



Sterling Community School

251 Sterling Rd,
Sterling, CT 06377
nurse@sterlingschool.org

Dear Parent/Guardian,

Welcome to the Sterling Community School, I would like to inform parents of the policies for medication administration at school. All medications, including daily scheduled and as needed medications (inhalers, EpiPens, Tylenol, and/or ibuprofen) require a medication authorization signed by the child's physician and a parent to be administered at school. State law requires medication authorizations to be completed annually for school administration. If you wish to have your child receive Tylenol at school, you may provide the health office with a medication authorization form from your child's doctor with their own supply of medicine to be given. Your child will **NOT** be given Tylenol unless the proper form and personal supply are provided. As a reminder, **NO** medication of any kind should be sent to school with a child. All medications must be in a pharmacy labeled container and delivered to the school nurse by an adult.

State law requires CT schools to carry epinephrine in the event of a life-threatening allergic reaction (anaphylaxis) for individuals with an undiagnosed allergy. The Sterling Community School is fortunate to receive their epinephrine free of charge from the EpiPen4Schools program offered by Mylan. This program is not intended to replace epinephrine brought to school for students with a diagnosed/known allergy. State law also requires the school to offer an opt-out for parents who do not wish to enroll their children in this program. If you do not want your child to be administered epinephrine in the event of a life-threatening allergic reaction (anaphylaxis), please complete and sign the EpiPen Opt-Out form located on our school website and return it to the school as soon as possible. These forms are only valid for one school year.

The State of Connecticut offers public health coverage for eligible children, parents, relative caregivers, and more. HUSKY Health offers a full health benefits package which pays for doctor visits, prescriptions, vision and dental care, and much more. For most families and individuals, HUSKY Health coverage is cost-free or low-cost. If you or your child is currently not covered by health insurance, please contact 1-877-CT-HUSKY (1-877-284-8759) or visit <http://www.ct.gov/hh/site/default.asp> for further information.

Please keep in mind, all absences require a written note from a parent/guardian on the day the child returns to school. Absences of 3 or more days in a row require a doctor's note to return to school. Students with a fever of 100.0, vomiting/diarrhea, or severe/excessive cough should be kept home from school and call the nurse to discuss return to school protocol. A child on an antibiotic should be kept home for the first 24 hours after the initial dose, to ensure they are no longer contagious. If a student is found to have active lice, they will be sent home immediately. All nits must be removed after receiving treatment and the student must be checked by the school nurse before re-entry into the classroom. If you have any questions or concerns, please feel free to contact me at 860-564-2728 option #4. I look forward to another great year. Thank you.

Sincerely,

Carrie Tetreault, RN

Sterling Community School
Annual Health Questionnaire and Emergency Contact Information

Name of Child _____ Grade _____
(last) (first) (m.i.)

Address _____ Phone _____

Father/Guardian Name _____ Work phone _____

Cell phone _____

Mother/Guardian Name _____ Work phone _____

Cell phone _____

(Please indicate order of contact for above numbers)

If parent can not be reached:

Emergency contact #1: _____ Phone: _____

Emergency contact #2: _____ Phone: _____

Name of doctor: _____ Phone: _____

Name of dentist: _____ Phone: _____

1. If your child has a medical condition we should know about, please list below.

2. Please list any illness, injury or surgery your child had during the last year.

3. Does your child have any of the following conditions? If yes, please specify.

Allergies _____ No _____ Yes

To a Medication: Name _____ Reaction _____

To a Food: Type _____ Reaction _____

Environmental: type _____ Reaction _____

Asthma Condition _____ No _____ Yes

Describe _____

(continued on opposite side)

4. List any medications your child takes on an emergency basis: _____

5. List any medications your child takes on a regular basis:

6. List any communicable diseases (Covid, etc.) your child had during the past year and give date:

7. Is your child vaccinated for Covid? If so, please provide a copy of the vaccination record.
_____ No _____ Yes

8. List any physical limitations or restrictions for activity your child may have:

9. Does your child have health insurance? _____ No _____ Yes
Insurance Company _____ Policy Number _____
Name of insured member _____

I, the undersigned, do hereby authorize officials at Sterling Community School to contact directly the person on this form and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency for the health of said child. The school district will not be held financially responsible for the emergency care and/or transportation for said child. I, the undersigned, do hereby authorize the sharing of this information with appropriate staff members for the direct care of my child.

Parent/Guardian's Signature _____ Date _____

Daily Symptom Checklist

If your child has any of the following symptoms, this indicates a possible illness that may decrease the student's ability to learn and also puts them at risk for spreading illness to others.

Symptom	YES	NO
Fever (100.0 or greater) when taken by mouth		
Chills (feeling feverish)		
Shortness of breath		
New or Uncontrolled cough		
Loss of Taste or Smell		
Sore throat		
Nausea or Abdominal Pain		
Vomiting or Diarrhea		
Fatigue or Body Aches		
Headache		

- If you answered yes to any of the above symptoms, you should remain **HOME** and contact the school regarding your absence.
- If you answered yes to any of the above symptoms and have had *close contact* with someone who has tested positive for COVID-19, please either take a home test or have a PCR or rapid antigen test at a testing location.

Close contact is defined as being within 6 feet of an individual with confirmed COVID-19 for 15 minutes or longer.