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

3755 Church Street
Zachary, LA 70791
225.658.4969
Fax 225.658.5261
www.zacharyschools.org

Dear Parent,
Attached you will find the Zachary Community School Board HIPAA policy Notice of Use of Personal Health Information. Please sign and return this form, so that we may maintain a record of your having received the information. Failure to return the signed form may result in a delay in servicing your child.

Thank you,

Zachary Community School Nurses

This is to certify that I have received and read a copy of the "Notice of Use of Personal Health Information".

____

Parent's Signature

Names of children attending Zachary Community Schools and grades/homeroom teachers of each:

Name	Grade	Homeroom Teacher
________________________	________	______________________
________________________	________	______________________
________________________	________	______________________
________________________	________	______________________
________________________	________	______________________

If you have any questions, please feel free to contact your child's school.

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
3755 Church 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.

FINAL 11/06

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: M 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: Private   Medicaid/LaCHIP   None
If your child does not have health insurance, would you like information on no cost health insurance? Yes   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: No   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.

❑ ALLERGIES

Allergy Type:
- Food (list food(s)) ______________________
- Insect sting (list insect(s)) ______________________
- Medication (list medication(s)) ______________________
- Other (list) ______________________

Reactions: (Date of last occurrence if yes.)

Coughing (Date:)	Hives (Date:)	Rash (Date:)
Difficulty breathing (Date:)	Local swelling (Date:)	Wheezing (Date:)
Generalized swelling (Date:)	Nausea (Date:)	Other ________(Date:)

Currently prescribed medications and treatments:
Oral antihistamine(Benadryl, etc.)   Epi-pen   Other ______________

❑ ASTHMA

Triggers: Environmental (i.e., tobacco, dust, pets, pollen, etc.) (list) __________   Other (list) __________
Does your child experience asthma symptoms with exercise? No   Yes
Symptoms:
Chest tightness, discomfort, or pain   Difficulty breathing   Coughing   Wheezing   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? No   Yes
Is peak flow monitoring used? No   Yes

Name: ____________________ DOB: ________

❑ **DIABETES**

Currently prescribed medications and treatments:

Insulin: Syringe Pen Pump

Blood sugar testing

Glucagon

Oral medication(s) List medication(s) ____

Is special scheduling of lunch or Physical Education required? No Yes

❑ **SEIZURE DISORDER**

Type of seizure:

Absence (staring, unresponsive) Complex Partial Generalized Tonic-Clonic (Grand Mal/Convulsive)

Other (explain) ____

Physical Education Restrictions: No Yes

Medication(s)*:* No Yes List medication(s) ______________________________

Date of last seizure ____________________ Length of seizure ____________________

❑ **OTHER HEALTH CONDITIONS**

Anemia ADD/ADHD Cancer Cerebral Palsy Chicken Pox Cystic Fibrosis

Depression Digestive disorders Emotional/Psychological Juvenile Rheumatoid Arthritis

Hemophilia Heart condition Physical disability Sickle Cell Disease Skin disorders

Speech problems Other (explain)____________

Physical Education Restrictions: No Yes (explain): ______________________________

____

Medication(s)*:* No Yes List medication(s) ______________________________

____

Special procedures required (i.e., catheterization, oxygen, gastrostomy care, tracheostomy care, suctioning): No

Yes (explain):____

____

Special diet required (i.e., blended, soft, low salt, low fat, liquid supplement): No Yes (explain): _________

____

____

Are there anticipated frequent absences or hospitalizations? No Yes

(explain):____________________

❑ **VISION CONDITIONS**

Contacts/glasses

Other ____________________

❑ **HEARING CONDITIONS**

Hearing aid(s)

Other ____________________

❑ **ENVIRONMENTAL ADJUSTMENTS DUE TO A HEALTH CONDITION**

Special school environmental adjustments of the school environment or schedule: No Yes (explain):_________

____

(i.e., seizures, limitations in physical activity, periodic breaks for endurance, part-time schedule, building modifications for access)

Special school environmental adjustments to classroom or school facilities: No Yes (explain):_________

____

(i.e., temperature control, refrigeration/medication storage, availability of running water)

Special safety considerations: No Yes (explain):______________________________

(i.e., special precautions in lifting, positioning, special transportation emergency plan, special safety equipment, special techniques for positioning, feeding)

Special assistance with activities of daily living: No Yes (explain):____________________

(i.e., eating, toileting, walking)

PART 3: SCHOOL NURSE TO COMPLETE **if parent/legal guardian indicates medical condition.**

____ ____________________

School Nurse Signature Date

Notes:

RETURN COMPLETED FORM TO SCHOOL NURSE/HEALTH OFFICE AS SOON AS POSSIBLE

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 #***____________________________