TENNESSEE SCHOOL FOR THE BLIND

ADMISSIONS PACKET – SECTION 3 OF 3

CLINIC DOCUMENTS

TENNESSEE SCHOOL FOR THE BLIND CLINIC
115 Stewarts Ferry Pike – Nashville, Tennessee 37214
Phone: 615-231-7399 – Fax: 615-231-7417

The TSB clinic would like to welcome returning students and new students to our school. The TSB clinic is here to provide auxiliary medical care for your student in case of accidental injury or illness away from home.

We have two part-time doctors on our staff. Our medical doctor is on campus every Tuesday, and Dr. Ahad, our school ophthalmologist, is scheduled to examine all TSB students once a year to confirm blindness. We have six nurses on staff, two RN's and four LPN'S. These nurses are here to assist your child with medication as well as to take care of minor illness or injuries.

Below is a check list with the required information your child needs to receive services from our clinic. Please read and check off the registration material that you are required to provide to the TSB Clinic. Once again, welcome to our clinic.

Kathy Craft, RN
TSB Clinic Supervisor

****REQUIRED REGISTRATION MATERIALS**** **(Please check that you have enclosed these forms before sending or bringing to TSB.** **These forms are good for Summer Camp and the school year).**	**CHECK**
1. *IF* YOU WOULD LIKE A TSB NURSE TO ASSIST IN GIVING YOUR CHILD MEDICATION, PLEASE PROVIDE US WITH A DOCTOR'S ORDER. PLEASE MAKE A COPY OF THE PRESCRIPTION BEFORE YOU TAKE IT TO THE PHARMACY, OR HAVE YOUR DOCTOR WRITE A HAND-WRITTEN DOCTOR'S ORDER. (*WE WILL NOT ACCEPT THE PAPERWORK FROM THE PHARMACY AFTER THE MEDICATION IS FILLED; THIS IS NOT A DOCTOR'S ORDER).* ALSO, *IF* YOU WOULD LIKE US TO GIVE YOUR CHILD VITAMINS OR OTHER OVER-THE-COUNTER MEDS THAT YOU BRING FROM HOME, *WE NEED A DOCTOR'S ORDER*.	
2. TSB PHYSICAL EXAM FOR 2018-19 SCHOOL YEAR *(one sheet)*	
3. PHYSICIAN CONSENT FOR OVER-THE-COUNTER MEDICATIONS	
4. CLINIC FACE SHEET W/STUDENT MEDICAL HISTORY AND CONSENTS *(one sheet)*	
5. COPY OF CURRENT INSURANCE CARD *(front and back)*	
6. COPY OF TDOH CERTIFICATE OF IMMUNIZATION FORM *(signed by doctor, shots current)*	
7. COPY OF EYE REPORT/EXAM *(signed by doctor)*	
8. AUTHORIZATIONS FOR RELEASE OF HEALTH INFORMATION *(complete and sign)*	
9. *SPECIAL CLINIC ORDER FORMS (*please circle the ones that apply, if any)*: (*seizure disorder, anaphylaxis, asthma, tube feeding, diabetes, growth hormone disorder)*	

TENNESSEE SCHOOL FOR THE BLIND PHYSICAL EXAM FOR 2018-2019

STUDENT NAME: _____ DOB: _____ SEX: _____ ALLERGIES: _____
_____

VITAL SIGNS

HEIGHT: _____
WEIGHT: _____
BMI: _____
BP: _____
PULSE: _____
RESP: _____
TEMP: _____

DIET

CIRCLE YES OR NO:

REGULAR DIET: YES NO
SPECIAL DIET: YES NO

***IF YES ORDER DIET:* _____**
TUBE FEEDING: YES NO
SPECIAL ORDER FORM NEEDS TO BE FILLED OUT FOR TUBE FEEDING.

PHYSICAL ACTIVITY

CIRCLE YES OR NO
AMBULATES W/O DIFFICULTY YES NO
NEEDS ASSISTIVE DEVICE: YES NO

***NAME DEVICE:* _____**

SPORTS PARTICIPATION: YES NO
SPORTS RESTRICTIONS: YES NO

NAME RESTRICTIONS: _____
_____

(CONTACT SPORTS AT TSB ARE GOAL BALL, WRESTLING.
NON-CONTACT SPORTS ARE: GOLF, TRACK, SWIMMING, CHEERLEADING.

IMMUNIZATIONS

IMMUNIZATIONS CURRENT YES NO
IMMUNIZATIONS GIVEN TODAY: _____
_____
DATE OF LAST TDAP: _____

PHYSICAL EXAM

ARE THE FOLLOWING NORMAL?	NORMAL	DESCRIBE ABNORMAL FINDINGS
SKIN/HAIR/NAILS		
EARS, (HEARING)		
EYES		
MOUTH/THROAT/TEETH		
NOSE/HEAD/NECK		
HEART		
LUNGS		
ABDOMEN		
SPINE (SCOLIOSIS?)		
GENITOURINARY		
EXTREMITIES		
HIPS, BUTTOCKS		
NEUROLOGICAL		

IF TSB NURSES GIVE MEDICATION: PARENT MUST BRING SIGNED COPY OF A DOCTOR'S ORDER, OR A COPY OF THE PRESCRIPTION BEFORE GIVING TO PHARMACY, THIS INCLUDES VITAMINS OR OVER THE COUNTER MEDS BROUGHT TO SCHOOL.

CURRENT DOCTOR'S ORDERS

MEDICATION	DOSAGE	ROUTE	TIMES GIVEN

DOCTOR'S SIGNATURE: _____ DATE: _____
Print Physicians Name: _____
PHONE #: _____

TENNESSEE SCHOOL FOR THE BLIND

Physician Consent for Over-the-Counter Medications

Student's Name _____ **Date** _____

Check ✓	MEDICATION	SYMPTOMS
	IBUPROFEN, ADVIL, MOTRIN	HEADACHE, FEVER
	TYLENOL, ACETAMINOPHEN	HEADACHE, FEVER
	ROBITUSSIN, GUIAFENISIN	COLD SYMPTOMS
	KAOPECTATE	DIARRHEA
	TUMS, MAALOX	INDIGESTION
	BENADRYL, DIPHENHYDRAMINE	ALLERGIC SKIN REACTION
	CLARITIN, ZYTREC	SEASONAL ALLERGIES
	EYE WASH	MINOR EYE IRRITATION
	WOUND SEAL	NOSE BLEEDS
	SALINE NASAL SPRAY	NASAL DRYNESS
	STING-KILL	RELIEF FOR INSECT STINGS
	TRIPLE ANTIBIOTIC	MINOR SCRAPES AND CUTS
	HYDROCORTISONE CREAM 2%	ITCHING, ALLERGIC REACTION
	COLACE	CONSTIPATION
	INSECT REPELLENT	REPELS MOSQUITOES
	A&D OINTMENT	DIAPER RASH
	SUNSCREEN	HELPS TO PREVENT SUNBURN
	LAMISIL	ATHLETES FOOT, RINGWORM
	CARMEX	CHAPPED LIPS
	ORAJEL	TOOTH AND GUM PAIN RELIEF

I give my consent for the above name student to receive the medications I have (✓) checked for the specific symptoms as directed by the manufacturer's label.

_____ _____

Parent's Signature **Date**

_____ _____

Physician's Signature **Date**

Revised
9/6/17

TENNEESSEE SCHOOL FOR THE BLIND

CLINIC FACE SHEET WITH STUDENT MEDICAL HISTORY AND CONSENTS

STUDENT NAME:			**DATE OF BIRTH:**_____SEX:_____		
MOTHER/GUARDIAN INFORMATION			FATHER/GUARDIAN INFORMATION		
NAME:			NAME:		
ADDRESS:			ADDRESS:		
CITY STATE: ZIP:			CITY: STATE: ZIP:		
HOME#	**CELL#**	**WK#**	HOME #	**CELL#**	**WK#**
EMERGENCY CONTACT:		**RELATION TO STUDENT:**		**EMERGENCY #:**	

I, _____GIVE CONSENT FOR MY CHILD_____TO RECEIVE MEDICAL TREATMENT FOR ILLNESS OR INJURY OCCURING AT TENNEESSEE SCHOOL FOR THE BLIND OR ON ANY SCHOOL RELATED ACTIVITY. IT IS MY UNDERSTANDING THAT I WILL BE NOTIFIED AS SOON AS POSSIBLE.

PARENT SIGNATURE: _____ DATE: _____ STUDENT ALLERGIES: _____

HEALTH HISTORY PLEASE CHECK	Y	N	HEALTH HISTORY PLEASE CHECK	Y	N	HEALTH HISTORY PLEASE CHECK	Y	N	HEALTH HISTORY PLEASE CHECK	Y	N
ACTIVITY RESTRICTION			DEPRESSION			KIDNEY DISEASE			STREP THROAT		
ACID REFLUX			DIABETES INSIPIDUS			LEUKEMIA			THYROID DISEAE		
ACNE			DIABETES I (INSULIN)			LIVER DISEASE			TUBERCULOSIS		
ADHD			DIABETES ii (no insulin)			LUNG DISEASE					
AFO'S			EATING DISORDER			MALARIA			TUBE FEEDING		
ALLERGIES			EATING (NEEDS ASSISTANCE)			MEASLES			USES WHEELCHAIR		
ASTHMA			ECZEMA			MENSTRUAL PROBLEMS			USES WALKER		
BED WETTING			EYE DISEASE			MUMPS			WALKS WITH ASSISTANCE		
BLIND			GALL BLADDER PROBLEMS			PNEUMONIA			WALKS WITHOUT ASSISTAN		
BIPOLAR			GLAUCOMA			POST TRAUMATIC STRESS			WEARS DIAPERS OR PULL-U		
BROKEN BONES			GLASSES OR OPTICAL DEVICE			PRECOCIOUS PUBERTY					
CANCER			GROWTH HORMONE DEFICIEI			ORGAN TRANSPLANT			*ADD DISEASES NOT LISTED.*		
CEREBRAL PALSY			HEADACHES			RETINAL DETACHMENT					
CHICKEN POX			HEART PROBLEMS			SEIZURE DISORDER					
CHOKING RISK			HEART MURMUR			SHUNT					
CONCUSSION			HERNIA			SICKLE CELL ANEMIA					
DEAFNESS			HYPERTENSION			SLEEPING PROBLEMS					

YES, I GIVE MY CONSENT FOR TSB NURSES UNDER THE DIRECTION OF AN RN TO ASSIST MY CHILD WITH PRESCRIBED MEDICATION AND TREATMENTS ACCORDING TO STATE LAW TCA 49-5-415.

PARENT OR GUARDIAN SIGNS "YES". _____ DATE: _____

NO, I DO NOT WISH MY CHILD TO RECEIVE MEDICATION OR TREATMENT BY TSB NURSES. I WILL COME TO SCHOOL AND MEDICATE AND TREAT MY CHILD IF NECESSARY. _____ DATE: _____

YES, I GIVE MY CONSENT FOR MY CHILD TO RECEIVE THE FLU VACCINE FOR FLU SEASON 2018-2019. PARENT OR GUARDIAN SIGNS "YES". _____ DATE: _____

NO, I DO NOT WANT MY CHILD TO RECEIVE FLU VACCINE AT TSB. I WILL MAKE OTHER ARRANGEMENTS TO PROTECT MY CHILD AGAINST THE FLU. PARENT/GUARDIAN SIGNS: _____ DATE: _____

ONCE A YEAR, TN LAW REQUIRES ALL STUDENTS AT TSB TO BE SEEN BY OUR OPHTHALMOLOGIST TO CONFIRM DIAGNOSIS OF BLINDNESS OR EYE DISEASE. PARENT/GUARDIAN SIGNS: _____ DATE: _____

***** (YOUR CHILD SHOULD CONTINUE TO SEE THEIR REGULAR OPHTHALMOLOGIST FOR ROUTINE EYE APPOINTMENTS) ******

*****PLEASE ATTACH A COPY OF YOUR CHILD'S INSURANCE CARD AND PHARMACY CARD*****

Revised 7/21/17 SCHOOL YEAR: _____

COPY OF INSURANCE CARD

(FRONT AND BACK)

COPY OF IMMUNIZATION RECORD

(*Must be on TN Department of Health* ***Certificate of Immunization*** *form and signed by doctor)*

EYE REPORT FOR CHILDREN WITH VISUAL PROBLEMS

NAME OF STUDENT: _____ SEX _____ ETHNICITY _____
(TYPE OR PRINT) (FIRST) (MIDDLE) (LAST)

ADDRESS _____ D.O.B. _____/_____/_____
(NO. AND STREET) (CITY OR TOWN) (COUNTY) (STATE/ZIP)

GRADE _____ SCHOOL _____ SCHOOL SYSTEM _____

I. HISTORY

A. Probable age at onset of vision impairment. Right eye (O.D.) _____ Left eye (O.S.) _____

B. Severe ocular infections, injuries, operations, if any, with age at time of occurrence. _____

C. Has pupil's ocular condition occurred in any blood relative(s)? _____ If so, what relationship? _____
_____

II. MEASUREMENTS (See back of form for preferred notation for recording visual acuity and table of approximate equivalents)

A. Visual Acuity

	Distant Vision			Near Vision			Prescription		
	Without Correction	With Best Correction	With Low Vision Aid	Without Correction	With Best Correction	With Low Vision Aid	Sph.	Cyl	Asia
Right Eye (O.D.)	_____	_____	_____	_____	_____	_____	_____	_____	_____
Left Eye (O.S.)	_____	_____	_____	_____	_____	_____	_____	_____	_____
Both Eyes (O.U.)	_____	_____	_____	_____	_____	_____	_____	_____	_____

B. If glasses are to be worn, were safety lenses prescribed in: Plastic ❑ Tempered glass ❑ With ordinary lenses ❑

C. If low vision aid is prescribed, specify type and recommendation for use: _____
_____

D. FIELD OF VISION: Is there a limitation? ❑ Yes ❑ No If so, record results of test on chart on back of form
What is the widest diameter (in degrees) of remaining visual field? O.D. _____ O.S. _____

E. Is there impaired color perception? ❑ Yes ❑ No If so, for what color(s)? _____

III. CAUSE OF BLINDNESS OR VISION IMPAIRMENT

A. Present ocular condition(s) responsible for Vision impairment. (If more than one, speci but underline the one which probably first ca severe vision impairment.)
O.D. _____
O.S. _____

B. Preceding ocular condition, if any, which led present condition, or the underlined conditio specified in A.
O.D. _____
O.S. _____

C. Etiology (underlying cause) of ocular Primarily responsible for vision impairment, (e.g., specific disease, injury, poisoning, her or other prenatal influence.)
O.D. _____
O.S. _____

If etiology is injury or poisoning, indicate circumstance and kind of object or poison involved: _____

IV. PROGNOSIS AND RECOMMENDATIONS

A. Is the student's vision impairment considered to be: Stable ❑ Deteriorating ❑ Capable of Improvement ❑ Uncertain ❑

B. What treatment is recommended, if any? _____

C. When is reexamination recommended? _____

D. Glasses: Not needed ❑ To be worn constantly ❑ For close work only ❑ Other (specify) _____

E. Lighting requirements: Average ❑ Better than average ❑ Less than average ❑

F. Use of eyes: Unlimited ❑ Limited, as follows: _____

G. Physical activity: Unrestricted ❑ Restricted as follows: _____

SEND EYE REPORT COPY TO:

Date of Examination _____
Name of Examiner _____
(Print or type)
Signature of Examiner _____ Degree _____
Address _____
No. and Street City State Zip code

If Clinic Case: Case Number _____
Clinic Name _____

Preferred Visual Acuity Notations

DISTANCE VISION: Use Snellen notation with test distance of 20 feet. (Examples: 20/100, 20/60). For acuities less than 20/200, record distance at which 200-foot letter can be recognized as numerator or fraction and 200 as denominator. (Examples: 10/200, 3/200). If the 200-foot letter is not recognized at 1 foot, record abbreviations for best distant vision as follows:

HM HAND MOVEMENTS
PLL PERCEIVES AND LOCALIZES LIGHT IN ONE OR MORE QUADRANTS
LP PERCEIVES BUT DOES NOT LOCALIZE LIGHT
No LP LO LIGHT PERCEPTION

NEAR VISION: Use standard A.M.A. notation and specify best distance at which pupil can read. (Example: 14 70 at 5 in.)

TABLE OF APPROXIMATE EQUIVALENT VISUAL ACUITY NOTATIONS

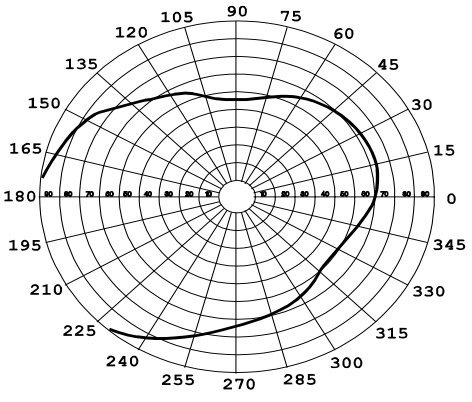
These notations serve only as an indication of the approximate relationship between recording of distant and near vision and point type sizes. The teacher will find in practice that the pupil's reading performance may vary considerably from the equivalents shown.

Distant Snellen	Near A.M.A.	Near Jaeger	Near Metric	% Central Visual Efficiency for Near	Point	Usual Type Size
20/20 (ft.)	14./14. (in.)	1	0.37(M.)	100	3	Mail order catalogue
20/30	14'/21	2	0.50	95	5	Want ads
20/40	14/28	4	0.75	90	6	Telephone directory
20/50	14/35	6	0.87	50	8	Newspaper directory
20/60	14/42	8	1.00	40	9	Adult text books
20/80	14/56	10	1.50	20	12	Children's books 9-12 years
20/100	14/70	11	1.75	15	14	Children's books 8-9 years
20/120	14/84	12	2.00	10	18	
20/200	14/140	17	3.50	2	24	Large type text
12.5/200	14/224	19	6.00	1.5		
8/200	14/336	20	8.00	1.0		
5/200	14/560					
3/200	14/900					

FIELD OF VISION Record results on chart below

Type of test used_____ Illumination in ft. candles_____

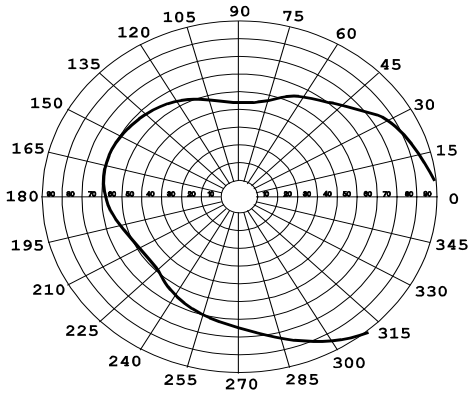
LEFT EYE



Test Object: Color (s) _____ Size (s) _____

Distance (s) _____

RIGHT EYE



Test Object: Color (s) _____ Size (s) _____

Distance (s) _____

AUTHORIZATION FOR RELEASE OF INFORMATION

*(**Please make multiple copies of this form if needed**)*

I hereby give consent for release of the specified information indicated below from the records of:

Child's Name	Date of Birth	Social Security #
Home Address		

Information to be released from: _____

_____ _____ _____

(Address) (Phone) (Fax)

to the: Tennessee School for the Blind 115 Stewarts Ferry Pike Nashville, TN 37214

Type(s) of information requested are check below:

❑ Office Administrative Record (Cumulative File)	❑ Medical History Reports
❑ Observations and rating by agency Personnel	❑ Scholastic Achievement
❑ Individual Education Plans (IEPs)	❑ Therapy Evaluations, Reports & Programming
❑ Eye Exams	❑ Psychological Evaluations
❑ Functional Vision Assessments	❑ Low Vision Evaluations
	❑ Transition Plans
	❑ Other_____

1. I understand that this authorization will remain in force for a reasonable time in order to effectuate the purposes for which it is given.
2. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken upon it.
3. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to receive services (evaluation, enrollment) from Tennessee School for the Blind.
4. This authorization does not authorize discussion of applicant's health information or medical care with anyone other than the assessment team members and/or clinic staff at Tennessee School for the Blind.

By: _____ Date:_____

Signature of Parent or Representative authorized by law

_____ _____

Printed Name of Parent/Representative Relationship to Applicant

**OPHTHALMOLOGIST

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby give consent for release of the specified information indicated below from the records of:

Child's Name	Date of Birth	Social Security #
Home Address		

Information to be released from: _____

_____ _____ _____
(Address) (Phone) (Fax)

to the: Tennessee School for the Blind 115 Stewarts Ferry Pike Nashville, TN 37214

Type(s) of information requested are check below:

- ❑ Office Administrative Record (Cumulative File)
- ❑ Observations and rating by agency Personnel
- ❑ Individual Education Plans (IEPs)
- ❑ Eye Exams
- ❑ Functional Vision Assessments
- ❑ Medical History Reports
- ❑ Scholastic Achievement
- ❑ Therapy Evaluations, Reports & Programming
- ❑ Psychological Evaluations
- ❑ Low Vision Evaluations
- ❑ Transition Plans
- ❑ Other_____

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3. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to receive services (evaluation, enrollment) from Tennessee School for the Blind.
4. This authorization does not authorize discussion of applicant's health information or medical care with anyone other than the assessment team members and/or clinic staff at Tennessee School for the Blind.

By: _____ Date:_____
Signature of Parent or Representative authorized by law

_____ _____
Printed Name of Parent/Representative Relationship application

Tennessee School for the Blind (TSB) does not and shall not **discriminate** on the basis of race, color, religion (creed), gender, gender expression, age, national origin (ancestry), disability, marital status, sexual orientation, or military status, in any of its activities or operations.

TSB CLINIC

SPECIAL FORMS

(COMPLETE ONLY FORMS APPLICABLE TO STUDENT)

TENNESSEE SCHOOL FOR THE BLIND CLINIC

115 STEWARTS FERRY PIKE
NASHVILLE, TN 37214
PHONE: (615) 231-7399 FAX: (615) 231-7417

HEALTH CARE PROVIDER'S ORDER FOR DIASTAT AND ADMINISTRATION OF DIASTAT

NAME OF CHILD: _____ DOB: _____

1. **DIASTAT ORDER:**
   _____
2. **HAS STUDENT EVER RECEIVED DIASTAT:**
   _____
3. **WHAT SIDE EFFECTS MAY BE EXPECTED AFTER DIASTAT IS GIVEN:**
   _____
4. **DOES THE STUDENT TAKE ANY MEDICATION THAT MAY POTENTIATE THE SIDE EFFECTS OF DIASTAT?**
   _____
5. **IF STUDENT HAS A RESPIRATORY VIRUS, INFECTION OR A FEVER, SHOULD DIASTAT BE GIVEN?**
   _____
6. **LIST ALL MEDICATION STUDENT IS TAKING:**
   _____

ACCORDING TO TENNESSEE SCHOOL FOR THE BLIND POLICY, AFTER DIASTAT IS GIVEN 911 WILL BE CALLED, SUPERINTENDENT WILL BE CALLED, AND PARENTS WILL BE CALLED.

NURSES WILL BE RESPONSIBLE FOR ADMINISTERING DIASTAT WHILE STUDENT IS AT A SCHOOL. HOWEVER, DURING A TSB SUPERVISED OUTING, OR DURING LONG-TERM BUSSING, A TRAINED VOLUNTEER IF AVAILABLE, MAY ADMINISTER DIASTAT AS ORDERED AND 911 WILL BE CALLED.
IF A TRAINED VOLUNTEER IS UNAVAILABLE, 911 WILL BE CALLED.

FOR LOCAL BUSSING, LEA WILL BE MADE AWARE OF DIASTAT ORDER FOR LOCAL BUSSING.

PHYSICIANS SIGNATURE: _____DATE: _____
PHYSICIANS OFFICE ADDRESS_____OFFICE PHONE: _____

IT IS UNDERSTOOD THAT THE ADMINISTRATION OF DIASTAT IS GIVEN SOLELY AT THE REQUEST OF, AND AS AN ACCOMODATION TO THE UNDERSIGNED PARENT OR GUARDIAN. IN CONSIDERATION OF THE ACCEPTANCE OF THIS REQUEST TO PERFORM THIS SERVICE BY A SCHOOL NURSE OR TRAINED VOLUNTEER EMPLOYED BY TENNESSEE SCHOOL FOR THE BLIND; THE PERSONNEL SHALL NOT BE LIABLE FOR ANY INJURY RESULTING FROM REASONABLE AND PRUDENT ASSISTANCE IN THE ADMINISTRATION OF EMERGENCY ANTI-SEIZURE MEDICATION ACCORDING TO (TCA 49-5-415). PERMISSION IS GIVEN FOR COMMUNICATION WITH THE HEALTH CARE PROVIDER REGARDING THIS MEDICATION.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN **DATE**

HOME PHONE AND CELL NUMBERS:
_____

EMERGENCY CONTACT AND NUMBER:
_____

TENNESSEE SCHOOL FOR THE BLIND CLINIC
115 STEWARTS FERRY PIKE
NASHVILLE, TN 37214
PHONE: (615) 231-7399 FAX: (615) 231-7417

FOOD ALLERGY AND ANAPHYLAXIS FORM

NAME OF STUDENT_____ DOB: _____

THIS STUDENT HAS A POTENTIALLY LIFE-THREATENING ALLERGY.

THIS STUDENT IS ALLERGIC TO:

_____

_____

TYPICAL SYMPTOMS OF ANAPHYLACTIC REACTION INCLUDE:

- **PRESENCE OF KNOWN ALLERGEN**
- **SWELLING OF LIPS FACE OR BODY**
- **GENERALIZED SKIN RASH**
- **REPEATED VOMITING**
- **DIFFICULTY TALKING**
- **DIFFICULTY BREATHING (WHEEZE OR STIDOR)**
- **COUGH**
- **DIFFICULTY SWALLOWING**
- **LOSS OF CONSIOUSNESS**
-

PHYSICIAN OR NURSE PRACTITIONERS ORDER:

_____

_____

PHYSICIAN SIGNATURE_____ DATE: _____

IF STUDENT SHOWS SYMPTOMS OF ANAPHYLACTIC REACTION, GIVE EPI-PEN JR. AS PRESCRIBED BY MD.
CALL 911: TELL THEM SOMEONE IS HAVING A LIFE-THREATENING EMERGENCY REACTION. ASK THEM TO SEND AN AMBULANCE IMMEDIATELY.
EVEN IF SYMPTOMS ARE MILD, SEND TO NEAREST HOSPITAL.
IF STUDENT STOPS BREATHING, START CPR AND SEND FOR AED. CONTINUE CPR UNTIL EMERGENCY PERSONELL RELIEVES YOU.

EMERGENCY CONTACT INFORMATION:

NAME	RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE

THE UNDERSIGNED PARENT/GUARDIAN HEREBY AUTHORIZES TENNESSEE SCHOOL FOR THE BLIND TRAINED STAFF TO ADMINISTER EPINEPHRINE TO THE ABOVE CHILD IN THE EVENT OF ANAPHYLACTIC REACTION AS DESCRIBED ABOVE.

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

TENNESSEE SCHOOL FOR THE BLIND CLINIC

115 STEWARTS FERRY PIKE
NASHVILLE, TN 37214
PHONE: (615) 231-7399 FAX: (615) 231-7417

ASTHMA ACTION PLAN
(*Physician or N.P. must fill out*)

STUDENT NAME: _____DOB:_____

ASTHMA MEDICATION ORDER: _____

IF NORMAL RESPIRATIONS DO NOT RETURN, WHEN INHALER SHOULD BE GIVEN AGAIN:

_____

POSSIBLE SIDE EFFECTS OF ASTHMA MEDICATION:

_____

STEPS TO BE TAKEN IN THE MANAGEMENT OF AN ASTHMA EPISODE, PLEASE CHECK ALL THAT APPLY:

_____*TALK CALMLY TO STUDENT***
_____*HELP THE STUDENT SIT IN A COMFORTABLE POSITION; LEANING FORWARD MAY ASSIST BREATHING***
_____*ENCOURAGE DEEP SLOW BREATHING***
_____*NOTIFY SCHOOL NURSE TO BRING INHALER; OR IF STUDENT CARRIES INHALER ASSIST IN ADMINISTRATION OF INHALER***
_____*OBTAIN PEAK FLOW READING IF APPLICABLE***
_____*MONITOR AND RECORD VITAL SIGNS AND RESPIRATIONS UNTIL BREATHING IMPROVES***
_____*GIVE WARM CLEAR LIQUIDS ESPECIALLY TEA IF AVAILABLE.***
_____*MONITOR AND RECORD LUNG SOUNDS UNTIL IMPROVEMENT***

DOES STUDENT TAKE ANY MEDICATION WHICH MAY POTENTIATE OR INTERFERE WITH ASTHMA MEDICATION?

_____

MAY THE STUDENT CARRY ASTHMA INHALER _____ (IF STUDENT IS UNABLE TO CARRY INHALER, PLEASE EXPLAIN) _____

TENNESSEE SCHOOL FOR THE BLIND HAS A 24 HOUR NURSING STAFF AVAILABLE TO HELP ADMINISTER ASTHMA INHALER. Also if nurse is unavailable, trained volunteers will be available to assist.

911 WILL BE CALLED:

_____CHILD SHOWS NO SIGN OF IMPROVEMENT AFTER EMERGENCY INHALER IS GIVEN.
_____HAS A PEAK FLOWS RATING OF _____.
_____BLUE OR GRAY DISCOLORATION OF LIPS AND/OR FINGERNAILS
_____STUDENT HAS DIFFICULTIES WALKING OR TALKING (CANNOT SPEAK IN COMPLETE SENTENCES.
_____STUDENT CONTINUES TO STRUGGLE FOR BREATH, HUNCHES OVER, OR SUCKS IN CHEST AND NECK MUSCLES IN AN ATTEMPT TO BREATH
_____OTHER ACTIONS PER PHYSICIAN INCLUDE THE FOLLOWING:

_____

ACCORDING TO TENNESSEE STATE LAW TCA 49-5-415: STUDENT MAY CARRY AND SELF ADMINISTER A PRESCRIBED ASTHMA INHALER UNDER THE FOLLOWING CIRCUMSTANCES: THE PHYSICIAN MUST PROVIDE THE NAME, PURPOSE, and DOSE. TIMES AND CIRCUMSTANCES FOR USE OF EMERGENCY INHALER. THE PHYSICIAN MUST PROVIDE FURTHER DOCUMENTATION THAT THE STUDENT HAS BEEN TRAINED IN THE PROPER USE OF THE INHALER. If student is unable to self administer, physician needs to specify asthma instructions.
PHYSICIAN'S SIGNATURE INDICATES THE AGREEMENT WITH THE PLAN AND ORDER FOR THE CURRENT SCHOOL YEAR.

PHYSICIAN SIGNATURE: _____DATE:_____

PHYSICIAN PHONE NUMBER: _____

PARENT/GUARDIAN SIGNATURE ACKNOWLEDGING PLAN:_____DATE:_____

TENNESSEE SCHOOL FOR THE BLIND CLINIC

115 STEWARTS FERRY PIKE
NASHVILLE, TN 37214
PHONE: (615) 231-7399 FAX: (615) 231-7417

GASTROSTOMY TUBE FEEDING ORDER FOR GT FEEDINGS AT SCHOOL

NAME OF STUDENT: _____ DOB: _____

TYPE OF G-TUBE

- BUTTON: _____
- CATHETER: _____
- OTHER: _____

FORMULA NAME AND SPECIFIC DOCTOR'S ORDER FOR TUBE FEEDING:_____
_____
_____
_____

FEEDING METHOD: (PLEASE CHECK BELOW)
BOLUS: _____
GRAVITY DRIP: _____
FEEDING PUMP: _____

FEEDING POSITION: PLEASE CHECK BELOW
SITTING: _____
RECLINED: _____
SUPINE: _____

STUDENT MAY SELF ADMINISTER TUBE FEEDING: _____ _____
YES NO

PARENT WILL BE NOTIFIED IF TUBE BECOMES CLOGGED OR DISLODGED.
FEEDING FORMULA MUST BE SENT TO SCHOOL IN ORIGINAL UNOPENED CONTAINER.

ADDITIONAL PHYSICIAN'S COMMENTS:_____
_____
_____

MD SIGNATURE: _____ DATE: _____ PHONE: _____

PARENTS SIGNATURE: _____ DATE: _____

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EMERGENCY GLUCAGON FORM

NAME OF STUDENT: _____ DOB: _____

Glucagon Order: _____
_____
_____

Has glucagon ever been given before? _____

When should glucagon be given? _____
_____

Possible side effects after receiving glucagon?_____
_____

After administration of glucagon, 911 will be called and parents will be notified.

If student is local, LEA will be notified that glucagon has been ordered for student.

IF GLUCAGON NEEDS TO BE GIVEN WHILE ON TSB BUSSING FROM HOME TO SCHOOL AND RETURN HOME, OR ON AN APPROVED TSB OUTING. STATE LAW TCA 49-5-415 STATES: "SCHOOL PERSONNEL WHO VOLUNTEER UNDER NO DURESS OR PRESSURE, AND WHO HAVE BEEN PROPERLY TRAINED BY A REGISTERED NURSE OR DESIGNEE EMPLOYEED OR CONTRACTED BY THE LOCAL EDUCATION AGENCY MAY ADMINISTER GLUCAGON IN AN EMERGENCY SITUATION BASED ON INDIVIDUAL HEALTH PLAN. GLUCAGON TRAINING SHOULD OCCUR YEARLY."

IF A TRAINED VOLUNTEER IS UNAVAILABLE, 911 WILL BE CALLED.

PHYSICIAN'S SIGNATURE: _____ DATE: _____

IT IS UNDERSTOOD THAT THE MEDICATION IS ADMINISTERED SOLELY AND AT THE REQUEST OF, AND AS AN ACCOMMODATION TO THE UNDERSIGNED PARENT OR GUARDIAN, AND IN ACCEPTANCE OF THE REQUEST TO PERFORM THIS SERVICE BY A SCHOOL NURSE OR A TRAINED VOLUNTEER EMPLOYEED BY THE TENNESSEE SCHOOL FOR THE BLIND, AND THE PERSON SHALL NOT BE LIABLE FOR ANY INJURY RESULTING FROM REASONABLE AND PRUDENT ASSISTANCE IN THE ADMINISTRATION OF GLUCAGON UNDER TCA-49-5-435. PERMISSION IS GIVEN TO GIVE THIS MEDICATION AS ORDERED BY THE PHYSICIAN AND TO COMMUNICATE WITH THE HEALTH CARE PROVIDER REGARDING THIS MEDICATION.

PARENT OR GUARDIAN SIGNATURE:

_____ DATE: _____

PHONE NUMBER WHERE PARENT/GUARDIAN CAN BE REACHED:

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NASHVILLE, TN 37214
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CORTISONE REPLACEMENT THERAPY

Student's Name: _____ DOB: _____

The pituitary gland is considered the MASTER gland of the body because it sends signals to the other glands to produce hormones.

- *Causes* of this lack of function of the pituitary gland or pan hypopituitarism are:

  Surgery
  Stroke
  Infection
  Genetic factors
  Injury
  Septo Optic Dysplasia

- The *problems associated with* missing or damaged pituitary gland are:

Women - Missed menstrual periods, osteoporosis, infertility, loss or reduction in the female characteristics (ex: no pubic hair, inability to produce milk)
Men – Reduced size of the testicles, decreased sperm, no beard, lack of muscle mass
Insufficient Growth Hormone - Children do not grow
Insufficient Thyroid - Poor concentration, confusion, weakness and difficulty tolerating exercise
Insufficient Cortisol - Low blood sugar (*Glucagon* does not work; must give solu-cortef), low blood pressure, slow heart, stiff muscles, fatigue, weight loss and vomiting (*which may be life-threatening)*
Insufficient Anti-diuretic Hormone – Diabetes Insipidus, excessive thirst and excessive urinating, fluid imbalance *(which may be life-threatening*)
Need Hormone Replacement Therapy

- ****PROBLEMS TO WORRY ABOUT:**
  1. ANY MAJOR STRESS TO THE BODY CAN BE LIFE-THREATENING
  2. VOMITING (UNABLE TO TAKE ORAL MEDICATION)
  3. BROKEN BONE OR TRAUMA TO THE BODY
  4. FLU AND OTHER ILLNESSES SUCH AS STREP THROAT
  5. FEVER OVER 101

WHEN THIS OCCURS, THEY NEED AN EMERGENCY DOSE OF CORTISONE (oral **OR** 'im'***) AND TO BE SENT TO THE EMERGENCY ROOM IF 'IM' IS GIVEN.***

Name of Physician: _____ Physician Signature _____

DATE: _____

NEW PHARMACY SERVICES

(*OPTIONAL*)

- Automatic refills prevent students running out of medication
- No transporting medication between home and TSB. Meds would always be where the patient is located.
- Pharmacy would communicate directly with the physician regarding refills and necessary orders to refill medication.
- Medication would be pre-packaged at no additional cost
- Labeled medication contained in package
- Labeled as to day and time dose due
- Easy to carry and store
- Medication sent home monthly for weekend use/holiday use
- Medication for weekday use will remain at TSB
- No disruption during summer vacation. Medication shipped directly to home or designated location at NO additional cost
- Voluntary participation

****For additional information, please call Kathy Craft, RN4, Director of Clinical Services: 615-231-7398**