Approved Nurse Initiated Procedures 2014-2015

- Allergies:
  Mild –*Benadryl, Zyrtec, Sudafed or Loratadine* **Anaphylactic Reaction:** *Epipen*

- Breathing Difficulties: O2 Sat < 93%, wheezing, or retracting
  Albuterol nebulizer treatment with Oxygen (Until parent/guardian can pick up)

- Cough or Congestion:
  Cough Drops, Robitussin, Tylenol /Motrin Cold and Cough or Dayquil

- Dental Issues:
  Loose baby teeth may be removed if ready. Give treasure box and certificate.
  Toothache/gum pain: Kanka, Orajel, or all natural eugenol

- General Wound Care:
  1. Clean the wound and remove debris with soap and water or hydrogen peroxide.
  2. Apply triple antibiotic ointment (if no allergy) and then dress with a bandage.

- Headache or generalized body aches or injury:
  Pain Reliever or Ibuprofen per recommended package dosing

- Itching due to insect bite or rash:
  Hydrocortisone cream or Benadryl (cream or spray).

- Nausea, Indigestion, or Upset Stomach:
  Tums, Mylanta, Maalox, or Children's Pepto-Bismol chewable tablets.

- Sprained or Strained Muscles or Bone Injury:
  If necessary: Ice, sling, ace wrap, splint, or muscle rub.

- Symptoms of Hypoglycemia: (Blood Glucose < 70)
  Can check blood glucose via glucometer and give juice and/or oral glucose.

A parent will be notified prior to administering medication. Written documentation will be sent with the student documenting time and dosage given.

_______ I give my consent for any of the treatment listed.
Please indicate any exceptions: ____
____

_______ I do **NOT** give my consent for ANY of the treatment outlined.

Student Name: ___________________________ Parent's Signature: _______________________________

cfa Academy
154 Warren C. Coleman Blvd.
Concord, NC 28027
Phone: 704.793.4750 Elementary Fax: 704.793.4784 Upper School Fax: 704.793.4835

Student's Name______________________________________Grade_____Homeroom_____________

Please complete reverse side.

My Child has one of the following Medical Conditions listed below:

I realize that if any of these are marked, I will receive the appropriate *Action Care Plan* from the school nurse that needs to completed and returned to have on file in the clinic.

____ Asthma
____ Diabetes
____ Food, Medication or Latex Allergy
____ Seizures
____ Attention Deficit/Hyperactivity
____ Other (Please explain)

____

____

Clinic Notes:
______ Parent Contacted
______ Action Care Plan Received
______ Medication Received, if applicable

CONTACT INFORMATION

Please circle the number to call first

Home Phone Number: ___________________________

Mother's Work Number: ___________________________ Cell Number: ______________________

Father's Work Number: __________________________ Cell Number: ______________________

OTHER CONTACTS

	Name	Relationship	Number
1.	___________________________	________________	____________________________
2.	___________________________	________________	____________________________
3.	___________________________	________________	____________________________

Additional Information:

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