



ZACHARY COMMUNITY SCHOOLS SCHOOL NURSE DEPARTMENT

Welcome to Zachary Community Schools. We are excited that you have chosen our school system, which is one of the fastest growing, top-rated districts in the state, to educate your child.

In order to provide the best care possible for your child while at school, it is important for us to be aware of any medical conditions that might affect them during school hours or any condition that requires medication or possible nursing assistance (e.g. asthma, seizure disorder, diabetes, severe allergies, etc.). If your child does not have any medical issues or does not require any medication at school, we only need your signature on the "HIPAA Policy" form to be returned to school.

If your child has special medical needs, please complete and sign the enclosed forms. In addition, if your child requires medication at school, you may pick up the state mandated medication packet at your child's school or you may download these forms from your child's school's website (click "Teacher Pages", then "Nurses" icon, then "Medication Packet"), and complete and return them to school. A parent will have to bring the medication to school to be checked and logged in. **Please note that medication of any kind, including over-the-counter medication, may NEVER be sent to school with your child, and MUST be checked in by a parent along with the medication packet completed.**

Also, please ensure that your child's immunizations are up-to-date and that his/her school has an updated copy. This is required by Louisiana Department of Health and Hospitals and must be on file for your child to attend school.

Thank you in advance for your cooperation. We look forward to caring for your child.

Zachary Community School Nurses

ZACHARY COMMUNITY SCHOOL BOARD

NOTICE OF USE OF PERSONAL HEALTH INFORMATION

This Notice Describes How Medical Information About Your Child May Be Used and Disclosed and How You Can Get Access To This Information. Please Review It Carefully.

We understand that information we collect about your child and their health is personal. Keeping health information of your child private is one our most important responsibilities. We are committed to protecting their health information and following all laws about its use. You have the right to discuss with the system's Privacy Officer your concerns about how their health information is shared. The law says:

1. We must keep their health information from others who do not need it.
2. You may ask us not to share certain health services information. Sometimes, we may not be able to agree to your request.

Your child may receive certain services from nurses, therapists, social workers, doctors or other health care related individuals. They may see, use and share your child's health or medical information to determine any plan of treatment, diagnosis, or outcome of information as described in an Individualized Education Program (IEP) or other plan document. This use may cover such health services your child had before now or may have later.

We review such health services information and claims to make sure that you get quality services and that all laws about providing and paying for such health services are being followed. We may also use the information to remind you about service or to tell you about treatment alternatives. We also use the information to obtain payments for such services as a result of the Medicaid program. We must submit information that identifies you and your child, your child's diagnosis and the treatment of services provided to your child for reimbursement by Medicaid.

We may share your health care information with health plans, insurance companies, or government programs to help get the benefits and so that the School System can be paid or pay for such health care or medical services.

In most cases, you may see your child's health information but the request cannot include psychotherapy notes or information gathered for judicial proceedings. There may be legal reasons or safety concerns that may limit the amount of information that you may see. You may ask in writing to receive a copy of your child's health information. We may charge a small amount for copying costs.

If you think some of the health information is wrong, you may ask in writing that we correct or add to it. You may ask that the corrected or new information be sent to others who have received your child's health information from us. You may ask us for a list of where we sent the health information.

You may ask to have the health information sent to others. You will be asked to sign a separate form, called an authorization form, permitting the health information of your child to go to them. The authorization form tells us what, where and to whom the information must be sent. You can stop or limit the amount of information sent any time by letting us know in writing.

Note: A child 18 years old or older can give consent for his or her health information to be kept private from others unless the child signs an authorization form.

We follow laws that tell us when we have to share health information of your child even if you do not sign an authorization form. We always report:

1. Contagious diseases, birth defects and cancer;
2. Firearm injuries and other trauma events;
3. Reactions to problems with medicines or defective medical equipment;
4. To the police or other governmental agencies when required by law;
5. When a court orders us to;
6. To the government to review how our programs are working;
7. To a provider or insurance company who needs to know if your child is enrolled in one of our programs;
8. To Worker's Compensation for work related injuries;
9. Birth, death and immunization information;
10. To the federal government when they are investigating something important to protect our country, the President and other government workers;
11. Abuse, neglect and domestic violence, if related to child protection or vulnerable adults; or
12. To parents and other designated by law.

We may also share health care information for permitted research purposes, for matters concerning organ donations and for serious threats to public health or safety.

This notice is yours. You may ask for a copy at any time. If there are important changes to this notice, you will get a new one within 60 days.

If you have any questions about this notice of privacy rights of your child or that such rights have been violated, you can contact:

Zachary Community School Board Office
(225) 658-4969 telephone
4656 Main Street, Zachary, LA 70791

You can also complain to the federal government Secretary of Health and Human Services (HHS) or to the HHS Office of Civil Rights. Your health care services will not be affected by any complaint made to the School Board, Secretary of Health and Human Services or Office of Civil Rights.

STATE OF LOUISIANA

HEALTH INFORMATION

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN EACH SCHOOL YEAR

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE. Parent/Legal Guardian is encouraged to participate in the development of an Individual Health Care Plan if needed. Use additional sheets, if necessary, for further explanation.				
Name of School:			Grade:	
Student's Name: Last		First		M.I.
Student's Date of Birth:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	State or Country of Birth:	
Student's Mailing Address:		City:	State:	Zip Code:
Student's Physical Address:		City:	State:	Zip Code:
Name of Mother or Legal Guardian:	Home Phone: ()	Work Phone: ()	Cell Phone: ()	Employer:
Name of Father or Legal Guardian:	Home Phone: ()	Work Phone: ()	Cell Phone: ()	Employer:
Name of child's pediatrician or primary care provider:		Names of medical specialists or special clinics caring for your child:		
Parent or Legal Guardian Signature			Date	
Please check the type of health insurance your child has: <input type="checkbox"/> Private <input type="checkbox"/> Medicaid/LaCHIP <input type="checkbox"/> None				
If your child does not have health insurance, would you like information on no cost health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No				
In case of emergency—if parent or legal guardian cannot be reached—contact the following:				
Name		Complete Phone Number ()		
My child has a medical, mental, or behavioral condition that may affect his/her school day: <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please complete Part 2.)				
PART 2: COMPLETE ALL BOXES THAT APPLY TO YOUR CHILD. Parent/Legal Guardian is responsible for providing the school with any medication and may be responsible for providing the school with any special food or equipment that the student will require during the school day. Check with the school nurse to obtain correct medication and procedure forms.				
<input type="checkbox"/> ALLERGIES				
Allergy Type:				
<input type="checkbox"/> Food (list food(s)) _____				
<input type="checkbox"/> Insect sting (list insect(s)) _____				
<input type="checkbox"/> Medication (list medication(s)) _____				
<input type="checkbox"/> Other (list) _____				
Reactions: (Date of last occurrence if yes.)				
<input type="checkbox"/> Coughing (Date: _____)		<input type="checkbox"/> Hives (Date: _____)		<input type="checkbox"/> Rash (Date: _____)
<input type="checkbox"/> Difficulty breathing (Date: _____)		<input type="checkbox"/> Local swelling (Date: _____)		<input type="checkbox"/> Wheezing (Date: _____)
<input type="checkbox"/> Generalized swelling (Date: _____)		<input type="checkbox"/> Nausea (Date: _____)		<input type="checkbox"/> Other _____ (Date: _____)
Currently prescribed medications and treatments:				
<input type="checkbox"/> Oral antihistamine (Benadryl, etc.)		<input type="checkbox"/> Epi-pen		<input type="checkbox"/> Other _____
<input type="checkbox"/> ASTHMA				
Triggers: <input type="checkbox"/> Environmental (i.e., tobacco, dust, pets, pollen, etc.) (list) _____ <input type="checkbox"/> Other (list) _____				
Does your child experience asthma symptoms with exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Symptoms:				
<input type="checkbox"/> Chest tightness, discomfort, or pain <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Coughing <input type="checkbox"/> Wheezing <input type="checkbox"/> Other _____				
Currently prescribed medications and treatments: _____				
Date of last hospitalization related to asthma _____ Date of last emergency room visit related to asthma _____				
Does your child have a written asthma management plan? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Is peak flow monitoring used? <input type="checkbox"/> No <input type="checkbox"/> Yes				

**ZACHARY COMMUNITY SCHOOL SYSTEM
MEDICAL HISTORY UPDATE FORM**

To Be Completed By Doctor

(This information will be utilized by the school nurse to provide health services to students.)

Student's Name _____ **DOB** _____ **Grade** _____

School _____ **Teacher** _____ **School Nurse** _____

CURRENT DIAGNOSIS & MEDICAL STATUS *(additional information may be attached to this form)*

Recommendations For Student Integration Into The School Setting

Activity Restrictions/Limitations _____

Accommodations _____

Nutritional/Dietary _____

Adaptive Physical Education _____

Physical Therapy _____

Occupational Therapy _____

Special Procedures _____

Return to Clinic _____

Physician's Signature _____ *Date* _____

Print Physician Name Here _____ *Office #* _____

Address _____ *Fax #* _____