address_____________________________________ Development_____________________ Home Phone_____

Resides with______________________________________ Relationship______________________________________

Mother/Guardian's Name_____________________________________ Father/Guardian's Name____________________

Mother's Place of Employment____________________________________ Phone______________________ Ext.____

Father's Place of Employment____________________________________ Phone______________________ Ext.____

Pager number______________________________________ Cellular number_______________________

If parents/guardians cannot be reached, call:

1. ____ ________________
Name Address Phone

2. ____ ________________
Name Address Phone

3. ____ ________________
Name Address Phone

Family Physician__________________ Phone____________ Family Dentist________________ Phone____________

Indicate student's serious medical conditions____

Student is allergic to: ( ) Penicillin ( ) Aspirin ( ) Other_________________________________

Medical Insurance: Medicaid No.________________________________ Other:________________________________
Certificate No. Group No. Type

This information may be shared only on a "need to know" basis with school personnel and emergency medical staff.

- -

SCHOOL EMERGENCY PROCEDURES

Your schools have adopted the following procedures in caring for a student when he/she becomes sick or injured at school:

In case of a life-threatening emergency, the school will call 911 and then follow the steps below. In case of other emergencies and/or need of medical or hospital care:

1. The school will call the home. If there is no answer,
2. The school will call the father's, mother's or guardian's place of employment. If there is no answer,
3. The school will call the other telephone number(s) listed and the physician.
4. If none of the above answer, the school will call an ambulance, if necessary, to transport the student to a local medical facility.
5. Based upon the medical judgment of the attending physician, the student may be admitted to a local medical facility.
6. The school will continue to call the parents, guardians, or physician until one is reached.

If I cannot be reached and the school authorities have followed the procedures described, I agree to assume all expenses for moving and medically treating this student. I also hereby consent to any treatment, surgery, diagnostic procedures or the administration of anesthesia which may be carried out based on the medical judgment of the attending physician.

Parent/Guardian Signature____ Date___________________________

Last Name	First and Middle Name	M	F	Date of Birth	*

SCHOOL HEALTH RECORD – STATE OF DELAWARE

Parent/Guardian Name: ______________________________

Medical Alert *(Chronic illness, Injury, Surgery, with Date; example: 4/98 Asthma)*

School Student is Attending
(Record School Number)

Pre-KN	KN	1	2	3	4	5	6	7	8	9	10	11	12

Immunizations
(May attach State Form)

Exempt	Type	1	2	3	4	5	6
	DTP/DtaP						
	OPV/IPV						
	Hep B						
	Measles						
	Mumps						
	Rubella						
	HIB						
	Varicella						
	Other						

Testing

Date	Test	Type (circle one)	Results	Initials	Date	Test	Type (circle one)	Results	Initials
	TB	**PPD/Risk Assess**				**Lead**	**Blood**		

Physical Examinations
(Documentation in Student's File)

Date	Significant Findings	Date	Significant Findings

Long-term Medications

Name	Start	Stop	Name	Start	Stop

School Nurse Name and Initials

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

*Color Code
BLACK – Neuro BLUE - Respiratory GREEN – Ortho ORANGE – Allergies, Other PINK - Kidney RED - Cardiac YELLOW – Vision

Document #

Student Name: (Last)___________________________________ (First)______________________________

Screening Results

Vision Screening
(Record Actual Acuity, ex: 20/20, 10/10, etc.)

Color Test Date:_______________ ___Pass ___Fail
Depth Perception Date:___________ ___Pass___Fail

Grade													
Date													
Device													
Acuity: *Far* R													
L													
Both													
Near R													
L													
Both													
Glasses/Contacts													
Muscle Balance													
Initials													

Hearing Screening
(P = Pass; F = Fail)

Grade													
Date													
Decibels													
R 1000													
2000													
4000													
L 1000													
2000													
4000													
Aid													
Initials													

Postural Screening

Grade					
Phase I Date					
Results					
Phase II Date					
Initials					

Other Information *(Ex: Comments, Conferences, etc)*

Referral Information
(Follow Up for Screenings Only)

Issue/Concern	Date Sent	Follow-up Summary	Issue/Concern	Date Sent	Follow-up Summary

Student Name: (Last)________________________ (First)_________________________

Delaware School Health Record

Additional Notes

Date	Conferences, Comments, Etc.

STATE OF DELAWARE

INDIVIDUAL HEALTH SERVICES LOG

District/School: ____

School Nurse: ________________________________ ________________________________

(printed name / signature / initials) (printed name / signature / initials)

Date	In/Out	Class/ Grade	Reason (Category/Chief Complaint)		Intervention/ Comments	Outcome	Rx/Tx	Referral (to whom/complete)		Initials

Category:

ILA – Illness: Acute
ILC – Illness: Chronic
INON – Injury: On-going care

INS – Injury: School
INO – Injury: Outside of school
T – Tube feeding, ostomy, other

Rx – Medication
C – Catheterization
P – Special Procedure

M – Miscellaneous
C – Conference
S – Screening

Medical Alerts:______________________________ Birth Date:__________________ Student:____

CHILDREN'S SERVICES COST RECOVERY PROJECT LOG

EPSDT Nursing Service Description by Medicaid Reporting Number

Date: ____/_____/______ District/School:____

School Nurse:____

Signature(s) Required (Initial below if more than one nurse)

EPSDT Reporting Number	Time In	Time Out	Student Name

Document #229

STUDENT ACCIDENT REPORT FORM

This form, or a similar one preferred by the district, is to be completed on each injury which occurs in the school building, on the school grounds, while the student is on his/her way to or from school activities that result in one-half or more day's absence from school or requires a doctor's attention or both. Submit all completed reports to the designated office in school district. It is recommended that a duplicate copy of this report be prepared for the school's file.

1. NAME____ AGE________ SEX: M______ F________

2. DISTRICT__________________ SCHOOL_______________ GRADE OR CLASSIFICATION_______

3. TIME Accident Occurred: Hour_______a.m. or p.m. Date_________ DATE Accident Reported________

4. NATURE OF ACCIDENT. Check all appropriate areas. (To be completed by nurse or other designated personnel.)

Nature of Injury		Part of Body Injured (Indicate L or R for left or right when applicable)			
___ Abrasion	___ Dental	___ Ankle	_____ Face	____ Knee	____ Shoulder
___ Bite	___ Dislocation	___ Arm	_____ Finger	____ Leg	____ Stomach
___ Bruise	___ Foreign body in eye	___ Back	_____ Foot	____ Lip	____ Tooth
___ Burn	___ Laceration	___ Chest	_____ Hand	____ Mouth	____ Wrist
___Chemical Burn	___ Puncture	___ Collar Bone	_____ Head	____ Neck	____ Other
___ Concussion	___ Sprain/Strain	___ Elbow	_____ Hip	____ Nose	
___ Cut	___ Other (specify) ____________________	___ Eye		____ Scalp	

5. Subjective Data____

____

____

____

Objective Data____

____

____

____

____ Date of last tetanus shot______________

Assessment____

Intervention____

____

____

CONTINUE TO NEXT PAGE

STUDENT ACCIDENT REPORT FORM - continued

6. How did accident happen? What was student doing? Where was student? List specifically any unsafe act(s) and/or unsafe condition(s). Specify any tool, machine or equipment involved.

____

____

____

7. What action(s) was taken and by whom?

First aid treatment	________	By whom?	(Enter name)______________________
Sent to school nurse	________	By whom?	(Enter name)______________________
Sent home	________	By whom?	(Enter name)______________________
Sent to physician	________	By whom?	(Enter name)______________________
Sent to hospital	________	By whom?	(Enter name)______________________

8. Was parent/guardian or anyone notified? Yes_ No_______________

   When: Date____________________ Time__________ How_____________________________

9. Please complete below:

Location		Activities		Area	
Athletic Field	____	Apparatus	___	Building	____
Auditorium	____	Ball Playing	___	Grounds	____
Cafeteria	____	Baseball	___	Interscholastic	____
Classroom	____	Basketball	___	Intramural	____
Corridor	____	Field Hockey	___	Physical Education	____
Dressing Room	____	Football	___	Shops	____
Gymnasium	____	Free Play	___	Labs	____
Home Economics	____	Gymnastics	___		
Laboratories	____	Running	___		
				To and From School	
Lockers	____	Soccer	___	Bicycle	____
School Grounds	____	Softball	___	Motor Veh Passenger	____
School Shops	____	Swimming	___	Motor Veh Bicycle	____
Science	____	Track and Field	___	Motor Veh Pedes.	____
Showers/Dressing Room	____	Volleyball	___	School Bus	____
Stairs Inside	____	Wrestling	___	Streets and Walks	____
Stairs and Walks Outside	____	Other	___	Other	____
Toilet Rooms	____				
Voc and Indus. Arts	____				

10. Total number of school days lost ______ (To be recorded when student returns to school)

11. Student is covered by Student Accident Insurance Yes______ No_________

12. Person in charge when accident occurred (Signature)________________________________

______________________________	______________________________
Nurse	Principal

School Year 2008-2009

Due Date: August 31, 2009

Return to :
Linda C. Wolfe, RN
Health Services

Justification:

The State Board shall prescribe rules and regulations governing the protection of health, physical welfare and physical inspection of public school children in the State. 14 Del Code 122(b)(2)

School or School District: ____

I. Clients	Students	Staff	Visitors	Total	% Total Stud Population	% Total Staff Population
A. Unduplicated Clients receiving Health Services						
B. Nurse Office Visits (minutes out of class)						
1. < 15 min.						
2. 16 - 30 min.						
3. 31 - 45 min.						
4. 46 - 60min.						
5. 61 - 120 min.						
6.> 120 min.						
7. Average time						
8. Total Visits (B1 - B6)						
C. Disposition:						
1. Returned to class/activity						
2. Sent to school staff (ex. principal, counselor)						
3. Sent to Wellness Center						
4. Sent home (nurse directed)						
5. Went home (parent directed)						
6. Exclusion for communicable disease						
7. Sent for immediate evaluation/treatment						
8. 911						
9. Not Seen						
10. Other						
D. Contacts/Communication/Notification re: client						
1. Parents/Guardian						
2. School						
3. Community						

II. Nursing Care: Assessment & Intervention	Students	Staff	Visitors	Total	Outcome (Resolution/ Improvement)	
A. Functional: *Care to promote basic health needs*						
1. Activity/Exercise					n/a FY09	
2. Comfort/Rest					n/a FY09	
3. Growth & Development/Nutrition					n/a FY09	
4. Self-Care					n/a FY09	
B. Physiological: *Care to promote optimal biophysical health*						
1. Physical Health & Well-Being						
a. Special Nursing Procedures					n/a FY09	
b. First Aid/ Emergency Care					n/a FY09	
c. Body Systems Support (ex. cardiac, resp., tissue)					n/a FY09	
2. Pharmacological					n/a FY09	

a. Medications						
b. Treatments						
c. Unduplicated Students receiving Rx/Tx						
C. Psychosocial: *Care to promote optimal emotional health and social functioning*						
1. Coping/Emotional Support					n/a FY09	
2. Communication/Relationships					n/a FY09	
3. Knowledge					n/a FY09	
4. Behavior/Self-perception					n/a FY09	
D. Environment: Car*e to protect and promote health and safety*						
1. Health Care System					n/a FY09	
2. Risk Management					n/a FY09	
3. Individual Emergency Plan						
4. Individualized Healthcare Plan						
5. IEP/504 Plan						
E. Nursing Assessments/Interventions *unclassified*						
F. Non-Nursing Interventions						
G. TOTAL Interventions (A through G)						
	Total	Referred	Completed Referral	% Completed		
H. Office Visits						
III. Health Screening	Total Screened	Referred	Completed Referral	% Completed	*Number Required	# Required Screened
A. Required (Students)						
1. Hearing						
2. Immunization						
3. Postural/Gait						
4. Physical report						
5. Athletic Exam (DIAA)						
6. TB Questionnaire/Reading						
7. Vision						
8. Total Number of Required Screenings						
B. Non-Required (Students)						
1. Blood Pressure						
2. BMI						
3. Dental						
4. Developmental						
5. Pediculosis						
6. Record Review						
7. Other						
8. Total Number of Non-Required Screenings						
C. Total Student Screenings						
D. Staff						
1. BP						
2. TB Questionnaire/Reading						
3. Other						
4. Total Number						
E. Total Screenings (III. C + III. D.4)						

*Reg. 815.2.1.1 Each public school student in kindergarten and in grades 2,4, 7 and grades 9 or 10 shall receive a vision and a hearing screening by January 15th of each school year.

Date: ______________________ Signature______________________________

INTERAGENCY CONSENT TO RELEASE INFORMATION

Sharing information helps agencies provide better services to me/my child and/or my family. Only those agencies listed below that are planning or giving services to me or my child may receive information.

When relevant, shared information will include:

* my/child's full name	* telephone number	* address
* social security number	* birthdate	* names of parents/brothers/sisters/spouse
		* items specified below

I understand that this form is **not** used to release information about drug and alcohol treatment.

I, ____, also allow all of the listed agencies to share the following information about my child/me, ____ (birthdate ____________________________).

Please specify: INFORMATION THAT MAY BE SHARED

____

____

____

____

____

____

____

____

____

____

Please specify: AGENCIES THAT MAY SEND/RECEIVE INFORMATION
(Include Originating Agency Name)

____

____

____

____

____

____

____

____

____

____

AGREEMENT TO RELEASE

This permission is good for one year after I sign it.

I agree to the interagency sharing of information. I can take away my permission at any time. I can also change it at any time unless the information has already been released.

Print Name: ____

Signature: ____

Date: ____

Please check all that apply:
Parent [ ] Guardian [ ] Legal Adult (18 years) [ ] Minor 12-18, required below *[ ] Custodian [ ]

*A minor must specifically consent to the release of HIV [ ], STD [ ], and pregnancy information [ ].
Signature of minor: ______________________ Date ________________

ORGANIZATION'S AFFIRMATION

As the participating organization's representative, I affirm that I have reviewed this form and its use with the consenting person and that to the best of my knowledge he/she understands.

Witness ______________________ Date __________

Agency ____________________________________

TRANSLATOR'S STATEMENT

I have orally translated/read/signed the above into ______________ (language). To the best of my knowledge, I believe the consenting person understands the nature and use of this form.

Translator's Signature ____________________________ Date ______________________

……………………………………..
Revocation Statement

I, ____ (consenting person), take away the consent I gave to

___________________________ (originating organization) on ______________ (date). I understand

that ____________________________ (originating organization) will notify any participating organization to

which information has been sent or from which information has been received.

Signature ____________________________________ Date ______________________

Witness ____________________________________ Date ______________________

Agency ____________________________________ Revocation letter attached (Yes/No) ______

- ♦ The Interagency Consent to Release Information Form is based on the Interagency Confidentiality Agreement for Accessibility in Data Sharing between Participating Organizations: Department of Health & Social Services (DHSS), Department of Services for Children, Youth and their Families (DSCYF), Department of Education (DOE), Department of Correction (DOC), Department of Labor (DOL) and local school districts. This document has been approved by the Attorney General's Office. This form may not be altered in any manner without written authorization from the State of Delaware Interagency Confidentiality Committee. This form may be photocopied for use by the participating organizations.

The State of Delaware does not discriminate or deny services on the basis of race, religion, color, national origin, sex, disability and/or age.

Letter Regarding School Entry

Dear Parent/Guardian:

According to Delaware laws and Department of Education regulations, all children entering school for the first time are required to provide documentation of the following:

Immunizations[1]
- 5 or more doses of DTaP, DTP or TD vaccine (unless 4th dose was given after the 4th birthday)
- 4 doses of IPV or OPV (unless the 3rd dose was given after the 4th birthday)
- 2 doses of measles, mumps and rubella vaccine (first dose after the age of 12 months, second dose after the 4th birthday)
- 3 doses of Hepatitis B vaccine
- 2 doses of Varicella or a written disease history by a licensed healthcare provider **(09/10 School Year:** New enterers to Grades K-6; **10/11 School Year:** New enterers to Grades K-7; etc.)

Physical[2]
- Current, within the two years prior to entry into school

Tuberculosis[3]
- Results of Mantoux screening completed within the past 12 months or risk assessment as recommended by Delaware Division of Public Health

Lead blood test[4]
- Documentation for children entering kindergarten or pre-school program

Please provide the school nurse with the necessary information. We appreciate your cooperation in complying with the law.

Sincerely,

(Superintendent or Principal)

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[1] Delaware Code, Title 14, Section 131
[2] Department of Education Regulation 804
[3] Department of Education Regulation 805
[4] Delaware Code, Title 16, Chapter 26

Varicella Verification

(School/School District Name)

VARICELLA (Chickenpox) IMMUNITY STATEMENT

Name:______________________________________ Birthdate:_______________
Please Print

Check one of the following boxes regarding Varicella (Chickenpox) Immunity:

- ☐ Varicella Vaccine Date Given:__________________________________
- ☐ Varicella Lab Evidence Date:_______________________________________
- ☐ Varicella Disease Age of child when he/she had Chickenpox:__________

Printed Name:________________________________
Licensed healthcare provider

Signature:___________________________________ Date:___________________

IMMUNIZATION AFFIDAVIT REQUIRED PER 14 DEL. CODE SEC. 131

AFFIDAVIT OF RELIGIOUS BELIEF
STATE OF DELAWARE
………. COUNTY

1. (I) (We) (am) (are) the (parent[s]) (legal guardian[s]) of ………………………..
Name of Child

2. (I) (We) hereby (swear) (affirm) that (I) (we) subscribe to a belief in a relation to a Supreme Being involving duties superior to those arising from any human relation.

3. (I) (We) further (swear) (affirm) that our belief is sincere and meaningful and occupies a place in (my) (our) life parallel to that filled by the orthodox belief in God.

4. This belief is not a political, sociological or philosophical view of a merely personal moral code.

5. This belief causes (me) (us) to request an exemption from the mandatory school vaccination program for ______________________________________.
Name of Child

____
Signature of Parent(s) or Legal Guardian(s)

SWORN TO AND SUBSCRIBED before me, a registered Notary Public, this _________
day of ________, 2_______.
______________________________(Seal)

Notary Public
My commission expires:

____

Instructions for Completing School Immunization Records

1. *If a computer is not used for immunization records, initiate a School Immunization Record form on each new enterer in Grades K-12 even if no immunization information is available. If a computer is used, print a copy and mail to Immunization Program.*
2. *Print legibly with a ballpoint pen and bear down.*
3. *Enter the appropriate "School Information" and "Student Information."*
4. *Enter the dates of documented immunizations in the area entitled "Immunizations."*
5. *Retain one copy of the Immunization Record for pupil's record folder. Mail one copy to Immunization Program.*
6. *Obtain additional forms from your District Coordinator, District School Nurse Liaison or Immunization Program (1-800-282-8672).*
7. *Access Delaware's Immunization Registry at http://vacattack.dhss.delaware.gov.*

Delaware Division of Public Health
School Immunization Record

Mail To: Immunization Program, HMPC
Jesse Cooper Bldg. D320A, Dover DE 19901

1. School Information

School Code:	School:

2. Student Information

Date of Birth:	Student Name:		
Sex: oMale oFemale	Last	First	Mi
Race: oAlaskan Native oAmerican Indian oAfrican American oCaucasian oHispanic oPacific Island/Asian oUnknown oOther	Student Address: Address City	 State	 Zip

3. Immunizations – Shaded Vaccines Required

DTP/Hib 1 / /	**DTP/Hib 2** / /	**DTP/Hib 3** / /	**DTP/ Hib 4** / /	**DTaP/Hib 4** / /
DTP/DTaP 1 / /	**DTP/DTaP 2** / /	**DTP/DTaP 3** / /	**DTP/DTaP 4** / /	**DTP/DTaP 5** / /
DT/Td 1 / /	**DT/Td 2** / /	**DT/Td 3** / /	**DT/Td 4** / /	**DT/Td 5** / /
OPV/IPV 1 / /	**OPV/IPV 2** / /	**OPV/IPV 3** / /	**OPV/IPV 4** / /	**OPV/IPV 5** / /
MMR 1 / /	**MMR 2** / /	**HepB 1** / /	**HepB 2** / /	**HepB 3** / /
Hib 1 / /	**Hib 2** / /	**Hib 3** / /	**Hib 4** / /	
Hep B 1 (2 dose Version Only) / /	**Hep B 2 (2 dose Version Only)** / /	**Hep B/Hib 1** / /	**Hep B/Hib 2** / /	**Hep B/Hib 3** / /
Varicella 1 / /	**Varicella 2** / /	**Lyme Vax 1** / /	**Lyme Vax 2** / /	**Lyme Vax 3** / /
Pneumococcal Conjugate 1 / /	**Pneumococcal Conjugate 2** / /	**Pneumococcal Conjugate 3** / /	**Pneumococcal Conjugate 4** / /	
Pneumococcal Polysaccharide1 / /	**Pneumococcal Polysaccharide 2** / /	**Hep A 1** / /	**Hep A 2** / /	
Influenza 1 / /	**Influenza 2** / /	**Other:** / /	Other: / /	

CH- 125 New 12/00 DOC. # 35-05-20/00/12/06

Employee Name:____ Date:_____________

Employee Signature:____

Delaware Department of Education[1]
CONFIDENTIAL TB Health Questionnaire for School Employees

The Delaware Department of Education Regulation 805[2] requires all school employees to provide Mantoux tuberculosis (TB) skin test results during the first 15 days of employment. Every 5th year, by October 15, all[3] personnel shall complete the TB Health Questionnaire for School Employees as a routine follow-up screening. This document shall be retained in the same manner as other confidential personnel medical information.

Please consider the following questions and indicate one response in the box below:

1. In the past five years, have you lived or been in close contact with anyone who had TB disease?
2. Do you currently have any of the following symptoms which are unexplained and which have lasted at least three weeks?
   Cough
   Fever
   Night sweats
   Weight loss
3. Have you ever had a positive HIV test?
4. In the past five years, have you ever used illegal intravenous drugs?
5. In the past five years, have you been incarcerated?
6. In the past five years, have you been homeless?
7. Consider the list of countries/continents below:
   - Africa
   - Asia
   - Eastern Europe
   - Caribbean
   - Latin America
   - Pacific Islands

   In the past five years, have you stayed/lived in one of these countries for 1 month or longer?
   In the past five years, have you lived or been in close contact with someone who stayed/lived in one of these countries for 1 month or longer?

Can you answer "yes" to any of the above questions? ( ) Yes ( ) No

If you checked YES, you are <u>required</u> (within 2 weeks) to provide verification from a licensed health care provider or the Division of Public Health that there is no communicable threat.

If you have any questions about your risk of infection, please speak with your healthcare provider or contact the Delaware Division of Public Health TB Elimination Program at 302-741-2923.

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[1] Developed in collaboration with the Division of Public Health, 2/05.
[2] Regulation 805 can be accessed at http://www.state.de.us/research/AdminCode/title14/800
[3] Anyone with a previous positive Mantoux shall provide updated information regarding disease status and treatment to the public school by October 15 every fifth year if treatment was previously contraindicated, incomplete or unknown.

Delaware Department of Education[1]
Student TB Risk Assessment Questionnaire

Prior to use of this form, the school nurse must review the student's health records and assure that the student is compliant with the requirement for a current physical (within past 2 years) and up-to-date immunizations. The questionnaire must be administered by the school nurse to the parent/guardian in person or by phone and signed by the parent who answered the questions.

Name:____
Last First MI

Date of Birth: ____/_____/____ Date Form Completed ___/___/___

1. Has your child had any contact with a case of TB?
2. Was any household member, including your child, born in or has he/she traveled to areas where TB is common (i.e., Africa, Asia, Latin America, and the Caribbean)?
3. Does your child have regular (i.e., daily) contact with adults at high risk for TB (i.e., those who are HIV infected, homeless, incarcerated, and/or illicit drug users)?
4. Does your child have any health conditions or take medications that might affect his/her immune system?

Any "yes" response is considered a positive risk factor and is an indication for administering a Mantoux tuberculin skin test to the child.

This child has been screened by his/her school nurse for risk of exposure to tuberculosis. Based upon the results of the TB Risk Assessment Questionnaire the child,

____**does not** require a Mantoux skin test

____**does** require a Mantoux skin test

Mantoux testing and documentation is required to be completed and given to the school nurse by ____/_____/____ (date) or your child will be excluded from school.

School Nurse comments:____

____

____

School Nurse (signature) ____

I give permission for the school nurse and my child's primary care physician ___________________________ (name of physician) to share information relating to this form.

Parent/Guardian (signature) ____

[1] Student questionnaire was developed in collaboration with the Division of Public Health, 8/04. Regulation 805, The School Health Tuberculosis (TB) Control Program, can be accessed at http://www.state.de.us/research/AdminCode/title14/800

Name____ **Date**______________________

DELAWARE DEPARTMENT OF EDUCATION
CONFIDENTIAL HEALTH QUESTIONNAIRE FOR VOLUNTEERS

All school employees are required to have a tuberculosis (TB) skin test. The purpose of this requirement is to safeguard school-aged children from exposure to TB in the school setting. In the same way, this questionnaire is designed to identify volunteers who MAY have been exposed to TB and thus need further screening. A school designee will collect and monitor the Health Questionnaire, which will be stored in the School Nurse's office in a confidential manner.

Please consider the following questions:

Have you ever lived or been in close contact with anyone who had TB disease?
Have you ever had a positive HIV test?
Have you ever used illegal intravenous drugs?
Have you ever been incarcerated?
Have you ever been homeless?
Do you <u>currently</u> have any of the following symptoms which are <u>unexplained</u> and which have lasted at least <u>three weeks</u>?
  Cough
  Fever
  Night sweats
  Weight loss

7. Consider the list of countries/continents below:
   - Africa
   - Asia, including China, Vietnam, Korea, Indonesia, India, Pakistan, Bangladesh
   - Eastern Europe, including Russia and former Soviet Union, Armenia
   - Haiti
   - Latin America, including Mexico, Guatemala, and South America
   - Pacific Islands, including Philippines

   Were you born in one of these countries?
   Have you ever stayed/lived in one of these countries for 1 month or longer?
   Have you ever lived or been in close contact with someone who stayed/lived in one of these countries for 1 month or longer?

Can you answer "yes" to <u>any</u> of the above questions? ( ) Yes ( ) No
If you checked <u>yes</u>, you are <u>required</u> to have a Mantoux test prior to your assignment as a volunteer.

Have you ever had a positive skin test for tuberculosis? ( ) Yes ( ) No
If you checked <u>yes</u>, you are <u>required</u> to provide documentation related to current disease status prior to your assignment as a volunteer.

These requirements are for the safety of our school and for your personal health. Screening for tuberculosis is recommended by health professionals for any individual who is at risk. Routine screening, using a Mantoux tuberculin skin test, can detect if a person has been exposed to tuberculosis. Such early identification is of great benefit in reducing the effects of disease.

If you have any questions about your risk of infection, please speak with your healthcare provider or plan to discuss it at your next examination. For additional information, you can contact the Delaware Division of Public Health TB Elimination Program at 302-739-6620.

Affidavit of Religious Belief

STATE OF DELAWARE

____________ COUNTY

1. (I) (We) (am) (are) the (parent[s]) (legal guardian[s]) (Relative Caregiver[s]) of

____
Name of Child

1. (I) (We) hereby (swear) (affirm) that (I) (we) subscribe to a belief in a relation to a Supreme Being involving duties superior to those arising from any human relation.

2. (I) (We) further (swear) (affirm) that our belief is sincere and meaningful and occupies a place in (my) (our) life parallel to that filled by the orthodox belief in God.

3. This belief is not a political, sociological or philosophical view of a merely personal moral code.

4. This belief causes (me) (us) to request an exemption from the mandatory Mantoux tuberculin skin test for ____.
Name of Child

____
Signature of Parent(s) or Guardian(s)

SWORN TO AND SUSCRIBED before me, a registered Notary Public, this ___________ day of _______________________________, 20____.

_______________________________(Seal)
Notary Public

My commission expires:

____

DELAWARE SCHOOL PHYSICAL EXAMINATION FORM

To be completed by licensed medical physician, nurse practitioner or physician's assistant.

Name:____________________ **Sex:**______ **DOB:**____________

Date:____________________ **Examiner:**____________________

PLEASE CHECK IF CHILD HAS HAD DIFFICULTY WITH ANY OF THE FOLLOWING. GIVE DATES AND ADDITIONAL INFORMATION UNDER COMMENTS.

[ ] ADD/ADHD	[ ] Body Piercing/Tattoo	[ ] Emotional	[ ] Physical Disability
[ ] Allergies	[ ] Bone/Spine	[ ] Hearing	[ ] Seizures
[ ] Asthma	[ ] Bowel/Bladder	[ ] Heart	[ ] Speech
[ ] Behavior	[ ] Chicken Pox	[ ] Infections	[ ] Surgery
[ ] Bleeding	[ ] Diabetes	[ ] Kidney	[ ] Vision

[ ] OTHER ____

Comments:____

____

Height:________ **Weight:**________ **BP:**________ **Pulse:**________

Vision: **Right**____________ **Left**____________

Hearing: **Right**____________ **Left**____________

Lead Screening: **Date Completed**____________ **Results**____________

Hematocrit/Hemoglobin: **Date Completed**____________ **Results**____________

PPD (Mantoux): Date Placed________ **Date Read**________ **Results (in mm)**______
or
TB Risk Assessment: Date Completed____________ **Results**____________

3. Immunizations – *Shaded Vaccines Required*

DTP/Hib 1 / /	**DTP/Hib 2** / /	**DTP/Hib 3** / /	**DTP/ Hib 4** / /	**DTaP/Hib 4** / /
DTP/DTaP 1 / /	**DTP/DTaP 2** / /	**DTP/DTaP 3** / /	**DTP/DTaP 4** / /	**DTP/DTaP 5** / /
DT/Td 1 / /	**DT/Td 2** / /	**DT/Td 3** / /	**DT/Td 4** / /	**DT/Td 5** / /
OPV/IPV 1 / /	**OPV/IPV 2** / /	**OPV/IPV 3** / /	**OPV/IPV 4** / /	**OPV/IPV 5** / /
MMR 1 / /	**MMR 2** / /	**HepB 1** / /	**HepB 2** / /	**HepB 3** / /
Hib 1 / /	**Hib 2** / /	**Hib 3** / /	**Hib 4** / /	
Hep B 1 (2 dose Version Only) / /	**Hep B 2 (2 dose Version Only)** / /	**Hep B/Hib 1** / /	**Hep B/Hib 2** / /	**Hep B/Hib 3** / /
Varicella 1 / /	**Varicella 2** / /	**Lyme Vax 1** / /	**Lyme Vax 2** / /	**Lyme Vax 3** / /
Pneumococcal Conjugate 1 / /	**Pneumococcal Conjugate 2** / /	**Pneumococcal Conjugate 3** / /	**Pneumococcal Conjugate 4** / /	
Pneumococcal Polysaccharide1 / /	**Pneumococcal Polysaccharide 2** / /	**Hep A 1** / /	**Hep A 2** / /	
Influenza 1 / /	**Influenza 2** / /	**Other:** / /	Other: / /	

CHILD'S NAME__________________________

PHYSICAL EXAMINATION	Check (✓) NORMAL	ABNORMAL	COMMENTS
General Appearance			
Head/Scalp			
Eyes			
Ears			
Nose/Throat			
Mouth/Teeth/Gums			
Heart			
Chest/Lungs			
Skin			
Abdomen/Hernia			
Genitalia			
Neurological			
Developmental			
Musculoskeletal			
Nutrition			

Health Concerns or Special Needs Identified:__________________________________

____

____

FOR CHRONIC CONDITIONS:

Please attach care plan, protocols, and/or emergency care plan.

Children with life-threatening conditions need an emergency care plan in place.

Recommendations or Referrals:____

____

____

Examiner's Signature:___________________________ **Date:**___________________

Printed Name_______________________________ **Phone Number:**_____________

Address:____

DELAWARE INTERSCHOLASTIC ATHLETIC ASSOCIATION

Parents/Guardian: The DIAA pre-participation physical evaluation and consents form is a five page document. Pages one, two and four require your signature while page five is a reference for you to keep. This physical evaluation must be completed after May 1 of the current year playing sports and runs through June 30 of the following year.

Athlete: __________________ Phone: ____________ School: ______________

Age:________ Gender: ________ Date of Birth: __________ Grade: ______

Parent/Guardian Name: (Please Print) ______________________________________

PARENT/GUARDIAN CONSENTS

_________________________ Has my permission to participate in all interscholastic
(Name of Athlete) sports **not checked below**.

If you check any sport in this box it means the athlete will not be permitted to participate in that sport.

Collision		Contact		Non-Contact	
___football	ice hockey	___ volleyball	__ softball	__ cross country	__ tennis
___soccer	boys' lacrosse	___field hockey	__ baseball	__ swimming	__ golf
___wrestling		___basketball	__ girls lacrosse	__ track	__ crew
		___squash		__ cheerleading	

1. My permission extends to all interscholastic activities whether conducted on or off school premises. I have read and discussed page 5, which is the list of items that protect against the loss of athletic eligibility, with said participant and I will retain that page for my reference. I have also discussed with him/her and we understand that physical injury, including paralysis, coma or death can occur as a result of participation in interscholastic athletics. I waive any claim for injury or damage incurred by said participant while participating in the activities not checked above.
   Parent Signature: ________________________________ **Date**: ____________________

2. To enable DIAA and its full and associate member schools to determine whether herein named student is eligible to participate in interscholastic athletics, I hereby consent to the release of any and all portions of school record files, beginning with the sixth grade, of the herein named student, including but not limited to, birth and age records, name and residence of student's parent(s), guardian(s) or Relative Care Giver, residence of student, health records, academic work completed, grades received and attendance records.
   Parent Signature: ________________________________ **Date**: ____________________

3. I further consent to DIAA's and its full and associate member schools use of the herein named student's name, likeness, and athletically related information in reports of interscholastic practices, scrimmages or contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics.
   Parent Signature: ________________________________ **Date**: ____________________

4. By this signature, I hereby consent to allow the physician(s) and other health care providers(s) selected by myself or the schools to perform a pre-participation examination on my child and to provide treatment for any injury received while participating in or training for athletics for his/her school. I further consent to allow said physician(s) or health care provider(s) to share appropriate information concerning my child that is relevant to participation, with coaches, medical staff, Delaware Interscholastic Athletic Association, and other school personnel as deemed necessary. Such information maybe used for injury surveillance purposes.
   Parent Signature: ________________________________ **Date**:__________________

DIAA Preparticipation Physical Evaluation

HISTORY FORM

DATE OF EXAM____________________

Name________________________________ Sex_______ Age________ Date of birth_______________

Grade______ School________________________ Sport(s)______________________________________

Address____ Phone____________________

Personal physician____

In case of emergency, contact

Name______________________ Relationship__________ Phone (H)____________ (W)________________

Explain "**YES**" answers below.
Circle questions you don't know the answers to.

		Yes	No
1.	Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2.	Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5.	Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6.	Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8.	Does your heart race or skip beats during exercise?	☐	☐
9.	Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection		
10.	Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	☐	☐
11.	Has anyone in your family died for no apparent reason?	☐	☐
12.	Does anyone in your family have a heart problem?	☐	☐
13.	Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
14.	Does anyone in your family have Marfan syndrome?	☐	☐
15.	Have you ever spent the night in a hospital?	☐	☐
16.	Have you ever had surgery?	☐	☐
17.	Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:	☐	☐
18.	Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
19.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	☐	☐

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/ fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/toes

		Yes	No
20.	Have you ever had a stress fracture?	☐	☐
21.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22.	Do you regularly use a brace or assistive device?	☐	☐
23.	Has a doctor ever told you that you have asthma or allergies?	☐	☐
24.	Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
25.	Is there anyone in your family who has asthma?	☐	☐
26.	Have you ever used an inhaler or taken asthma medicine?	☐	☐
27.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28.	Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29.	Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30.	Have you had a herpes skin infection?	☐	☐
31.	Have you ever had a head injury or concussion?	☐	☐
32.	Have you been hit in the head and been confused or lost your memory?	☐	☐
33.	Have you ever had a seizure?	☐	☐
34.	Do you have headaches with exercise?	☐	☐
35.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36.	Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37.	When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39.	Have you had any problems with your eyes or vision?	☐	☐
40.	Do you wear glasses or contact lenses?	☐	☐
41.	Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42.	Are you happy with your weight?	☐	☐
43.	Are you trying to gain or lose weight?	☐	☐
44.	Has anyone recommended you change your weight or eating habits?	☐	☐
45.	Do you limit or carefully control what you eat?	☐	☐
46.	Do you have any concerns that you would like to discuss with a doctor?	☐	☐

FEMALES ONLY

47. Have you ever had a menstrual period? ☐ ☐
48. How old were you when you had your first menstrual period?____
49. How many periods have you had in the last 12 months?________

Explain "Yes" answers here:______________________________

____

____

____

____

____

____

____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete________________________ Signature of parent/guardian____________________ Date_________

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DIAA PRE-PARTICIPATION PHYSICAL EVALUATION

Name____ Date of Birth________________________
Height__________ Weight_________ %Body fat (optional)________ Pulse__________ BP___/___(___/___)
Vision R 20/___ L20/___ Corrected: Y N Pupils: Equal____ Unequal____ Risk behaviors discussed: Y N
(diet, weight, driving, drugs, alcohol, sexuality, safety, stress)

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary(males only)+			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only +Having 3rd party present is recommended for the genitourinary exam

Notes:

Please choose one of the following four (4) options:

___1. Cleared without restriction
___2. Cleared, with recommendations for further evaluation or treatment for:
____
___3. **Not Cleared, but needs additional evaluation by (whom):*____
___4. Not Cleared for either ___All sports ___Certain sports:____
Reason:____

Please note any necessary equipment, medications, or restrictions for cleared athlete to play or practice:

By this signature, I hereby state that I have performed a pre-participation examination in accordance with DIAA standards (current edition of Physician and Sports Medicine's Pre-participation Physical Evaluation) and certify that the above clearance and attached PPE is accurate, complete and compliant to such standards. I also agree that I have documented and signed any playing restrictions on the High School Athlete Medical Card (pg 4).

HealthCare Provider's Signature:____ Date:________________
Printed Name:____________________________________ Title:_______________ Phone:_______________

**If Option 3 checked then Referred Physician needs to complete below:*
____ Cleared- no restriction _____Cleared with the following restrictions:_________________________________
____ Not Cleared for ___All sports ___Certain sports:____
Referred Physician Signature:______________________________Print:____________________ Date:__________

SCHOOL ATHLETE MEDICAL CARD

(Parent/Guardian: please print and complete Sections 1, 2 & 3)

Section 1: **CONTACT/PERSONAL INFORMATION**

NAME:____ SPORT:________________ SS#:________________

AGE:____GRADE:____ BIRTH DATE:___________ GUARDIAN NAME:___________________________________

ADDRESS:____

PHONE: (H)_____________________ (W)_________________ (C)_________________ (P)_________________

Other authorized person to contact in case of emergency:

NAME:____ PHONE(s):______________________________________

NAME:____ PHONE(s):______________________________________

Preference of Physician (and permission to contact if needed):

NAME:____ PHONE:______________________________

HOSPITAL PREFERENCE:_______________________ INSURANCE:_______________________________________

POLICY #:_________________________ GROUP:__________________________ PHONE:____________________

Section 2: **MEDICAL INFORMATION**

MEDICAL ILLNESSES:____

LAST TETANUS (mo/yr):____________ ALLERGIES:____

MEDICATIONS:____

(any medications that may be taken during competition require a physician's note)

PREVIOUS HEAD/NECK/BACK INJURY:____

PREVIOUS HEAT-RELATED PROBLEMS:____

PREVIOUS SIGNIFICANT INJURIES:____

ANY OTHER IMPORTANT MEDICAL INFORMATION:____

Section 3: **Consent for Athletic Conditioning, Training and Health Care Procedures**

I hereby give consent for my child to participate in the school's athletic conditioning and training program, and to receive any necessary healthcare treatment including first aid, diagnostic procedures, and medical treatment, that may be provided by the treating physicians, nurses, athletic trainers, or other healthcare providers employed directly or through a contract by the school, or the opposing team's school. The healthcare providers have my permission to release my child's medical information to other healthcare practitioners and school officials. In the event I cannot be reached in an emergency I give permission for my child to be transported to receive necessary treatment. I understand that Delaware Interscholastic Athletic Association or its associates may request information regarding the athlete's health status, and I hereby give my permission for the release of this information as long as the information does not personally identify my child.

Parent/Guardian Signature:____ **Date:**_______________

Athlete's Signature:____ **Date**:_______________

Section 4: **Clearance for Participation**

__ Cleared without restrictions **__ Cleared with the following restrictions:**

Health Care Provider's Signature:_____________________________________ **MD/DO, PA,NP Date**:__________

For office use only*:* *This card is valid from May 1, 20_______ through June 30, 20________*

Note: If any changes occur, a new card should be completed by the parent/guardian. The original card should be kept on file in the school athletic director's or athletic trainer's office. A copy should be kept in the sports' athletic kits. This card contains personal medical information and should be treated as confidential by the school, its employees, agents, and contractors.

Name of School*:* _______________________________ ***Name of ATC:*** ______________________________

Protect Your Athletic Eligibility

YOU ARE NOT ELIGIBLE:

1. If you attend a high school and become 19 years of age before June 15. (Reg. 1009.2.1.1)
2. If you attend a junior high/middle school that terminates in the 8th grade and become 15 years of age before June 15. (Reg. 1008.2.1.1.1)

*3. If you are not legally enrolled at the school which you represent. (Reg. 1008.2.3.1 and Reg. 1009.2.3.1)

4. If you are not residing with your custodial parent(s), court appointed legal guardian(s), Relative Caregiver, or are a student 18 years of age or older and living in the attendance zone of the school you attend unless you are participating in the Delaware School Choice Program, attend a private school or are a boarding school student. **IF YOUR CUSTODIAL PARENT(S), LEGAL GUARDIAN(S) OR RELATIVE CAREGIVER(S) RELOCATES TO A DIFFERENT ATTENDANCE ZONE, YOU MUST NOTIFY YOUR ATHLETIC DIRECTOR IMMEDIATELY.** (Reg. 1008.2.2.1 and Reg. 1009.2.2.1)

*5. If you were absent unexcused or absent due to illness or injury; have been suspended (in-school or out-of-school); or have been assigned to homebound instruction or an alternative school for disciplinary reasons. (Reg. 1008.2.3.4 and 1008.2.3.5 Reg. 1009.2.3.5 and 1009.2.3.6)

6. If you failed to complete the preceding semester for reasons other than personal illness or injury. (Reg. 1008.2.3.6; Reg. 1009.2.3.7)

*7. If you do not pursue a regular course of study and pass at least five credits per marking period (equivalent of four credits in junior high/middle school), two credits of which must be in the areas of Mathematics, Science, English, or Social Studies. **IF YOU ARE A SENIOR, YOU MUST PASS ALL COURSES WHICH SATISFY AN UNMET GRADUATION REQUIREMENT.** (Reg. 1008.2.6.; Reg. 1009.2.6.1)

8. If you transferred and have not been in regular attendance at your receiving school for at least 90 school days unless the transfer was the result of a change in residence by you and your custodial parent(s) or court appointed legal guardian(s) from the attendance zone of the sending school to the attendance zone of the receiving school or you transferred after the end of the previous academic year and completed registration at your receiving school before the first student day of the current academic year. (Reg. 1008.2.4 and Reg. 1009.2.4)
9. If you participated in the Delaware School Choice Program during the previous academic year and transferred to your "home school" for the current academic year without completing your two-year commitment or receiving a release from the sending school. (Reg. 1008.2.3.3; Reg. 1009.2.3.4)
10. If you participated in the Delaware School Choice Program during the previous academic year and transferred to another "choice school" for the current academic year unless you are playing a sport not sponsored by the sending school. (Reg. 1008.2.4.6.1; Reg. 1009.2.4.7.1)
11. If you reached the age of majority (18), occupied a residence in a different attendance zone than your custodial parent(s) or court appointed legal guardian(s), and have not been in regular attendance at your receiving school for at least 90 school days unless you are participating in the Delaware School Choice Program and your application was properly submitted prior to your change of residence. (Reg. 1009.2.2.1.7)
12. If you attend a high school and more than four years has elapsed since you first entered 9th grade, or more than five years has elapsed since you just entered 8th grade in schools with 8th grade eligibility for high school sports. (Reg. 1009.2.7.1 and 2.7.2.1)
13. **If you attend a junior high/middle school in which only grades 7-8 are permitted to participate in interscholastic athletics and more than two years has elapsed since you first entered 7th grade. (Reg. 1008.2.7.1)**
14. **If you attend a junior high/middle school in which grades 6-8 are permitted to participate in interscholastic athletics and more than three years has elapsed since you first entered 6th grade. (Reg. 1008.2.7.2)**
15. If you have played on or against a professional team or have accepted cash or a cash equivalent (savings bond, certificate of deposit, etc.); a merchandise item(s) with an aggregate retail value of more than $150; a merchandise discount; a reduction or waiver of fees; a gift certificate or other valuable consideration for athletic participation. (Reg. 1009.2.5.1.4 and 2.5.1.5)
16. If you have used your athletic status to promote a commercial product or service in an advertisement or personal appearance. (Reg. 1009.2.5.1.7)
17. If you have not received a physical examination from a licensed physician (M.D. or D.O.), a certified nurse practitioner or a certified physician's assistant on or after **May 1** and written consent from your custodial parent(s) or court appointed legal guardian(s) to participate in interscholastic athletics is not on file in the school office. (Reg. 1009.3.1.1.1 and Reg. 1008.3.1.1)
18. If you participate in an all-star game not approved by DIAA before you graduate from high school. (Reg. 1009.5.4)
19. If you are a foreign exchange student not participating in a two-semester program listed by the Council on Standards for International Educational Travel (CSIET). (Reg. 1009.2.8.1.2)
20. If you are an international student not in compliance with all DIAA regulations including Reg. 1009.2.2 residency requirements. (Reg. 1009.2.8.2)

***IF YOU ARE NOT IN COMPLIANCE WITH THESE REQUIREMENTS, YOU MAY NOT PRACTICE, SCRIMMAGE OR PLAY IN A GAME.**

NOTE: Consult with your coach, athletic director, or principal for information concerning additional eligibility requirements.

STUDENT HEALTH HISTORY UPDATE

This information will be shared on a need to know basis with staff, administration and emergency medical staff in the case of an emergency unless you notify us otherwise.

*Date*______________________________*Parent/Guardian's Signature*______________________

*Student*_________________________ *DOB:*________ *Grade*____ *Teacher*_________________

PLEASE CHECK IF CHILD HAS HAD DIFFICULTY WITH ANY OF THE FOLLOWING. GIVE DATES AND ADDITIONAL INFORMATION UNDER COMMENTS.

1.
[ ] ADD/ADHD
[ ] Allergies
[ ] Asthma
[ ] Behavior
[ ] Bleeding
[ ] Body Piercing/Tattoo
[ ] Bone/Spine
[ ] Bowel/Bladder
[ ] Chicken Pox
[ ] Diabetes
[ ] Emotional
[ ] Hearing
[ ] Heart
[ ] Infections
[ ] Kidney
[ ] Physical Disability
[ ] Seizures
[ ] Speech
[ ] Surgery
[ ] Vision
[ ] OTHER____
Comments:____
____

2. Does your child have allergies to medicine, food, latex or insect bites?
NO [ ] YES [ ] To What__________________ What happens________________________
Treatment____

3. Has your child had any illnesses since school ended in June?
NO [ ] YES [ ] Type of illness, with date(s)____

4. Has your child had surgery since school ended in June?
NO [ ] YES [ ] Type of surgery, with date(s)_______________________________________

5. Has your child received any immunizations since school ended in June?
NO [ ] YES [ ] List immunizations, with dates_____________________________________

6. Is your child being treated or evaluated for any health conditions?
NO [ ] YES [ ] List condition____

7. Is your child on any medication or treatment?
NO [ ] YES [ ] Name of medication and/or treatment______________________________
Does your child need medicine during school hours?
NO [ ] YES [ ] ***If yes, please contact the school nurse to make arrangements.***

8. Has your child ever been examined by an eye doctor?
NO [ ] YES [ ] Date of last exam____
NO [ ] YES [ ] Glasses Prescribed
If your child wears glasses or contact lenses, when was the prescription last changed________

9. Has your child had any emotional upsets (recent move, death, separation, divorce) since school ended in June?
NO [ ] YES [ ] List____

10. What is the name of your child's dentist? ____
What is the date of his/her last dental exam? _______________________________________

11. What is the name of your child's primary healthcare provider? __________________________
What is the date of his/her last physical exam? ______________________________________

Thank you.

Vision Referral Letter

Date__

Dear Parent/Guardian:

A recent vision screening test at school indicates that______________________________
(student and grade)
may have some vision difficulty. An eye examination is recommended. Please take

this form with you at the time of examination.

____
(School Nurse)

____
(School)

REASON FOR REFERRAL

Vision Test Results_____________________________________

______Frequent headaches after reading ______Blinking ______Blurred Vision

______Squinting ______Watering Eyes

Remarks____

____

EYE EXAMINER'S REPORT TO SCHOOL

______Glasses Prescribed ______Not Prescribed

____To be worn at all times.
____To be worn at all times except during physical education.
____To be worn for driving.
____To be worn in the classroom.
____Preferential Seating

______Vision to be expected with correction: R 20/ L 20/

______When should student return for reexamination?______

We would appreciate any additional information which may be pertinent to this student's school adjustment.

Date______________________________________ ______________________________________
Signature of Eye Examiner

NOTE: Please complete and return to the school nurse. Thank you.

School Nurse Address__________________________________

School Nurse Fax______________________________________

Hearing Referral Letter

DATE: ________________

Dear Parent/Guardian:

Your son/daughter ____recently failed a hearing screening and may have a hearing problem. You may already be aware of this possible problem and are taking steps to correct it. If not, a medical examination is recommended. Please contact me to discuss the suspected problem.

Many hearing losses today may be corrected before they become serious. While some individuals have a temporary hearing loss during a cold or other infection, it is important that the cause of such a temporary loss be determined and treated to protect the individual's future hearing.

____
Nurse

____
School

EXAMINING PHYSICIAN

(Please complete and return to the school nurse.)

Name___________________________ School____________________ Grade________

Diagnosis _

State Treatment Complete____

____

Additional Medical Recommendations:

Prognosis: Stationary _____ Will improve _____ Progressive _____ Intermittent _____

Educational Recommendations:

Do you advise any of the following educational recommendations for the student?

Speech reading _____ Auditory Training _____ Use of hearing aid or amplifier _____

Date of Examination:______________ Examiner______________ M.D.______________

Date of Return Visit: ____________________

NOTE: Please complete and return to the school nurse. Thank you.

Address____

Fax____

Postural & Gait Screening

STUDENT'S NAME ________________________ SCHOOL____________________________

SCHOOL EXAMINER ______________________ DATE OF REFERRAL__________________

1. POSTURE
   a) Poor________ (unable to correct)

2. WALKS WITH
   a) Limp________ (unknown cause)
   b) Unusual Gait________
   c) Feet turned in ________ (problem of tripping)

3. UPPER EXTREMITIES
   a) Abnormalities ________ (contractures or lack of ROM - range of motion)

4. SPINE
   a) Lateral Curvature (Scoliosis) ________ (all curves)
   b) Posterior Curvature (Kyphosis) ________ (cannot correct)
   c) Anterior Curvature in lower spine (Lordosis) ________ (cannot reduce)
   d) Back pain ________

5. LOWER EXTREMITIES
   a) Hip problem ________ (Pain, lack of ROM)
   b) Knee problem ________ (Pain, lack of ROM, unstable knee)
   c) One shorter

6. FEET
   a) Any conditions causing pain, excessive shoe wear and/or other problems
   ____

7. MUSCULATURE
   a) Generalized weakness ________ (overall poor muscle tone, cannot keep up with peers)
   b) Apparent weakness _________ (one or more extremities)

8. REMARKS (Explanation of above, if desired, or any other unlisted abnormalities)

____

____

____

FINAL SCREENING (Phase II)

a) Impression____

b) Recommendation____

SIGNATURE (Physical Therapist)____

Posture/Gait Referral Letter

DATE: ________________

Dear Parent/Guardian:

A recent postural/gait screening test at school indicates that _______________________ may have a postural or gait irregularity which could affect his/her during these growing years.

The physical therapist will be at this school on __________ to perform Phase II of the postural screening. He/she will examine your child to determine if a referral to the doctor is needed. Please make every attempt to have your child at school on time this day.

After this exam, you will be notified if the physical therapist feels that your child needs to have an additional exam by his/her doctor.

Please call the school nurse with any questions.

____
School Nurse

____
Phone

Parental Request to Have Prescription Medication/Treatment Administered in School

If it is necessary for your child to receive medication during the school day, please do the following:

- Send the medication to school with a responsible individual if you are unable to take it to school.
- Send the medication in the original container properly labeled with correct name, time, dose and date.
- Count the tablets (unless the number of tablets is the exact number on the label) or approximate amount of liquid in the bottle.
- Fill out the following information:

Date ______________________________

Student's Name ____

Medication ____

Dose ______________________________ Time ______________________________

Reason for Medication ____

Allergies to any medications ____

Number of tablets sent _________________

Amount of liquid _____________________

I am aware that the school nurse may have need to contact the prescribing healthcare provider or pharmacist relative to the medication/treatment and I give my permission.

Parent/Guardian Signature ____

Nurse's Signature ____

Number of tablets/amount of liquid received ____

Letter to Parents/Guardians About Non Prescription Medications

School nurses may give nonprescription medications with parental permission. The following guidelines need to be followed:

1. The school nurse must assess the child's complaint and symptoms to determine if other measures can be used before medication is given.
2. The school nurse must be notified of any allergies, especially to medication, that your child has.
3. All medications sent to the school must be in the original container. (This is the law.)
4. A record of the medication given will be kept by the school nurse.
5. Nurses must use restraint at all times in the use of nonprescription medicines.

Please contact the school nurse, ____, if you have any questions. Nurse Name and Phone Number

- -

I have read the above and request ____ to give
Name of Nurse

_______________________________________ to ____
Name of Nonprescription Drug Name of Student

on _________________________ for the following reason:____

____

List known allergies to medicine____

____

____

____
Signature of Parent or Guardian

____
Date

Medication Error Report

A medication error is the failure to administer a prescribed medication within the appropriate time frame, in the correct dosage, in accordance with accepted practice and/or to the correct student.

Date of report____________________ School____

Student's name_________________________________ DOB___________ Sex______ Grade_____

Home address____

Home telephone____

Date error occurred__________________________________ Time noted_____________________

Person administering medication____

Licensed prescriber (name and address)____

Reason medication was prescribed____

Date of order______________ Instructions for administration______________________________

Medication______________________ Dose_________ Route_________ Scheduled time________

Describe the error and how it occurred (use reverse side if necessary):

Action taken PRN____

Licensed prescriber notified: Yes • No • Date_________________ Time_____________

Parent/Guardian notified: Yes • No • Date_________________ Time_____________

Other person(s) notified:____

____

Yes • No • Date_________________ Time_____________

Outcome:

Name (type or print)___________________________ Signature___________________________

Title____ Date____________________________

SIGN-OFF SHEET

SCHOOL EMPLOYEE "MEDICATION ON FIELD TRIP"* INFORMATION

I received, read, and understand the medication information in the
"Assistance with Medication Information for School Staff."
I will abide by the safe practices and procedures set forth therein. I am aware that any questions regarding this information or the medication should be discussed with the School Nurse.

Printed Name of School Employee	Signature of School Employee	Date Information Received and Read

Signature of Staff Instructor:______________________________

* A field trip is an "off-campus, school-sponsored activity."

Board of Nursing Approval – 5/10/00

Parent/Guardian Permission to Assist with Medication to Student on Field Trip

I give permission for ____________________________ to go on ______________________
(Student's Name) (Specify field trip)

on ______________________. I understand a staff member will assist my child with
(date)
medication. Information about the medication that needs to be taken by ______________
(Student's
________________________ is as follows:
Name)

Name of medication____________________________

Dose (amount to be taken)_______________________

Time to be taken_______________________________

How it is taken_________________________________

I understand I must send the medication in the original container.

All of the above information is on the label on the container prepared by the pharmacist as prescribed by

____
(Doctor's Name)

The following are any allergies or health conditions my child has:____________________

____

Date ______________________ Parent/Guardian Signature ______________________

Please contact your school nurse ______________________ if you have any questions.

School ___________________________________ District_________________________

District________________________

Field Trip Medication Record*

Trip__________________________ School___________________________________ Date_____________________

Student's Name	Medication	Dose Amount Given	Route: By mouth or inhalation, etc.	Time	Assisted by

* To be kept in the school nurse's office.

REFERRAL TO THE SCHOOL NURSE

Although teachers cannot diagnose a child's condition or recommend medication, they are many times the first ones to note that a child is not performing like his/her peers or is having difficulty in the classroom. This information is valuable in facilitating the nurse's assessment and possible referral for further evaluation.

The School Nurse values your input and comments. Please complete this form with your concerns and return it to the School Nurse. Listed below are some signs of conditions and examples of behavior that may provide clues to physical and emotional problems. While none of these are infallible, none should be overlooked. Extremes such as constantly disruptive behavior, continual unhappiness, inability to learn, are especially significant. Please remember that this information is **confidential**.

Student____Grade/Section_____________

Date________________________ Student Achievement: Good________ Fair______ Poor________

General Appearance
______ Facial tic
______ Lethargic, unresponsive
______ Poor posture
______ Radical changes in weight
______ Unusual gait or limp
______ Unclean/unkempt
______ Very pale or flushed
______ Very thin or overweight
Ears
______ Asking to have things repeated
______ Discharge
______ Speaking loudly
______ Turning head to hear
Eyes
______ Crossed or turned out
______ Frequent styes
______ Holding page/book too close
______ Inflamed, watery
______ Squint, frown, scowl
Nose and Throat
______ Chronic cough
______ Enlarged glands in neck
______ Frequent colds
______ Nasal discharge
______ Persistent mouth breathing
Skin or Scalp
______ Bald spots
______ Frequent scratching
______ Nits on hair
______ Numerous pimples, blackheads
______ Patches of very dry skin
______ Rashes, sores or bruises
Teeth and Mouth
______ Bad bite
______ Cracked lips, esp. at corners of mouth
______ Dental caries
______ Inflamed or bleeding gums
______ Irregular teeth
______ Speech problem, hard to understand

School Performance
______ Compulsive neatness to the point that assignments are never completed
______ Excuses from P.E.
______ Failure to achieve
______ Frequent absences
______ Marked deterioration in work
______ Poor memory
______ Poor reasoning
______ Very careless work

General Behavior
______ Aggressive, cruel
______ Always tired
______ Constant need for attention
______ Cries easily
______ Depressed, unhappy
______ Destructive
______ Docile, apathetic
______ Excessive daydreaming, inattentive
______ Excessive requests to leave classroom
______ Restless, hyperactive
______ Temper tantrums
______ Unusually timid, fearful

Behavior at Play
______ Breathless after moderate exercise
______ Difficulty playing with other
______ Easily fatigued
______ Extremely excitable
______ Lack of interest
______ Poor coordination
______ Very clumsy

See reverse side →

Brief description of health problem(s):

____
Signature of Person Referring

Response to referral:

____
Signature of School Nurse

____

Note: It is advised that schools consult with DPH Epidemiology (Epi) prior to developing or sending home information on communicable disease. The school nurse should work with Epi to obtain individualized guidance on when it is advisable or necessary to contact families. Epi can also review the materials/letters for accuracy and identify which families, staff or communities need to receive information.

Contagious Disease Letter

Dear Parent/Guardian:

It is our school's goal to provide a safe and healthy learning environment for your child. It is very important to limit contagious diseases at our school.

At times, childhood illnesses are not preventable. It has been brought to our attention that your child may have been exposed to ____. Because your child may have been exposed to this illness, please watch for the signs and symptoms listed below:

____

____

____

____

If your child shows any of these signs and symptoms, please keep your child at home. Call your healthcare provider to discuss care for your child. Your child may need to stay home until the symptoms are gone or treatment is started. A medical note to return to school is needed. By notifying you of this possible exposure, we are trying to prevent new cases of this disease.

Thank you for your cooperation.

Sincerely,

Guidelines for Parent/Guardian/Relative Caregiver*

________________________________ was seen in the nurse's office today. It is recommended that you follow the following instructions or contact your healthcare provider for more information.

FEVER

____ Get extra rest and eat light meals.
____ Drink extra fluids every 15 to 60 minutes.
____ Ask your healthcare provider to recommend an over-the-counter medication to reduce the fever. **DO NOT TAKE ASPIRIN! CAN CAUSE REYES SYNDROME.**
____ If fever persists for more than 2 days, increases to over 102°, or symptoms continue to worsen, contact your healthcare provider.
____ No school until fever-free for 24 hours.

UPPER RESPIRATORY INFECTION (COLD SYMPTOMS)

____ Ask your healthcare provider to recommend an over-the-counter medication to ease symptoms. **DO NOT TAKE ASPIRIN! CAN CAUSE REYES SYNDROME.**
____ Drink plenty of fluids.
____ Use moist air from vaporizer to help relieve congestion.
____ Contact your healthcare provider if:

a.) breathing difficulties occur
b.) you cough up green or yellow phlegm that has a bad odor
c.) fever persists; or
d.) you feel sicker each day instead of feeling better

NAUSEA AND VOMITING

____ No solids for 8 hours.
____ Clear liquids only (not milk) until 4 hours have passed without vomiting. Start with one tablespoon every 10 minutes. If vomiting does not occur, double the amount every hour. If vomiting does occur, allow the stomach to rest for 1 hour and then start again. Key is to gradually increase the amount of fluid until taking 8 oz. every hour.
____ Resume normal diet as soon as tolerated.
____ Contact your healthcare provider if vomiting persists or if you suspect dehydration.

DIARRHEA

____ Drink water and/or sports drinks.
____ Resume normal diet as soon as tolerated.
____ Contact your healthcare provider if cramps, diarrhea or pain increases or persists or if you suspect dehydration.

CUTS, ABRASIONS, OR MINOR BURNS

____ Keep the area affected clean and dry.
____ Change the bandage in 24 hours or sooner if it becomes soiled.
____ Notify your healthcare provider if signs of infection develop such as swelling, red streaking, drainage or pus, pain, or fever.
____ According to school records, you have not had a tetanus booster since _______________. If one has not been given, arrange to have the booster with your healthcare provider and send copy of the immunization to the school nurse. If one has been received since this date, please contact the school nurse so that your record can be updated.

BRUISES, SPRAINS OR STRAINS

____ Elevate and rest the affected area of the body to reduce swelling and pain.
____ Apply ice packs or cold compresses for 10 minutes as many times as possible to the injured area for the first 24 hours after the injury. Wrap cold pack in a towel to minimize the risk of frostbite to the skin.
____ Notify your doctor immediately if the injured area becomes grossly swollen, discolored, cold or numb, or if the injured limb is unable to bear moderate pressure or body weight.
____ Ask your healthcare provider to recommend an over-the-counter medication to reduce pain and inflammation.
____ Contact your family doctor or go to an emergency room if not better in 48 hours.

HEAD INJURY

____ You should watch for any of the following signs of severe injury, in which case you should seek the advice of your healthcare provider **as soon as possible**.

a.) severe headache
b.) excessive drowsiness (unable to be awakened when asleep for 4 hours)
c.) nausea and/or vomiting
d.) doubled or blurred vision or pupils of different sizes
e.) inability to maintain erect posture, staggering, etc.
f.) unusual behavior, confusion, inappropriate anger
g.) convulsions or discharge from the ear

OTHER INSTRUCTIONS: ____
____
____
____

Nurse:________________________________Phone:____________Date:____________

*Uphold and Graham (2003); CLINICAL GUIDELINES IN FAMILY PRACTICE, FOURTH EDITION. Gainesville: Barmarrae Books, Inc.

Medical Referral Form

Name_______________________________ Date of Birth___________________ Male________ Female________

Injury

Date____________Time____________a.m./p.m.

Where did injury occur?_____________________

How did injury occur? Collision with___________

Hit by________________Fell on/from__________

Other____________________________________

Date of last known tetanus shot:_______________

Part of body injured (indicated L or R for left or right when applicable):

☐ Ankle	☐ Eye	☐ Hip	☐ Nose
☐ Arm	☐ Face	☐ Knee	☐ Scalp
☐ Back	☐ Finger	☐ Leg	☐ Shoulder
☐ Chest	☐ Foot	☐ Lip	☐ Stomach
☐ Collar Bone	☐ Hand	☐ Mouth	☐ Tooth
☐ Elbow	☐ Head	☐ Neck	☐ Wrist

☐ Other (specify)_____________________________

Illness

Complaint____

____

____

____

Assessment____

____

____

____

Comments:____

____

____

____

____

Nursing Intervention/Comments:____

____

Parent/guardian/Relative Caregiver advised: of injury/illness Yes _______ No _______
to seek medical attention: Yes _______ No _______

Signature:___________________________________, School Nurse Date:_________________________

Phone:_______________________________________

PLEASE COMPLETE AND RETURN TO SCHOOL NURSE:

Examining Physician:____ Date:________________

Diagnosis:____

____

Treatment:____

____

Send copy of emergency card if transporting to Emergency Room.

DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Public Health

2004

Puncture Incident in a School Setting

I hereby give permission for my child____
to receive the following services from the Division of Public Health. Only those services that are authorized by means of a check mark in the box next to the service will be provided.

Information pertaining to Hepatitis B and HIV (the virus that causes AIDS)

Hepatitis B immunization

Tetanus booster

Hepatitis B Immune Globulin

A blood test for previous hepatitis B exposure

A baseline testing for anti-hepatitis C virus and a follow-up testing at 4-6 months for anti-HCV and/or testing for HCV RNA at 4-6 months

A blood test for HIV exposure ... **OR**

All procedures noted above as recommended by the DPH

____ ___________________
Signature of parent or legal guardian Date

For Use by Division of Public Health Staff Only

Weight _____________ Amount of HBIG Administered ______________ Site ___________

Manufacturer _________________________________ Lot # _________________________

Signature ____ Date _________________

Physical Education Modification

The School Nurse assists the physical education teacher with the program modifications for the student who is restricted in physical education activities due to health problems. Recommendations from the student's licensed healthcare provider should be obtained in writing and based on the activities in which the student can participate.

Temporary excuses for up to three consecutive days of modification in physical education classes for minor illness and injury may be issued by the school nurse.

Temporary Medical Excuse for Physical Education Modification

School District ______________________School Name_________________________________

Student's Name____ Grade_________________

Address____

Student Referred by ______________________________________ Date ____________________

(School staff member and title)

Nature of disease or injury____

____

____

Length of time for modification____

Will re-examination be necessary?___________________________ Date ___________________

Student is able to do the following activities:

______ No physical activity

______ Non-vigorous physical activity

______ Vigorous physical activity

______ Exercises such as ____

______ Moderate Calisthenics

______ Moderate running

Beginning _________________________ (date), this student would benefit from exercises such as _____,

which may be taken during physical education class.

____
Date

____
Name of Physician (M.D. or D.O., N.P. or School Nurse)

____
Address

Parent/Guardian/Relative Caregiver's Request Form for School to Provide Specialized Nursing Treatment or Procedure

Permission and directions should be renewed at the start of each school year.

Child's Name ________________________________ Phone No.___________________

Physician's Name _____________________________ Phone No. ___________________

Address ____

I (We) request the following health care procedure to be done:

____

____

____

This procedure has been approved by the child's licensed healthcare provider, (Physician's Name) ______________________________________.* I (We) will notify the school immediately if there is a change in licensed healthcare provider, health status of child (Child's Name) ______________________________________, or change in procedures.

I understand the school nurse may need to speak with the prescribing healthcare provider. I grant permission for the sharing of information relative to my child's procedure and the related diagnosis.

Signature of Parent/guardian/Relative Caregiver(s) ________________________________

Address ____

Home Phone ____________________________ Work Phone _________________________

* Attach document to this effect.

Date ___________________________________

Physician's Approval of Procedure

The licensed healthcare provider will approve or authorize the procedure that is to be used in the school. The authorization will include the following information:

Name of Child _____________________________ Birth Date __________________________

Physical condition for which procedure is authorized ___________________________________

____

Name of procedure to be performed ____

____

Precautions, possible untoward reactions, and interventions _____________________________

____

____

____

Time schedule and/or indication for the procedure _____________________________________

____

Physician's Signature ____

Address ____

Phone Number _____________________________ Date ______________________________

Student's Name_____________________________

Individual Daily Prescribed Medication/Treatment

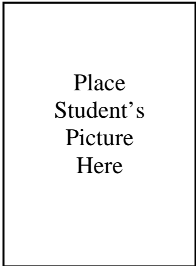
Date	Time	Medication/Treatment	Comments/Reactions	Initials*

*

________ ____ ________ ____
Initials Full Name Initials Full Name

________ ____ ________ ____
Initials Full Name Initials Full Name

Emergency Healthcare Plan



Name:_____________________________________ DOB:_____________

Teacher:____________________________________ Grade:____________

Medical Condition:____

Symptoms of Condition:____

Action/Treatment:____

Parent/Guardian/Relative Caregiver:__________________________________ Phone:____________________

Parent/Guardian/Relative Caregiver:__________________________________ Phone:____________________

Physician:____ Phone:____________________

Emergency Contact:____ Phone:____________________

If symptoms of health problems above occur, the school nurse will assess the student and institute the prescribed action/treatment. The school nurse or designee will contact the parent/guardian/Relative Caregiver of the student. If a parent/guardian/Relative Caregiver cannot be reached, the emergency contact person will be called. Emergency personnel may be given a copy of this form.

Parent/Guardian/Relative Caregiver Signature:______________________________ Date:________________

Physician Signature:____ Date:________________

Asthma Action Plan

General Information:

- Name ____________________
- Emergency contact ____________________ Phone numbers ____________________
- Physician/Health Care Provider ____________________ Phone numbers ____________________
- Physician Signature ____________________ Date ____________________

Severity Classification		Triggers			Exercise
Mild Intermittent	Moderate Persistent	Colds	Smoke	Weather	1. Pre-medication (how much and when) ____________
Mild Persistent	Severe Persistent	Exercise	Dust	Air pollution	____________
		Animals	Food		2. Exercise modifications ____________
		Other ____________			____________

Green Zone: Doing Well

Peak Flow Meter Personal Best =

Symptoms

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps all night

Peak Flow Meter
More than 80% of personal best or ________

Control Medications

Medicine	How Much to Take	When To Take It
____________	____________	____________
____________	____________	____________
____________	____________	____________

Yellow Zone: Getting Worse

Contact Physician if using quick relief more than 2 times per week.

Symptoms

- Some problems breathing
- Cough, wheeze or chest tight
- Problems working or playing
- Wake at night

Peak Flow Meter
Between 50 to 80% of personal best or
__________ to ____________

Continue control medicines and add:

Medicine	How Much to Take	When To Take it
____________	____________	____________
____________	____________	____________
____________	____________	____________

IF your symptoms (and peak flow, is used) return to Green Zone after one hour of the quick relief treatment, THEN
- o Take quick-relief medication every 4 hours for 1 to 2 days
- o Change your long-term control medicines by ____________________
- o Contact your physician for follow-up care

IF your symptoms (and peak flow, if used) DO NOT return to the GREEN ZONE after 1 hour of the quick relief treatment, THEN
- o Take quick-relief treatment again
- o Change your long-term control medicines by ____________________
- o Call your physician/Health Care Provider within ______________ hours of modifying your medication routine

Red Zone: Medical Alert

Ambulance/Emergency Phone Number:

Symptoms

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

Peak Flow Meter
Between 0 to 50% of personal best or
__________ to ____________

Continue control medicines and add:

Medicine	How Much to Take	When To Take It
____________	____________	____________
____________	____________	____________
____________	____________	____________

Go to the hospital or call for an ambulance if
- o Still in the red zone after 15 minutes
- o If you have not been able to reach your physician/health care provider for help
- o ____________________

Call an ambulance immediately if the following danger signs are present
- o Trouble walking/talking due to shortness of breath
- o Lips or fingernails are blue

SEIZURE REPORT

STUDENT____

AURA: Yes________ No________ If yes, Type: ☐ auditory ☐ tactile ☐ olfactory ☐ visual

Date:____________________ Time:___________________

DID STUDENT MAKE ANY NOISES? Yes_________ No_________

DURATION (length of time):____________________________________

DESCRIPTION OF MOVEMENT & BEHAVIORS (stiffness, shaking, repetitive behaviors, other)_____

____

____

LOSS OF CONSCIOUSNESS: Yes_________ No______ If yes, how long:_________________

ONSET: Face:________ Rt. Arm:_______ Rt. Leg:______ Left Arm:_______ Left Leg:________

Spreading:_______________________ Generalized at Onset:___________________

Turning of Eyes:__________ Turning of Body:___________ Direction:____________

POSTICTAL STATE:

A)	Sleepiness	Yes_____	No______
B)	Drowsiness	Yes_____	No______
C)	Confusion	Yes_____	No______
D)	Psychotic Behavior	Yes_____	No______

If answer to D) is Yes, Describe:____

____

DESCRIBE INJURIES, IF ANY:____

____

INCONTINENCE: Bowel - Yes_______ No______

Bladder - Yes_______ No______

EXCESSIVE SALIVATION: Yes_______ No______

CYANOSIS: Yes_______ No______

COMMENTS:____

____

____

Witnessed by:____

Signature Title

Contacted:

☐ Parent/Guardian/Relative Caregiver Date:______________ Time:_________

☐ Licensed healthcare provider Date:______________ Time:_________

☐ Other Date:______________ Time:_________

DELAWARE DEPARTMENT OF PUBLIC SAFETY
DIVISION OF MOTOR VEHICLES
DRIVER IMPROVEMENT UNIT – MEDICAL RECORDS SECTION
PO BOX 698 - DOVER, DE 19903-0698

MEDICAL REPORT OF PHYSICIAN'S FINDINGS

Name:___________________________________ DOB ____/___/____ License Number___________________

Address:____

I hereby authorize Doctor __________________________________ to perform any medical examination necessary for the purpose of determining my fitness to operate a motor vehicle. Also I understand that this authorization includes permission for the Director of Motor Vehicles and/or their designee to have this information reviewed by a Medical Board of unidentified physicians for the purpose of giving him/her a medical opinion on my case for a guidance in determining my medical capabilities to operate a motor vehicle safely. The information contained in this report is confidential and will be used solely for the purpose of driver's license considerations.

_____________________________________ _____________________________________

Date Signature of Applicant *(Required)*

(Legibility is a must)

Mental level for reading (circle one) Inadequate – Marginal – Adequate Height:______Weight:______

(A) **ORTHOPEDIC AND NEUROMUSCULAR**: *(Please check as appropriate)*

Spastic, Amputations or Ankylosed Joints	☐ YES ☐ NO	Joint Ataxia, Paralysis, or Weakness	☐ YES ☐ NO
Prosthetic Devices used for Driving	☐ YES ☐ NO	Other Deformities or Abnormalities	☐ YES ☐ NO

If **YES** to any of the above, please describe:____
____
____

(B) **CARDIO-VASCULAR**: *(Please check as appropriate)*

Strokes – Adams Syndrome	☐ YES ☐ NO	Syncope	☐ YES ☐ NO	Vertigos	☐ YES ☐ NO
Angina Pectoris	☐ YES ☐ NO	Arteriosclerosis	☐ YES ☐ NO	Arrhythmia	☐ YES ☐ NO
Cardiac Decompensation	☐ YES ☐ NO	Dyspnea	☐ YES ☐ NO	Blood Pressure_	

If **YES** to any of the above, please describe:____
____
____

(C) **DIABETES**: *(Please check as appropriate)*

Is he/she a known diabetic? ☐ YES ☐ NO Status of Control_____________________________________
Duration:__________________________ Diabetic Acidosis ☐ YES ☐ NO ___________________________
If **YES** to any of the above, please describe:____
____
____

(D) **HEARING**: Normal? ☐ YES ☐ NO If **NO**, please describe:______________________________
____

(E) **DRUGS AND/OR ALCOHOL**: *(Please check as appropriate)*

Any objective evidence or personal knowledge of addiction, habituation, or alcoholism? ☐ YES ☐ NO
If **YES**, please explain:____
____

 Patient Name:____ DOB:____/___/____

(F) **PSYCHOLOGICAL ASSESSMENT**: *(Please check as appropriate)*

Is there any evidence of emotional instability? ☐ YES ☐ NO Is further examination suggested? ☐ YES ☐ NO
Does he/she have or has he/she had any episodes of conditions listed below?

Mental Clouding	☐ YES ☐ NO	Blackouts	☐ YES ☐ NO	Dizziness	☐ YES ☐ NO
Unconsciousness	☐ YES ☐ NO	Convulsions	☐ YES ☐ NO		

If **YES** to any of the above, please explain nature and date of last episode:____
____

Diagnosis:____
____

(G) Does he/she have any other condition or diseases which would decrease ability to safely operate a motor vehicle?
(Please check as appropriate) ☐ YES ☐ NO
If **YES**, please explain:____
____

(H) What type(s) and quantities of drugs are being prescribed for the patient?_________________________________
____
____

(I) Do any of the above medications affect driving ability? *(Please check as appropriate)* ☐ YES ☐ NO
If **YES**, please explain:____
____

(J) From a medical standpoint, do you feel he/she is capable of operating a vehicle safely? ☐ YES ☐ NO
If **NO**, please explain:____
____
____

If <u>YES</u>, the treating physician must attest to one of the two below listed statements, as may be applicable, for any person who is subject to loss of consciousness due to disease of the central nervous system.

☐ I hereby certify that I am the treating physician duly, licensed to practice medicine and surgery, for the above named individual and that I have been the treating physician for him/her for a period of at least three months, that I am aware of his/her medical history, including his/her history with respect to diseases of the central nervous system, and that such person's infirmity is under sufficient control to permit him/her to operate a motor vehicle with safety to person and property.

☐ I hereby certify that I am the treating physician, duly licensed to practice medicine and surgery, for the above named individual and that I have been the treating physician for him/her for a period of at least three months, that I am aware of his/her medical history, including his/her history with respect to diseases of the central nervous system, and that such person's disease no longer requires treatment and that such person can reasonably expect to suffer no further losses of consciousness on account of such disease.

(K) How long have you been treating this patient?________________________ Date of last examination:_____/____/_____

(L) Additional comments:____
____
____

______________________________________ ______________________________________
Physician's Name (Printed or typed) Physician's Signature

______________________________________ ______________________________________
Address Phone Number

______________________________________ Date:__________________________________

Please mail form to: MEDICAL RECORDS SECTION – DRIVER IMPROVEMENT UNIT – PO Box 698 – Dover, DE 19903-0698
The form may be transmitted by facsimile to: (302) 739-5667 ATTN: MEDICAL RECORDS SECTION