Hello IST Families!

I hope you all are having a great summer! As the start of the new school year approaches, I will be needing some updated health documentation from some of you. As applicable, this will include updated physician-signed Statement of Health forms, updated immunization records, updated health forms pertaining to your student's asthma, food allergies, or other allergies, and any updates to your student's health and medical record. Please read the following information carefully as it may pertain to your student(s).

Student Health items below include:

1. Updated Physician-Signed Statement of Health Form
2. Any Updates to a Student's Health or Medical Records
3. Updated Vaccination Records for Children Ages 4-6 and entering Grade 7 or Grade 8
4. Updated Health Forms for Students with Asthma, Severe Food Allergies, or Other Severe Allergies

Please email all updated health information or any questions to nurse@istexas.org, and be sure to include your student's name and grade level in the subject line.

Thank you,
Nurse Bethany

✅Item #1 Updated Physician-Signed Statement of Health Form

The International School of Texas is moving towards requiring a new physician-signed statement of health form each school year, corresponding with each student's birthday.

If your student's birthday is/was any time during May-August, it is time to complete and submit a new physician-signed statement of health form to the school. Please make an appointment and be sure to submit the updated document within 45 days after your student's birthday. Failure to submit the updated document within this timeframe may result in your student being excluded from attending school until it is received.

✅Item #2 Any Updates to Student's Health or Medical Records

If your student has any changes or updates pertaining to their health or medical records, please reach out to me. It is important for the school nurse to be aware of these changes to better ensure the health and well-being of students on campus.

Items 3-4 are on the next page!

✅Item #3 Updated Vaccination Records for Children Ages 4-6 and Students Entering Grade 7 or Grade 8

Please see the detailed information below for further instructions if they applicable to your student's age/grade:

If your student is 4-6 years old, they are due for one or more of the following:

- 5th DTaP vaccine (Diphtheria, Tetanus, and Pertussis)
- 4th IPV vaccine (Polio)
- 2nd MMR vaccine (Measles, Mumps, Rubella)
- 2nd VAR vaccine (Varicella)

Some of you may have a couple of these immunizations already completed but please be sure to schedule an appointment to complete these age-based requirements. You must get all of these immunizations for your child by their 7th birthday to meet the State's requirements. If there are any alterations or health/medical concerns pertaining to your child's immunization schedule, please let me know.

If your student is going into G7 or G8, they are due for:

- MCV4 (Meningococcal) vaccine
- Tdap/Td (Tetanus, Diphtheria, Pertussis) booster vaccine

Please be sure to schedule an appointment to complete this requirement. If there are any alterations or health/medical concerns pertaining to your child's immunization schedule, please let me know.

✅Item #4 Updated Health Forms for Students with Asthma, Severe Food Allergies, or Other Severe Allergies

If your student has Asthma, Severe Food Allergies, or Other Severe Allergies, I will need new/updated health forms for the 2023-2024 school year. Please see the detailed information below for further instructions for the health condition that relates to your child:

Asthma

If your child has asthma, there are 2 forms I will need from you: one is the Individualized Healthcare Plan specific for asthma and the other form is an Asthma Action Plan. The Individualized Healthcare Plan is for you, the parents, to fill out while the Asthma Action Plan is

to be completed by your student's healthcare provider. These forms are necessary to better understand the nature of your child's asthma and to have a plan in place in the event of an asthmatic event while at school.

The Individualized Healthcare form must be completed and turned in to me by the first day of school, August 14th. Please make an appointment with your provider to complete the Asthma Action Plan as soon as possible, the deadline for this form is August 31st. If you are not able to see your provider by that date, please reach out to me and we will discuss our options.

If you would like to schedule a day/time to drop off your student's inhaler and fill out the medication administration form prior to the start of school, please email me. I must have your student's inhaler and the administration form completed before your student may attend school on August 14th.

Severe Food Allergies or Other Severe Allergies

If your child has severe food allergies or other severe allergies, there is one form I will need from you: the Individualized Healthcare Plan specific for food allergies. If your student has severe environmental allergies, you will use the same form. The Individualized Healthcare Plan is for you, the parents to fill out. This form is necessary to better understand the nature of your child's allergy and to have a plan in place in the event of an anaphylactic event while at school.

The Individualized Healthcare form must be completed and turned in to me by the first day of school on August 14th. If you have received an Anaphylactic Action Plan from your healthcare provider, please send that to me as well.

If you would like to schedule a day/time to drop off your student's emergency medication(s) and fill out the medication administration form prior to the start of school, please email me. **I must have your student's emergency medication (EpiPen) and the administration form completed before your student may attend school on August 14th.**

ADMISSION INFORMATION
2024-2025

School Name & Address	PYP Head of School	MYP Head of School
International School of Texas 15506C W. Hwy 71, Bee Cave, TX 78738	Gené Racinskas	Chad Hyatt

Child's Full Name	Child's Date of Birth	Child's Home Telephone No.

ADMISSION REQUIREMENT

Please check only one option:

1. ☐ HEALTH-CARE PROFESSIONAL'S STATEMENT: I have examined the above-named child within the past year and find that he / she is able to take part in the school program.

_____ _____

Healthcare Professional's Signature Date

2. ☐ A signed and dated copy of a health care professional's statement is attached.

3. ☐ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of. I have attached a signed and dated the required affidavit stating this information.

HEALTHCARE PROFESSIONAL INFORMATION

Name of Healthcare Professional:_____ Name of Practice/Hospital: _____

Address: _____ Phone No.:_____

IMMUNIZATION RECORD

☐ I have provided the International School of Texas with a copy of my child's most current immunization record.

☐ I have provided the International School of Texas with a notarized exemption affidavit for reasons of conscience, including religious belief, from required school immunizations.

VISION & HEARING SCREENING

Please check only one option:

☐ I have provided the International School of Texas with a copy of my child's most current vision & hearing screening.

☐ I hereby give permission for my child to have an annual vision screening undertaken by the school.

_____ _____

Signature – Parent or Legal Guardian Date

ALLERGIES & MEDICAL CONDITIONS

My child has the following allergies or medical conditions: _____

☐ I have provided the International School of Texas with a copy of my child's most current allergy and medical condition action plan.

☐ My child does not have allergies.

☐ My child does not have medical conditions.

_____ _____

Signature – Parent or Legal Guardian Date

The colors of a traffic light will help you use your asthma medicines.

Green = Go Zone!
Use preventive medicine.

Yellow = Caution Zone!
Add quick-relief medicine.

Red = Danger Zone!
Get help from a doctor.

PREDICTED NORMAL PEAK FLOW READING:

_____*lpm*

CENTRAL TEXAS ASTHMA ACTION PLAN

To be completed by Physician Designee and signed by Physician Date _____

Patient Name_____ Date of Birth _____

Has the patient ever been admitted to ICU? ( ) Yes ( ) No Grade in School _____
Has the patient ever required mechanical ventilation? ( ) Yes ( ) No

Please classify this patient's asthma. *Refer to these choices adopted from the NIH Asthma Management Guidelines.*
Asthma Classification by Physician: **( ) Mild intermittent** **( ) Moderate persistent**
( ) Mild persistent **( ) Severe persistent**

Classification	Days with symptoms	Nights with symptoms	FEV1 or PEF (% pred. normal)
Severe persistent	Continual	Frequent	≤ 60%
Moderate persistent	Daily	≥ 5/month	> 60% to <80%
Mild persistent	> 2/week	3 to 4/month	≥ 80%
Mild intermittent	≤ 2/week	≤ 2/month	≥ 80%

GREEN ZONE: *No signs or PF 80-100% of Predicted Normal or Personal Best – Take Preventative Medication*

PEAK FLOW FROM _____ TO _____

You have all of these

- Breathing is good
- No cough or wheeze
- Sleep through night
- Can work and play

1. What preventative medications are prescribed and how often are they given? Name and Dose:

_____

2. Does this patient have Exercised Induced Asthma? ( ) Yes ( ) No If yes, what medication should be given for EIA?
Take only one of the treatments 15-20 minutes before physical activity as needed.
❑ ALBUTEROL 2 puffs MDI & chamber ❑ ALBUTEROL 1 vial in nebulizer

❑ XOPENEX 2 puffs MDI & chamber ❑ XOPENEX 1 vial in nebulizer

❑ OTHER: _____

YELLOW ZONE: *Caution Signs or PF 50 – 79% of Predicted Normal or Personal Best – Continue Preventative Medication*

PEAK FLOW FROM _____ TO _____

You have ***any*** of these:

- First signs of a cold
- Exposure to known trigger
- Coughing doesn't stop
- Mild wheeze
- Chest tightness

In case of an asthma exacerbation, what quick-relief medication should be used?
Take one treatment every 4-6 hours as needed for 24-48 hours.
Recheck peak flow 15 minutes after treatment
❑ ALBUTEROL _____ puffs MDI & chamber ❑ ALBUTEROL 1 vial in nebulizer

❑ XOPENEX _____ puffs MDI & chamber ❑ XOPENEX 1 vial in nebulizer

❑ OTHER: _____
If treatments are needed for longer than 24-48 hours, call your doctor.

RED ZONE: *Danger Signs or PF Below 50% of Predicted Normal or Personal Best – Continue Preventative Medication*

PEAK FLOW BELOW _____

Your asthma is getting worse fast:

- Medicine isn't helping
- Breathing is hard and fast
- Nose opens wide
- Ribs show during breathing
- Can't talk well.
- **Inhale & exhale wheeze**

1. In case of an asthma exacerbation, what quick-relief medication should be used?
Take one treatment every 20 minutes for up to three treatments only.
Recheck peak flow 15 minutes after treatment
❑ ALBUTEROL _____ puffs MDI & chamber ❑ALBUTEROL 1 vial in nebulizer

❑ XOPENEX _____ puffs MDI & chamber ❑XOPENEX 1 vial in nebulizer

❑ OTHER: _____

2. Get **immediate** medical attention – Call your doctor. If at school, go to the nurse. Or, call 911.

Physician signature: _____ Physician name: _____ Telephone(____)_____ Date:_____

For children in school: ***School Name:*** _____ ***School district***: _____

I, the above signed physician, certify that the above named student has asthma and is capable of carrying and self-administering the above quick-relief asthma medication. (Texas Inhaler Law.) **( ) Yes ( ) No**

I give permission for the school nurse to administer the above physician orders and to communicate with my child's health care provider concerning my child's asthma.

Parent signature: _____ Parent name: _____ Telephone: (____)_____ Date:_____

THE INTERNATIONAL SCHOOL OF TEXAS

Individualized Healthcare Plan: ASTHMA

Student Name:	DOB:
Student Address:	Home Phone:
Mother/Guardian:	Day/Work Phone:
Father/Guardian:	Day/Work Phone:
Healthcare Provider:	HCP Phone:
Date of Diagnosis:	Allergies:
Emergency Contact:	Emergency Contact Phone:
Emergency Contact:	Emergency Contact Phone:

Asthma Action Plan on File: _____

Date of Most Recent Follow Up: _____ Frequency of Asthma Episodes: _____

Hospitalizations for Asthma: _____

Symptoms During Asthma Episodes:

Triggers to Asthma Episodes:

At Home Medications:
(Please include Med Name, Dose & Frequency, Route and Time of Administration)

Needs assistance with fast-acting inhaled medications: Y /N
Uses a spacer for fast-acting inhaled medication: Y/N

School: International School of Texas **Teacher:** _____ Year: _____
IHP Written By: Bethany Reed, BSN, RN **IHP Date:** _____ **Review Date:**_____
IST School Nurse Signature: _____

Parent/Guardian Statement: *I/We have read this plan and agree to its implementation.*

Parent/Guardian Signature: _____
Date: _____

Nursing Diagnosis	Goals	Nursing Interventions	Expected Outcome
Ineffective airway clearance associated with chronic inflammation causing bronchoconstriction and excessive mucus production.	The student will assist in the development of an Asthma Action Plan with the parent and healthcare provider. The student will have his/her needed asthma medication available and easily accessible at school. The student will increase his/her ability to identify and manage environmental triggers.	Obtain an Asthma Action Plan from the parents/guardians and the healthcare provider. Identify the student's level of asthma severity by monitoring peak flows and asthma signs and symptoms to help in establishing priority for intervention. Ensure that quick-relief medication is easily and quickly available to the student	The student will have an Asthma Action Plan on file in the school health office to be used in developing an IHP and ECP. The student will demonstrate proper technique for using asthma medications and medication. delivery devices The student will assist in making sure that necessary medication is easily accessible and available.

Nursing Diagnosis	Goals	Nursing Interventions	Expected Outcome
Deficient knowledge about asthma and asthma self-care	The student will increase his/her knowledge about asthma and skills in asthma self-management, including the importance of adherence to the Asthma Action Plan and IHP to avoid asthma episodes and possible long-term harm to airways.	Educate teachers and other school personnel about the student's asthma, monitoring of student's symptoms, and means to implement the asthma management plan. Educate the student and family about: -characteristics of good control of asthma; -early recognition of signs and symptoms of an asthma exacerbation, interpretation of peak flow meter results, and actions to take to manage asthma symptoms; -student's asthma triggers and specific strategies to avoid or control exposure to -rights and responsibilities for self-carrying of inhaler medication	The student will identify symptoms of asthma. The student will identify early indications of an asthma exacerbation. The student will identify his/her asthma triggers and list strategies for how to avoid these or how to control exposure to them. The student will identify and describe responsibilities for self- carrying of medication and demonstrate safe use of self- carry medications. The student will periodically review with the school nurse and parent the effectiveness of his/her asthma management.

THE INTERNATIONAL SCHOOL OF TEXAS

Individualized Healthcare Plan: SEVERE FOOD ALLERGY or OTHER SEVERE ALLERGY

Student Name:	DOB:
Student Address:	Home Phone:
Mother/Guardian:	Day/Work Phone:
Father/Guardian:	Day/Work Phone:
Healthcare Provider:	HCP Phone:
Date of Diagnosis:	Allergies:
Emergency Contact:	Emergency Contact Phone:
Emergency Contact:	Emergency Contact Phone:

Emergency Action Plan on File: _____ Epi-Pen: Y/N

Date of Most Recent Follow Up: _____
Hospitalizations for Allergy: _____ # of Times Epi-Pen Used: _____

Symptoms Experienced During Previous Episodes:

Symptoms Experienced After Epi-Pen Use:

At Home Medications:
(Please include Med Name, Dose & Frequency, Route and Time of Administration)

Does Student Self-Carry Epi-Pen: Y /N

School: International School of Texas Teacher: _____ Year: _____
IHP Written By: Bethany Reed, BSN, RN IHP Date: _____ Review Date:_____
IST School Nurse Signature: _____ **Date:** _____

Parent/Guardian Statement: *I/We have read this plan and agree to its implementation.*
Parent/Guardian Signature: _____
_____
Date:

Assessment Data	Nursing Diagnosis	Goals	Interventions	Outcome
Potential for anaphylactic shock secondary to severe food allergy or other severe allergy. Asthma: YES/NO (circle one)	Risk for ineffective breathing related to bronchospasm and inflammation of the airways secondary to allergic reaction.	Student will have FAAP/EAP and IHP in place to include student, parental and staff roles in preventing and managing an anaphylactic reaction.	Secure medical documentation of food or other allergy, FAAP/EAP and information about food substitutions. • Educate school staff on early signs of potential anaphylaxis and appropriate steps to take in emergency care. - School wide training on recognition of signs of allergic reaction. - Student specific training for classroom, administrative, cafeteria, custodial and transportation personnel. - Train designated staff in the use of the epi auto-injector, first aid care, EMS contact. - Designated personnel receive copy of FAAP/EAP and IHP.	* Medical documentation received (FAAP/EAP) * Yearly staff awareness training conducted and documented. * Student specific training delivered and documented in student file. * Staff demonstrate proper use of epi auto-injector. In event of allergic reaction, staff responds according to FAAP/EAP. * Staff responds to student report of allergen exposure and supports student with self-care or by administering epi auto-injector . * Post crisis review conducted in the event of an allergen exposure.
		Student will demonstrate awareness of the significance of allergic reactions, symptoms and treatment.	Educate staff regarding allergen and institute environmental controls. • Have students/personnel wash hands or use hand wipes before and after food handling or consumption. Emphasize that hand sanitizer is NOT effective in removing food allergens from hands or surfaces. • Review food allergy and exposure prevention strategies with food service staff.	* Student will read food labels before ingestion. * Student will not accept food offered by others. * Student can demonstrate assertiveness when encountering situations that have potential to result in exposure to food allergen. * Student will identify allergic reactions, notify school personnel and treat immediately.

	Establish a food safe environment for students with food allergies.	• Zero tolerance for bullying related to food allergy. • Educate student on assertiveness techniques. • Empower student to educate classmates.	* Student is NOT exposed to food allergen and has no allergic reactions.
Potential for diminished self-esteem secondary to food allergy diagnosis.	Protect/Enhance student's self-image.	• Zero tolerance for bullying related to food allergy. • Educate student on assertiveness techniques. • Empower student to educate classmates.	* Student does not experience bullying or discrimination related to food allergy. * Student demonstrates positive self- esteem related to food allergy via verbal and non-verbal communication.