THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
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Coordinated Student Health Services
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The School Board of Broward County, Florida

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February 15, 2018

Dear Principal,

This letter provides you with information regarding Extended School Year (ESY) for the 2017-2018 school year. Many of these students attend school with medical diagnoses that are known to their assigned school staff; however, in ESY these students are assigned to different schools with limited knowledge of these children's medical needs.

Coordinated Student Health Services has developed the attached checklist to assist you, as principal of the ESY site, in the provision of medical care for these students in a safe and healthy environment.

Please use this checklist to ensure all processes and trained personnel are in place to provide the medical services necessary for these students to attend the ESY program.

As you are completing the checklist, if you do not have the trained personnel for medication administration, please assign personnel to complete the Medication Administration Modules found on our website at www.browardhealthservices.com. If you have any questions, you may contact Denese Champagnie or Amber Henderson at 754-321-1575.

Thank you for your attention to this most important matter.

Sincerely,

Marcia Bynoe
Director

MB:etb
Attachment

The School Board of Broward County, Florida
Coordinated Student Health Services (CSHS)

ESY MEDICAL NEEDS CHECKLIST

DATE _____

SCHOOL NAME _____

PRINCIPAL'S NAME _____

- ☐ Current and completed Authorization for Medication and/or Treatment Form, on file in the clinic, for any medication or medical procedure that will need to be provided during the ESY school day.

  Note: If the form is expired the medication or procedure will not be provided until there is a current form obtained by the parent.

- ☐ Two school staff assigned to provide medications.

  Note: The two assigned staff members must have current certificates to administer medication in the school setting and must be checked-off by a Registered Nurse. (Certificates last 2 years).

- ☐ Staff members overseeing the care of students with health conditions have student specific training by a registered nurse and have the supporting documentation.

- ☐ Two staff members trained to administer CPR.

- ☐ One staff member assigned to check the AED every other week.

- ☐ A designated Emergency Team to respond to emergencies.

Note: Emergency Team members include:

- Two CPR trained personnel.
- Designated personnel to administer emergent medication (Epinephrine Pen, Diazepam seizure emergent medication, and Glucagon – emergent medication for students with Diabetes).
- Designated personnel to call 911.
- Designated personnel to call the student's family/residential home.
- Designated school personnel to ride with student to hospital.

- ☐ An Emergency Plan that is written and posted.
- ☐ Acknowledgment of the Emergency Plan by staff by signature on the plan.

Please fax the completed checklist to 754-321-1687 or scan and e-mail to amber.henderson@browardschools.com, by Thursday, May 31, 2018

HEALTH SERVICES REQUEST (HSR) FORM

This form is to be used to request health services or to request training by registered nurse to provide training for school-based personnel who will be performing health procedures. This form needs to be completed by the school and faxed along with the **completed Authorization for Medication/Treatment form** to Coordinated Student Health Services (CSHS) at **754.321.1687** For more information please call CSHS at 754.321.1575.

Date: _____

STUDENT AND SCHOOL INFORMATION:

Name of student: _____ DOB/Age: _____ Grade: _____

Program enrolled: ESE (not in gifted program) _____ 504 _____

School: _____ School Contact/Title: _____ Telephone Number: _____

Reason For Request: _____ **School Emergency Plan in Place** _____YES_____NO

PLEASE SUBMIT CURRENT MEDICATION/TREATMENT AUTHORIZATION FORM WITH REQUEST

Request For Health Training	Request For Direct Nursing Care for Student
List number of personnel who will attend training:	Potential Start date for Student:
If Education Support Professionals (ESP) will be trained and assigned to perform a medical procedure, list names and designation: 1. (Primary/Split) _____ 2. (Back-up/Split) _____	Parent/Guardian Name: _____ Student's address: _____ All contact telephone numbers for parent/guardian: _____
List three dates and times for Registered Nurse to conduct training: 1. _____ 2. _____ 3. _____	Transportation: Bus _____ Car _____ Bus: Pick-up Time: _____ Drop off Time: _____

(For CSHS staff only) NURSING COVERAGE REQUEST: Name of Nurse Requesting Coverage: _____
School of Employment/Hours of service: _____
Requested Dates Off: _____

****Please complete the student and school information and submit form with student(s) Authorization for medication/treatment form(s).**

Below to be completed by Coordinated Student Health Services: ___ RN ___ LPN ___ HST ___ Other

Date: _____ Time: _____ Agency: _____ Agency Representative: _____ Nursing Hours assigned: _____

For Billing: Student is enrolled in the assigned program (please check):

	ESE		ESE/Diabetes		504		504/Diabetes

__ SBBC Nurse Coverage: Send invoice directly to school