Nursing Office
Friendship Academy
255 South Negley Avenue
Pittsburgh, PA 15206
Phone (412) 365-3800
Fax (412) 365-3916

July 31, 2021

Dear Families,

We are looking forward to starting the new 2021/2022 school year with our students here at Watson. In order to have a good understanding of how best to care for your child, we ask that you please complete the enclosed health forms. We appreciate your cooperation with this, our goal is to assist and support your child in a healthy and safe environment.

Please note this year we have some new forms requiring parental/guardian consent and physician signature for any prescription medications.

All forms will be available for reprinting on Watson's website, under Friendship Academy.

If you have any questions or issues you would like to discuss, please feel free to contact the nursing office. The nurses can be reached by phone at 412-635-3931. Someone will be in the office starting August 18th, 2021. If you have a more urgent concern, please call the main line for the school.

We will be updating our COVID-19 guidelines as directed by the CDC as we approach the beginning of the school year.

Please let us know if there is anything we can do to help your child have a successful school year!

Watson Nursing Staff at Friendship Academy

Maria Devore, RN
Leah Froehlich, RN
Julia Grunden, RN, BSN

2021/2022 School Year

Your Child's History

Student's Name: _____D.O.B._____

(Last) (First)

1. Any complications during pregnancy or delivery? ☐ **YES** ☐ **NO** If yes, please indicate below.

_____

_____

_____

2. Your child's birth weight_____.

3. Any problems immediately following birth? ☐ **YES** ☐ **NO** If yes, please indicate below.

_____

_____

_____

4. Any developmental delays? ☐ **YES** ☐ **NO** If yes, please indicate below what and at what age first noted.

_____

_____

_____

5. Any special diet or feeding needs? ☐ **YES** ☐ **NO** If yes, what kind of diet or feeding need does your child require? Please include any food allergies or intolerance.

_____

_____

_____

6. Any health conditions such as diabetes, asthma, heart disease, or injuries? ☐ **YES** ☐ **NO** If yes, please indicate below.

_____

_____

_____

7. Has your child been hospitalized within the last year? ☐ **YES** ☐ **NO** If yes, please list date and reason for hospitalization.

_____

_____

_____

EMERGENCY ACTION PLAN
2021-2022

Date of Plan: _____ **Date of Birth:** _____

Student's Name: _____
(Last) (First)

Address: _____ **Mom's Cell Phone:** _____

Home Phone: _____ **Dad's Cell Phone:** _____

Emergency Contacts

Name		Relationship		Emergency Number

***In the event of an emergency such as respiratory distress related to asthma, severe allergic reactions or symptoms of hypo/hyperglycemia in which immediate intervention is required, please complete the following in detail.

	Description
Medical Condition:	
Medications:	
Signs of Emergency:	
Actions for school staff to take:	
Actions for transportation staff:	

Send to which hospital if necessary? _____Nearest Hospital or _____Hospital

_____ _____
Parent/Guardian Signature Date

_____ _____
School Nurse Signature Date

2021/2022 School Year

MEDICAL INFORMATION (Please keep at home for reference)

GUIDELINES FOR STUDENT ILLNESSES

When Should You Keep Your Child at Home?

Your child is to remain at home if they have any of the following symptoms:

- Oral temperature above 100 degrees
- Nausea/vomiting
- Diarrhea/loose stool
- Excessive nasal drainage
- Unusually irritable, restless or tired/sleepless night
- Persistent cough
- Sore throat
- Suspected pink eye, scabies, lice, ringworm, impetigo, chicken pox, rashes and MUST be seen by a doctor. Send in a note from doctor stating that your child is being treated and it is ok to return to school.

Guidelines For When Your Child Can Return To School After An Illness:

Condition	Minimum Days from State of Illness
Vomiting	After Child has kept food down for 24 hours
Diarrhea	24 hours after last diarrhea
Fever	Once the temperature is normal for 24 hours **WITHOUT** Tylenol
Strep Throat	24 hours after treatment begins, send note from doctor
Pinkeye, Lice, Scabies, Ringworm	24 hours after treatment begins, send note from doctor
Chicken Pox	6-7 days or until all blisters are dry, send note from doctor

If you child becomes sick at school, you will be contacted to come pick up your child.

It is **MANDATORY** that you have designated a family member or friend who is available to pick up your child if you are unable to.

HOSPITALIZATION POLICY

If your child stayed overnight in the hospital for ANY reason, they must remain at home for 24 hours after discharge before returning to school. This is to ensure that he/she does not relapse and is fully recovered.

The following information is **required** in order to return to school:

- Note from the doctor stating what date the student may return
- List of restrictions or no restrictions (i.e. gym, therapies, etc.)
- Hospital discharge papers

All paperwork can be faxed to the nursing office at Friendship Academy at (412) 365-3916. Any questions, please call 412-365-3931.

Date: _____ Student Name: _____

Parent Permission to Administer Medications at School
2021/2022 School Year

The Watson Institute requests that medication be administered at home during non-school hours. We do, however, recognize that sometimes it is essential for medication to be administered at school. In order to stay in compliance with state law, the nursing office requires that the following be provided to them in order to administer medication to your student. No prescription or "over-the-counter" (i.e. Tylenol/Motrin/Tums, etc.) medications will be given to any student without a signed order from a physician and signed emergency care form. All prescription medications **MUST** be in a pharmacy labeled container. The pharmacy labeled container must include the name and phone number of the pharmacy, the name of the student, the physician's name, the name of the medication, the currently prescribed dose, and time of administration. All "over-the-counter" medication MUST be in the original manufacturer's container with the student's name written on the container.

Please call your child's doctor to request orders to be sent to school. Please remember:

- Physician orders **MUST** be completed and dated July 1st or after for the upcoming school year.
- Prescription medication must be in the current and appropriate labeled pharmacy container. The order and the pharmacy bottle must match.
- Over the counter medication (nonprescription) must be in the original, unopened container and the type of non-prescription medication must match the physician's orders.
- An order completed by the physician is required for **each** medication**,** medication change, dose change and for **each** new school year, dated July 1st or after for the upcoming school year.
- If your child has a chronic medical condition or a medical emergency that may require Oxygen administration, a physician must write an order for administration here at school.
- All orders must contain the name of the medication, dosage, route, time of administration and doctor's signature.

Please remember that your child **will not** receive his/her medication if these procedures are not followed. Please feel free to contact your child's certified nurse if you have any questions or concerns regarding this matter.

Parent/Guardian Consent:

I give my permission for my child, _____, to receive medication ordered by a licensed prescriber during the school day. I understand that the medications will be given by school health personnel according to my child's licensed prescriber's directions.

Parent/Guardian signature: _____ Date: _____

Parent/Guardian name printed: _____ Phone: _____

Please send or fax prescription(s) for ALL medications to be given at school.

Friendship:
Telephone: (412) 365-3931
Fax: (412) 365-3916

STUDENT MEDICAL INFORMATION (Please return to school)

2021/2022 School Year

STUDENT'S NAME: _____**DOB:** _____

DIAGNOSES: _____

_____

DAILY MEDICATIONS: ☐ **YES** If yes, please list all medications student receives at home and school ☐ **NO**

Medication: _____ Dosage: _____ How often med taken: _____

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Medication: _____ Dosage: _____ How often med taken: _____

Medication: _____ Dosage: _____ How often med taken: _____

Medication: _____ Dosage: _____ How often med taken: _____

ALLERGIES: ☐ **YES** If yes, please complete section below ☐ **NO**

☐ Medications: _____ ☐ Pollen/Seasonal: _____

☐ Food: _____ ☐ Other:_____

Is student prescribed additional medication to treat allergies/allergic reaction? ☐ **YES** ☐ **NO**

☐ Benadryl ☐ Epi-Pen ☐ Other: _____

Date of last Menstrual Period (if applicable) _____

SEIZURES: ☐ **YES** If yes, please complete section below ☐ **NO**

Description of seizures

_____

_____

Date of last seizure _____ **Does student have a VNS:** ☐ **YES** ☐ **NO**

Does student have emergency seizure medications (please indicate): ☐ **YES** ☐ **NO**

☐ Diastat ☐ Versed

☐ Klonopin ☐ Other: _____

RECENT IMMUNIZATIONS: ☐ **YES** ☐ **NO**

Name of immunization: _____ Date Immunization received: _____

- Please send record of any recent immunization to school

RECENT ROUTINE MEDICAL EVALUATIONS: ☐ **YES** ☐ **NO**

☐ Physical: _____ ☐ Vision:_____

☐ Dental: _____ ☐ Other:_____

RECENT PROCEDURES: Name of Procedure: _____ Date of Procedure: _____