South Panola School District
Consent for Treatment at School

Treatment of minor ailments and injuries may be provided if the parent/guardian has completed the annual health form and signed the consent form for the school nurse to carry out first aid and administer care as listed in the South Panola School District Standing Nurse Orders. These orders have been approved by a local physician to be followed by the school nurses.

South Panola School District School Nurse Standing Orders

Condition	Treatment	Medication Treatment
BITES/STINGS	REMOVE STINGER. APPLY ICE FOR 20 MINUTES	TOPICAL ANALGESIC. BENADRYL 12.5-25 MG IF NEEDED WITH PARENT CONSENT
MINOR BURNS	COLD WATER RINSE FOR 5 MINUTES	BURN SPRAY
FEVER/PAIN	• FOR TEMPERATURE 100.4 OR GREATER NOTIFY PARENT TO CHECK OUT • IF LESS THAN 100.4 MAY TREAT AND NOTIFY PARENT • STUDENT MUST BE FREE OF FEVER FOR 24 HOURS BEFORE RETURNING TO SCHOOL • TREATMENT OF PAIN X 1 DOSE DURING SCHOOL DAY	• ACETAMINOPHEN-325 MG 1 OR 2 TABLETS AGES 12 AND UP. LESS THAN 12 YO BASE ON AGE/WEIGHT. ONE TIME DOSE IN SCHOOL DAY • IBUPROFEN-200 MG BY MOUTH 1 OR 2 TABLETS AGES 12 AND UP. LESS THAN 12 YO BASE ON AGE/WEIGHT • NO ASPIRIN
SIMPLE HEADACHE	REST IN QUIET AREA FOR 15-30 MINUTES	ACETAMINOPHEN/IBUPROFEN AS INDICATED ABOVE. REFER IF PERSISTS. ONE TIME TREATMENT IN SCHOOL DAY
CUTS/ABRASIONS	CLEANSE WITH SOAP AND WATER	APPLY ANTIBIOTIC CREAM. REFER IF SUSPECT SKIN INFECTION
MENSTRUAL CRAMPS	REST FOR 30 MINUTES. WARM COMPRESS	ACETAMINOPHEN/IBUPROFEN AS INDICATED ABOVE
SORE THROAT	GARGLE WITH WARM SALT WATER. IF FEVER OR SIGNS OF INFECTION, REFER TO MD	THROAT LOZENGES ACETAMINOPHEN/IBUPROFEN AS INDICATED ABOVE
TOOTHACHE	RINSE WITH WARM SALT WATER. COOL COMPRESS TO CHEEK	TOPICAL BENZOCAIN 1% ACETAMINOPHEN/IBUPROFEN AS INDICATED ABOVE
ABDOMINAL DISCOMFORT	REST FOR 15-20 MINUTES AND OBSERVE FOR VOMITING OR DIARRHEA. SEND HOME FOR VOMITING/DIARRHEA	ANTACID/MAALOX. FOLLOW LABEL INSTRUCTIONS
SUSPECTED RINGWORM	RULE OUT RINGWORM OF SCALP. IF SUSPECTED, REFER TO MD FOR FURTHER TREATMENT	ANTIFUNGAL CREAM TO AFFECTED AREA UNLESS LOCATED ON SCALP
RASHES	RULE OUT ALLERGIC REACTION. COOL COMPRESS TO AFFECTED AREA	CALADRYL/CALMINE LOTION TO AFFECTED AREA 1% HYDROCORTISONE CREAM TO AFFECTED AREA
CONJUNCTIVAL IRRITATION	EXAMINE FOR FOREIGN BODY. REFER IF SUSPECT INFECTION	SALINE EYE DROPS OR ARTIFICIAL TEARS. REFER IF PERSISTS
ALLERGIC REACTION	RULE OUT ANAPHYLAXIS. ATTEMPT TO DETECT ALLERGEN. CONTACT PARENT	ADMINISTER BENADRYL 12.5-25 MG BASED ON AGE/WEIGHT. REFER TO MD IF INDICATED
ANAPHYLACTIC SHOCK	IDENTIFY THAT CONDITIONS OF ANAPHYLAXIS ARE DEVELOPING OR PRESENT THEMSELVES	FOR INDIVIDUALS 33-66 POUNDS USE ONE EPIPEN JR AUTO INJECTOR TO DELIVER 0.15 MG OF EPINEPHRINE IM FOR INDIVIDUALS 66 POUNDS OR GREATER USE ONE EPIPEN AUTO INJECTOR TO DELIVER 0.3 MG OF EPINEPHRINE IM *IN EVERY CASE, 911 MUST BE NOTIFIED*

Parent Consent

I have read the above standing orders and I give permission for treatment of such conditions, including transportation to the emergency room, doctor's office or home of student or emergency contact. I understand that I am responsible for any bill associated with emergency treatment.

YES: _____ NO: _____

I HEREBY EXPRESSLY WAIVE AND RELEASE THE SOUTH PANOLA SCHOOL DISTRICT AND ITS EMPLOYEES, BOARD OF TRUSTEES, AGENTS, SUCCESSORS AND ASSIGNS (COLLECTIVELY "RELEASEES") FROM ANY AND ALL CLAIMS, NOW KNOWN OR HEREAFTER KNOWN, AND LIABILITY AGAINST ANY RELEASEE ON ACCOUNT OF INJURY, DISABILITY, DEATH, OR PROPERTY DAMAGE ARISING OUT OF OR ATTRIBUTABLE TO ANY TREATMENT OF MY MINOR CHILD'S CONDITIONS AS SET FORTH HEREIN, WHETHER ARISING OUT OF THE ORDINARY NEGLIGENCE OF THE DISTRICT OR ANY RELEASEES OR OTHERWISE. I COVENANT NOT TO MAKE OR BRING ANY SUCH CLAIM AGAINST THE DISTRICT OR ANY OTHER RELEASEE, AND FOREVER RELEASE AND DISCHARGE THE DISTRICT AND ALL OTHER RELEASEES FROM LIABILITY UNDER SUCH CLAIMS. THIS WAIVER AND RELEASE DOES NOT EXTEND TO CLAIMS THAT MISSISSIPPI LAW DOES NOT PERMIT TO BE RELEASED BY AGREEMENT. THIS RELEASE IS INTENDED TO BE A GENERAL RELEASE IN THE BROADEST FORM. IT IS UNDERSTOOD AND AGREED THAT I HEREBY EXPRESSLY WAIVE ANY AND ALL LAWS AND STATUTES, OF ALL JURISDICTIONS WHATSOEVER, WHICH MAY PROVIDE THAT A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS NOT KNOWN OR SUSPECTED TO EXIST AT THE TIME OF EXECUTING A RELEASE WHICH IF KNOWN WOULD HAVE MATERIALLY AFFECTED THE DECISION TO GIVE SAID RELEASE. IT IS EXPRESSLY INTENDED AND AGREED THAT THIS RELEASE DOES, IN FACT, EXTEND TO SUCH UNKNOWN AND UNSUSPECTED CLAIMS RELATED TO ANYTHING WHICH HAS HAPPENED TO THE DATE HEREOF WHICH IS COVERED BY THIS RELEASE, EVEN IF KNOWLEDGE THEREOF WOULD HAVE MATERIALLY AFFECTED THE DECISION TO GIVE THIS AGREEMENT OR THE RELEASE.

Parent/Guardian Signature: _____ Date: _____

South Panola School District
Health Information

Name: _____ Grade: _____ Homeroom: _____

Birthdate: _____ Sex: _____ Student's Doctor & Phone Number: _____

Mother: _____ Phone Number: _____

Father: _____ Phone Number: _____

Emergency Contact: _____ Phone Number: _____

Health History

If you mark yes, please make a note under Symptoms and Medications.

Problem	YES	NO	List Symptoms and Medications
Allergy to Food			
Allergy to Medicine			
Allergy to Insects			
			Does student require an EpiPen? ___ Yes ___ No **If Yes, what severe allergy is EpiPen used to treat?** **_____**
Asthma			**If Yes Please Provide Asthma Action Plan Completed By Doctor** **Does student use rescue inhaler? ___Yes ___No** **Does student require breathing treatments? ___Yes ___No**
Attention Deficit (ADD, ADHD)			
Bladder/Kidney Problems			
Diabetes			
Earaches (frequent)			
Emotional Disorder			
Hearing/Speech Problems			
Heart Problems			
High Blood Pressure			
Muscle/Skeletal Problems			
Nose Bleeds			
Past Surgeries			
Sickle Cell Disease			
Sinus Problems			
Skin Problems			
Stomach/Bowel Problems			
Vision Problems			Eyeglasses? YES or NO

Is the student taking any daily medications? ___ NO ___ YES If yes, please list medications: _____

_____

Turn Form Over to Complete