

DESCRIPTOR TERM: <b>EMERGENCY HEALTH CARE AND OTHER FIRST AID OR LIFE SAVING TECHNIQUES</b>	DESCRIPTOR CODE: <b>6125</b>	ISSUED DATE: <b>June 7, 2010</b>
	LATEST DATE REV.:	CROSS REFERENCE:

**STATUTORY PROVISIONS**

**G.S. 115C-307 (b) (c)**

**STATE BOARD POLICY**

None.

**LOCAL BOARD POLICY**

The students, parents, legal guardians, or other person standing in "loco parentis" are primarily responsible for student health. However, it is within the scope of duty of teachers, including substitute teachers, teachers' aides, student teachers, or any other public school employee when given such authority by the Board of Education or its designee, (a) to administer any drugs or medication prescribed by a doctor upon written request of a parent, guardian, or other person standing in loco parentis, (b) to give emergency health care when reasonably apparent circumstances indicate that any delay would seriously worsen the physical condition or endanger the life of the pupil, and (c) to perform any other first aid or life saving techniques in which the employee has been trained in a program approved by the State Board of Education (all of which shall be referred to hereinafter, for convenience of reference, as "administration of medical care"). Provided, however, that no person shall be required to administer drugs or medication or to attend life saving techniques training programs.

For the purposes of this Policy, a "public school employee" to whom authority may be given for the administration of medical care shall be any personnel of the Burke County Public Schools.

Administration of medical care shall be undertaken pursuant to this Policy with respect to a student only while such student is under the supervision of the Burke County Public Schools.

At the commencement of each school year, but prior to the beginning of classes, and thereafter as circumstances require, the principal of each school shall designate which persons will participate in the administration of medical care. The principal shall have responsibility for the following:

**A. Drugs or Medications**

Provisions shall be made for administering any drugs or medications prescribed by a doctor upon written request of a parent, guardian, or other person standing in loco parentis.

**B. First Aid**

Each school shall have two or more persons certified in First Aid and Cardiopulmonary Resuscitation who can provide for student needs.

**C. Emergency Health Care and Other Life Saving Techniques**

Authorized school staff shall be aware of the need to administer emergency health care when reasonably apparent circumstances indicate that any delay would seriously worsen the physical condition or endanger the life of the pupil. An Emergency Action Plan (EAP) will be obtained annually and revised by the school nurse when physician orders change. Teachers will be given an EAP to follow when they have direct contact with the student. Please refer to EAP for Allergies,

## Page 2 – EMERGENCY HEALTH CARE AND OTHER FIRST AID OR LIFE SAVING TECHNIQUES

Asthma, Seizures, and Various Health Issues.

### PROCEDURES FOR MEDICATIONS, FIRST AID AND EMERGENCY CARE

#### A. Drugs or Medication – Please refer to Medication Administration Policy

#### B. First Aid

1. In addition to the school nurses, the principal shall select staff members who are willing to take the training offered by the American Red Cross for certification in First Aid and Cardiopulmonary Resuscitation. (GS 115C-307 does not permit a particular employee to be required to administer drugs or medication or to attend life saving techniques training programs.)
2. At the end of each school year, the principal will identify two or more staff members who are willing to become certified in First Aid and Cardiopulmonary Resuscitation and provide those services when needed during the next school year. (This training should be at no expense to the staff member and should be accepted for certificate renewal for certified staff members.) Staff Development opportunities shall be made available several times each year for the convenience of those willing to take this training. Classes will be provided at an individual school if there is sufficient interest.
3. Certified individuals designated by the principal shall be made known to the entire school staff.

#### C. Emergency Health Care and Other Life Saving Techniques

If a student, while under the supervision of school officials, becomes ill or injured, the student's parent or designee should be contacted and emergency first aid procedures followed if deemed necessary. In the event the parents cannot be contacted immediately, and if there is sufficient evidence to believe that the student should receive medical attention, it becomes the responsibility of the principal to see that the student receives immediate medical aid. The manual, *North Carolina Emergency Guidelines for Schools*, should be used as a guide when school personnel administer first aid. If, in the opinion of the school principal or his designee, the injury or illness warrants immediate attention of a doctor or hospital, the principal or his designee should contact the student's parent or designee, and call 911 unless otherwise instructed by the parent/guardian. The principal or his designee should never sign for an operation for a student.

Whenever a student is injured, a written report should be promptly made and filed, including name and address of the injured party; the activity in which the injury occurred, such as recess, gymnasium, changing classes, etc.; the date, hour and place; the name of the person in charge; signed statements by witnesses to the accident; the cause and extent of the injury; and attention given. Please refer to "Student Injury Report Form".

If the school becomes aware that a student is present at the school who has a severe allergic reaction to insect stings and is to receive emergency treatment for severe reactions to insect stings, the student's file must contain authorizations by the parent or guardian and physician concerning the procedure for administration of medication to such students. The principal of such school shall request a minimum of two (2) staff members to volunteer for training in the treatment and administration of medication to any students who are severely allergic to insect stings. If at all possible, one of these individuals should be the student's teacher. These two (2) individuals should complete a training program administered by the school nurse. Once these staff members have received training, a form should be completed, stating that the school staff members have completed the training, and that they are authorized by the student's parent or guardian to administer medication, either orally or by injection, in the event that the student has a severe reaction to an

insect sting.

## ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

Chapter 115-307 of the General Statutes of North Carolina enables public school employees, when given the authority by the Board of Education or its designee, to administer medication prescribed by a doctor upon written request of the parents. As a result, a committee comprised of Burke County Public Schools School Nurses, Physician Advisor, and Administrators has jointly developed a medication administration policy.

### Medication Administration Policy

Medications administered during school hours by school personnel should be kept to a minimum. The student in need of medication to sustain his/her attendance in school may have an acute or chronic health problem, special health care need, and/or have an unusual health problem where emergency measures are indicated. The policy is intended for the following:

1. Acutely ill children may need medications for short periods of time to enable them to remain in school. Medications can be given at home before school and/or after school. If this is not possible, it is the parent's/guardian's responsibility to make arrangements with a school's principal/designee for the medicine to be given during school hours. The school nurse must be informed of all medications administered at school.
2. Students in grades 9-12 with written parental consent (on student health questionnaire), may carry and administer over-the-counter and prescription medication excluding controlled substances (e.g., Ritalin, Methylphenidate, Adderall, Dexedrine, Tylenol # 3, Xanax, etc.). Students who self-medicate must carry the medicine in the original container and at no time share medicine with other students.
3. When prescription medications such as asthma inhalers, epi-pens, etc. are to be self-administered, an individualized plan by the school nurse will be written. The parent/guardian and physician must complete the authorization form allowing self-administration. Students will be assessed for their competence in the self-administration of medication and must agree to secure their medicine from other students or the school will assume this responsibility. It is the parent/guardian's responsibility to ensure availability and current status (expiration date) of medication.
4. When children who are subject to unusual health hazards such as an allergy to bee stings, diabetes, seizures, asthma etc., attend school, it is the parent's/guardian's responsibility to notify the school administration of the condition so that emergency measures can be implemented if needed. The plan developed by the student's parent/guardian, personal physician/health provider, and the school nurse for responding to such an emergency may include administering medications such as epi-pens, glucagon, Diastat, inhalers, etc., until the student can be transported to a physician's office, an emergency room, or an area where treatment can be instituted.
5. Medications for ADD/ADHD may be given at school so student may obtain maximum performance in the classroom but these medications must be securely stored and administered by school personnel.

6. The school district retains the right to reject a request for administration of medication. Medications should not be administered to a student during school hours or by school personnel unless the health of the student will adversely be affected by failure to do so.

## **Standards For Medication Administration**

For school staff to administer medications, the proper medication form must be on record for prescriptions and over-the-counter drugs.

### **Medication Administration Procedure**

#### **Parent's/Guardian's Responsibility**

1. Discuss with personal healthcare provider an alternative schedule for administering medication (e.g., outside of school hours).
2. If medications must be administered at school, take the Medication Administration Request form for prescription medications to a family physician/primary care provider who will complete the "Physician's Instructions for Medications at School" and return it to the school. Parents/Guardians are to complete the "Parents Instructions for Medications at School" on the same form. A separate request form must be completed for each medication administered at school. For over-the counter medications, the parents must complete the "Parental Permission for Over-the-Counter Medications" and bring it to school.
3. Provide medication in a labeled container that includes the child's name, the name of the medication, the unit dosage, the number of dosage units, the time the medication is given, and how it is to be administered.
4. If necessary, have the pharmacist label two prescription containers—one for home use and one for school use.
5. Provide new-labeled containers when medication changes occur. Remove medications from school premises when treatment has been completed or at the conclusion of the school year. All medications not picked up by parents or returned to parents at the end of treatment or at the end of the school year will be destroyed according to state health regulations. It is prudent to have a witness observe disposal of drugs, especially controlled substances.
6. Assure that school administration is trained on the implementation of emergency measures for children with unusual health hazards (e.g., allergies, bee stings, diabetes, etc.). *See Emergency Action Plans.*
7. For students who are able to self-medicate over-the-counter drugs, parents/guardians will need to fill out the Parental Permission for Student's Self-Medication form. Parents/Guardians will be required to send medication in the original container with student's name, time to administer medication, and reason for administering medication. If student is not able to self-medicate, the parent/guardian may come to school and give the medicine to the student or have a physician complete the Medication Administration Request form. For students in grades 9-12, the Student

Health Questionnaire must be signed by a parent/guardian for the student to self-medicate over-the-counter and prescription medications, excluding controlled substances.

### **School Administration Responsibility**

1. All medications must be locked in a secure place in a centralized area in office unless deemed competent to self administer. Refrigerated medication must be kept in a locked box in a refrigerator. Security for medications that cannot be locked away, such as those students need to carry (e.g., asthma inhalers, epi-pens, glucagon kits), must be planned on an individual basis in an Emergency Action Plan.
2. The principal will assume responsibility for the security and administration of medication. Medications will be given by office staff at all schools. Several office staff members must be trained in case the primary person is absent. Annual training will be provided by the school nurses for designated personnel. Training will include tutorials, written test with passing score of 80 with two attempts at passing, and observed demonstration of medication administration. Office staff members must be deemed competent by the school nurse in order to administer medications.
3. School nurses shall coordinate and/or monitor the administration of medications. The school nurse must be notified of all medications being administered at school. School nurses will ensure that medication logs are maintained on all students receiving medication and will periodically audit these to assure effective administration. Nurses will train designated personnel responsible for the administration of medication and periodically review competence of personnel administering medications. The high school nurses will have information regarding students with permission to self-medicate.
4. Medication administration by school personnel during school hours is limited to the following:
  - a. Students with chronic health conditions (e.g., diabetes mellitus, asthma, etc.).
  - b. Students with a short-term health condition (e.g., an infection or communicable disease).
  - c. Students with an unusual health condition requiring emergency intervention (e.g., an allergic reaction to a bee sting, insulin shock, etc.).
  - d. Students with conditions, such as an attention deficit disorder, who may require the administration of controlled substances during the school day to maximize classroom performance.
5. All students who have received medication(s) will have documentation that is maintained by the school. The record will indicate name of medication, dosage, route of administration, frequency, date and time of administration, as well as initials and signatures of personnel administering. Also, the date that the medication is discontinued will be recorded on a medication log sheet. The person who is responsible for the medication will count the number of doses received and record it on the medication log sheet. A new medication record will be completed when medication orders are changed. When a medication is not given (e.g., student left early, early dismissal of school, etc.), this will be recorded on the medication log sheet (see Record of Medication Administration). The responsible person will complete a Medication Variance Report when failure to administer a prescribed medication in the appropriate time frame occurs, an incorrect dosage is given, or the medication is given to a student for whom it was not prescribed. The school nurse must be notified of Medication Variances with Variance Report forwarded to the school nurse.

6. Medication records, which are legal documents, must be maintained for all medications administered by school personnel. Written parental authorization, physician's authorization, medication logs, and records should be retained on file at a school for the duration of the child's school attendance plus three years beyond the student's 18<sup>th</sup> birthday.
7. An accessible current copy of a professional drug reference should be available to school nurses as a standard resource in reviewing medications.
8. Burke County Public Schools assumes **no** responsibility for students who self-medicate (see section on self-medication during school hours).

### **Emergency Action Plans**

Emergency action plans are for students who may have a medical crisis during the day. Potential health emergencies must be addressed in individualized written emergency plans and be approved by a child's parent/guardian. The attending physician who sees the student in his office or emergency room determines the follow-up care of the student. The child's parent/guardian has responsibility for assuring that an emergency care plan is developed for the child. Also, written permission must be given by a parent/guardian to institute emergency measures. School nurses can assist parents/guardians and the school with these plans. (*Emergency Action Plans are attached to this policy*)

### **Self-Medication During School Hours**

Specific student health conditions may arise in which self-medication by a student is appropriate. The decision for self-medication is determined by the parent/guardian with input from the child's physician or other primary health care provider. Under no circumstances are prescription medications containing controlled substance(s) to be self-administered (see Self-Medication Student Agreement; for grades 9-12, see # 2 under Medication Administration Policy).

### **Self-Medication For Over-The-Counter Drugs**

If a student is able to self-administer over-the-counter medications, the parent/guardian may fill out a Parental Permission For Student Self-Medication form. The parent will send the medication in the original container with the student's name on the container. If a student is unable to self-administer medication, the parent/guardian may come to the school and give the medication (see Parental Permission For Student Self-Medication form; for grades 9-12, see # 2 under Medication Administration Policy) or complete the form with physician's input so staff may administer.

### **Medication Issues Relating to Emergency Room Visits**

1. Obtain the parent's signature on the Medication Administration request form.
2. Attach the ER discharge sheet to the medication form.
3. Give the medication following the label instructions on the bottle.
4. Maintain a medication record for documentation of drug administration.

## **Field Trips (One Day)**

Since medications are administered by office staff at each school, in the event of a field trip where parents are not available to administer their child's medication, a teacher will be trained to administer scheduled prescription medications if unable to administer medications prior to departure or student can not self-administer. The teacher will also be responsible for the administration of "as needed" over the counter and emergency medications. The teacher must notify the school nurse to schedule this training prior to the field trip. The teacher will be responsible for securing the medications, documentation, Emergency Action Plans and other health plans and having available on the field trip. Controlled substances must be administered by trained school personnel.

## **Field Trips (Over Night)**

- The "Overnight Field Trip Permission and Information Form" should be sent home with each child participating. This form identifies students with medical needs.
- Contact parents of students with medical needs for instructions on specific medical care necessary during the trip.
- Make sure all children who need prescription medication on the trip have a "Medication Administration Form" on file. The form must indicate all times the medication is to be administered as well as the route and dosage of the medication. The parent and doctor may have to complete additional forms if the school does not have these on file for a complete 24 hour period of time. The parent must follow the BCPS medication policy by bringing the form and the medication for the trip in the original prescription bottle.
- Prepare and take a 1<sup>st</sup> aid kit with all appropriate medical supplies, including the over-the-counter medications listed on the permission form.
- Make sure all emergency medications (i.e. epi-pens, inhalers) and other emergency items are brought on the trip.
- Take all EAPs, medical permission forms and medication forms on the trip and administer the medication and medical care as needed. Document all medication administration on the "Field Trip Daily Medication Log". Secure all medical information to ensure confidentiality.
- Following the trip, file all medication forms with the school medication forms for that school year and retain according to the BCPS Medication policy. (*"duration of the child's school attendance plus three years beyond the student's 18<sup>th</sup> birthday"*)

**BURKE COUNTY SCHOOL HEALTH**  
**Medication Administration Request Form**

All Medication that must be administered by School Personnel

\_\_\_\_\_  
Student's Name

\_\_\_\_\_  
Date of Birth

-----  
**Physician's Instructions for Medication at School**

Dear Prescriber: When possible please prescribe QD, BID, or TID regimens of medication that can be given before and after school hours. When this is not possible, please use this form to provide instructions for staff to follow.

**Without this form, school staff will not be able to administer the medication while the student is at school.**

**Name of**

Medication: \_\_\_\_\_ **Dose:** \_\_\_\_\_

**Route** of administration:     by mouth                       topically to skin                       eye/ear drops  
    rectally                       IM injection                       SC injection                       inhaled

**Time** of medication administration: \_\_\_\_\_

**Reason** for medication: \_\_\_\_\_

- School to administer medicine.
- Student may self-administer inhaler or epi-pen. I have provided education and they are knowledgeable.

**Special instructions or possible adverse reactions:** \_\_\_\_\_

\_\_\_\_\_  
Prescriber's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Address

-----  
**Parent's Instruction for Medication at School**

Check one box:

- I hereby give my permission for school personnel to administer medication during the school day to my child.
- My child is knowledgeable of his/her treatment and is capable of self-administering his/her inhaler or epi-pen.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

-----  
**For Self-Administration by the Student:**

I agree and feel competent to take my inhaler or epi-pen as prescribed. I will not, at any time, share my medication with another student. I will keep it secure from other students.

\_\_\_\_\_

Student's Signature

Date

## BURKE COUNTY SCHOOL HEALTH

### Parental Permission for Over-the-Counter Medication

I have instructed my child, \_\_\_\_\_,  
Name of child

to take \_\_\_\_\_ at school.  
Name of Medication

The **time** he/she is to take this medication is \_\_\_\_\_.

The **amount/dose** of medication to be taken is \_\_\_\_\_.

Additional information the school should know about this medication (i.e., side effects, allergic reactions) is: \_\_\_\_\_

\_\_\_\_\_.

**Medication must be sent to school in the original container (bottle/package) or it will not and cannot be given. Your child must know why he/she needs the medication and must be capable of taking the medication while school personnel observes. All students through 8<sup>th</sup> grade must give the medication to office staff to store in a locked place.**

**YOUR CHILD MUST NOT, AT ANY TIME, SHARE MEDICATION WITH ANOTHER STUDENT.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**RECORD OF MEDICATION ADMINISTRATION BY SCHOOL PERSONNEL**

School Year: \_\_\_\_\_ School: \_\_\_\_\_ Student: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Grade: \_\_\_\_\_

Homeroom Teacher: \_\_\_\_\_ Name Of Medicine: \_\_\_\_\_ Physician: \_\_\_\_\_

Physician's Phone #: \_\_\_\_\_ Date Started: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time To Be Given: \_\_\_\_\_

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	No. Dose Received	
Aug.																																	
Sept.																																	
Oct.																																	
Nov.																																	
Dec.																																	
Jan.																																	
Feb.																																	
Mar.																																	
Apr.																																	
May																																	
June																																	
July																																	

**Initial Each Block When Giving Medicine.**

INIT.                      NAME

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CODES (chart reason)

WE:      Weekend                      F:      Field Trip

H:      Holiday                      D:      Early Dismissal

A:      Absent                      W:      Dose Withheld

N:      None Available                      O:      No Show

WD:      Workday                      S:      Snow Day

Number of tablets returned to parent/guardian \_\_\_\_\_ Parent's Signature: \_\_\_\_\_ Teacher's Signature: \_\_\_\_\_

**BURKE COUNTY SCHOOL HEALTH**  
**Parental Permission for Student Self-Medication**

I have instructed my child, \_\_\_\_\_,  
Name of child

to take \_\_\_\_\_ at school.  
Name of Medication

The **time** he/she is to take this medication is \_\_\_\_\_.

The **amount/dose** of medication to be taken is \_\_\_\_\_.

Additional information the school should know about this medication (i.e., side effects, allergic reactions) is: \_\_\_\_\_

\_\_\_\_\_.

**Medication must be sent to school in the original container (bottle/package) or it will not and cannot be given. Your child must know why he/she needs the medication and must be capable of taking the medication.**

**All students through 8<sup>th</sup> grade must give the medication to office staff to store in a locked place.**

**YOUR CHILD MUST NOT, AT ANY TIME, SHARE MEDICATION WITH ANOTHER STUDENT.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



**RECORD OF MEDICATION: TEACHER OBSERVATION OF STUDENT SELF-ADMINISTRATION OF OTC MEDICATIONS**

School Year: \_\_\_\_\_ School: \_\_\_\_\_ Student: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Grade: \_\_\_\_\_

Name Of Medicine: \_\_\_\_\_ Date Started: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time To Be Taken: \_\_\_\_\_

Homeroom Teacher: \_\_\_\_\_

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	No. Dose Received	
Aug.																																	
Sept.																																	
Oct.																																	
Nov.																																	
Dec.																																	
Jan.																																	
Feb.																																	
Mar.																																	
Apr.																																	
May																																	
June																																	
July																																	

**Initial Each Block When Observing Self-Administration of Medicine.**

INIT.	NAME
_____	_____
_____	_____
_____	_____
_____	_____

Number of tablets returned to parent/guardian \_\_\_\_\_ Parent's Signature: \_\_\_\_\_ Teacher's Signature: \_\_\_\_\_

# BURKE COUNTY SCHOOL HEALTH

## Medication Variance Report

Medication variance is defined as: failure to administer the prescribed medication within the appropriate time frame, in the correct dosage, in accordance with accepted practice, to the correct student.

Time of Report: \_\_\_\_\_ School: \_\_\_\_\_ Prepared by: \_\_\_\_\_

Name of Student: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Home address: \_\_\_\_\_  
Street City State

Home Phone #: \_\_\_\_\_

Date Variance Occurred: \_\_\_\_\_ Time: \_\_\_\_\_

Name of Person Administering Medication: \_\_\_\_\_ Title: \_\_\_\_\_

Reason Medication was prescribed: \_\_\_\_\_

Date of Order: \_\_\_\_\_ Instructions for Administration: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Scheduled Time: \_\_\_\_\_

Describe the Variance and how it occurred (use reverse side if necessary): \_\_\_\_\_

### Action Taken:

Licensed Prescriber Notified: Yes: \_\_\_\_\_ No: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Parent/Guardian Notified: Yes: \_\_\_\_\_ No: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Other Persons Notified: \_\_\_\_\_

Outcome: \_\_\_\_\_

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature Title

# Rules: Giving Medications

1. Parent's and Doctor's signatures **MUST** be completed for all meds administered. Parents' signature is required for Over-the-Counter meds.
2. All medicines must be sent to school in the original container so there is no question about what kind of medicine you are giving.
3. Keep medications locked up. Let the principal/school nurse know if you do not have a locked area.
4. Medications may be given 30 minutes before or after the stated time and still be considered "on time".
5. Always complete the medication log in ink.
6. Record that you gave the medication at the time given – waiting until another day will lead to errors.
7. Put initials in the appropriate boxes – no check marks. Sign and initial at the bottom of the log.
8. Keep the medicine forms in a confidential place where no one else can see them.
9. If a medicine changes or the dosage changes, a new form must be completed.
10. Each medication must have a separate log.
11. If a medication is not given, document the reason using the legend at the bottom of the log.
12. If you make an error such as wrong dose, the wrong time, the wrong child, etc., notify the nurse and complete a Medication Variance form.
13. Children who use inhalers for asthma or epi-pens for allergies are allowed to keep them. Use your discretion. You do not need to document each time they are used.
14. 9<sup>th</sup>-12<sup>th</sup> grade students with written parental consent (on the Student Health Questionnaire) may carry and administer over-the-counter and prescription meds **excluding** controlled substances.
15. All medication forms must be turned into the nurse at the end of the year and retained on file at the school.



**Every time medicine is administered remember the “5 Rights”:**

**Right Child**

**Right Medicine**

**Right Time**

**Right Route**

**Right Dose**

I have read and understand the above information.

School personnel's Signature

Date

**EMERGENCY ACTION PLAN**  
**SEVERE ALLERGIES**

**Place  
Child's  
Picture  
Here**

**Student's Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **School** \_\_\_\_\_

**Grade** \_\_\_\_\_ **Teacher** \_\_\_\_\_ **Bus #** \_\_\_\_\_ **Daycare?** \_\_\_\_\_

**ALLERGY TO** \_\_\_\_\_

**Physician to complete:**

Asthmatic Yes\*  No  \*Higher risk for severe reaction

**STEP 1: TREATMENT**

**Symptoms:**

**Give Checked Medication:**

\* If a food allergen has been ingested, but no symptoms:

EpiPen  Antihistamine

\* Mouth Itching, tingling, or swelling lips, tongue, mouth

EpiPen  Antihistamine

\* Skin Hives, itchy rash, swelling of the face or extremities

EpiPen  Antihistamine

\* Gut Nausea, abdominal cramps, vomiting, diarrhea

EpiPen  Antihistamine

\* Throat\*\* Tightening of throat, hoarseness, hacking cough

EpiPen  Antihistamine

\* Lung\*\* Shortness of breath, repetitive coughing, wheezing

EpiPen  Antihistamine

\* Heart\*\* Thready pulse, low blood pressure, fainting, pale

EpiPen  Antihistamine

\* Other\*\* \_\_\_\_\_

EpiPen  Antihistamine

\* If reaction is progressing (several of the above areas affected), give

EpiPen  Antihistamine

The severity of symptoms can quickly change. \*\*potentially life-threatening

**DOSAGE:**

Epinephrine: EpiPen EpiPen Jr. (circle one) Inject Intramuscularly

**Antihistamine/Dose:** \_\_\_\_\_ **By mouth**

Special Instructions: \_\_\_\_\_

School to administer.

Student may self-administer antihistamine or epi-pen. I have provided education and they are knowledgeable

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Address

**Step 2: EMERGENCY CALLS**

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Notify parent. Encourage parent to notify child's physician.
3. Emergency Contacts:

Name/Relationship	Phone Number(s)	
a. _____	a. _____	a. _____
b. _____	b. _____	b. _____
c. _____	c. _____	c. _____

**TRAINED STAFF MEMBERS**

1. _____ _____	Phone Extension
2	Phone Extension

**EPIPEN® AND EPIPEN® JR. DIRECTIONS**

**Expiration Date:** \_\_\_\_\_

- 1) Grasp unit, with the black tip pointing downward.
- 2) Form a fist around the auto-injector (black tip down).
- 3) With your other hand, pull off the gray activation cap.



- 4) Swing and jab firmly into outer thigh so that auto-injector is perpendicular (at a 90° angle) to the thigh.



- 5) Hold firmly in thigh for 10 seconds. Remove unit, massage injection area for 10 seconds.
- 6) Student must remain lying down, preferable on side, until Emergency Management arrives.
- 7) Once Epi-Pen is used, call 911. Additional epinephrine may be needed. Take the used Epi-Pen with child to the Emergency Room.

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date

- School Nurse has verified that child is competent to self-administer medication, if trained by physician.

\_\_\_\_\_  
School Nurse

\_\_\_\_\_  
Date

**EMERGENCY ACTION PLAN**

**ASTHMA**

**Student's Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **School** \_\_\_\_\_  
**Grade** \_\_\_\_\_ **Teacher** \_\_\_\_\_ **Bus #** \_\_\_\_\_ **Daycare?** \_\_\_\_\_  
**Emergency contact:** \_\_\_\_\_ **Ph:** \_\_\_\_\_  
**Physician treating student for asthma:** \_\_\_\_\_ **Ph:** \_\_\_\_\_  
**Allergies:** \_\_\_\_\_

Asthma medication may be used on school property during the school day, at school-sponsored activities, or while in transit to or from school-sponsored events.

**\*\*EMERGENCY PLAN:\*\***

**Emergency Action is necessary when the student has symptoms such as:**

<b>Coughing</b>	<b>Tight chest</b>	<b>Difficulty breathing</b>
<b>Wheezing</b>	<b>Nose opens wide</b>	<b>Difficulty talking</b>

1. Attempt to calm student. Stay with student.
2. Have student take prescribed medication as ordered by health care provider and parent (see back of form).
3. Have student sit in a resting position, breathing slowly through the mouth, exhaling slowly through pursed lips.
4. Offer fluids.
5. Notify school nurse if in the building.
6. Notify parent for severe breathing difficulty or if medication is not effective after 15 minutes.
7. If parent is unavailable or student is having extreme difficulty breathing, call 911 and transport to closest hospital.

Parents are responsible for providing back-up medications to the school in a location that the student has immediate access to if needed for an asthma or anaphylaxis emergency.

Back-up medication will be located \_\_\_\_\_.

If a student uses asthma medication prescribed for the student in a manner other than as prescribed, a school may impose on the student disciplinary action according to the school's disciplinary policy. A school may not impose disciplinary action that limits or restricts the student's immediate access to the asthma medication.

By signing below, the school nurse has your permission to share this Emergency Action Plan with appropriate school personnel.

\*BCPS and its employees/agents are not liable for an injury arising from a student's possession and self-administration of asthma medication.

**PARENT/GUARDIAN**

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PLEASE NOTE: All inhalers/nebulizers MUST be registered with the school nurse. Exp date:** \_\_\_\_\_

- Student has demonstrated ability to the school nurse to use the asthma medication and any device that is necessary to administer the medication appropriately.

**SCHOOL NURSE** \_\_\_\_\_ **DATE** \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Doctor: \_\_\_\_\_ Date: \_\_\_\_\_

Phone for Doctor or Clinic: \_\_\_\_\_

Predicted/Personal Best Peak Flow Reading: \_\_\_\_\_

**Asthma Triggers**

*Try to stay away from or control these things:*

- Exercise
- Mold
- Chalk dust/dust
- Pollen
- Animals
- Tobacco smoke
- Food \_\_\_\_\_
- Smoke, strong odors or spray
- Colds/Respiratory infections
- Carpet
- Change in temperature
- Dust mites
- Cockroaches
- Other \_\_\_\_\_

**1. Green – Go**

- Breathing is good.
- No cough or wheeze.
- Can work and play.



Use these controller medicines *every day* to keep you in the green zone:

Medicine: \_\_\_\_\_ How much to take: \_\_\_\_\_ When to take it: \_\_\_\_\_  Home  School

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Or Peak Flow \_\_\_\_\_ to \_\_\_\_\_ (80-100%)

5-15 minutes before very active exercise, use  Albuterol \_\_\_\_\_ puffs.

**2. Yellow – Caution**



Coughing



Wheezing



Tight Chest



Wakes up at night

**Keep using controller green zone medicines every day.**

**Add these medicines to keep an asthma attack from getting bad:**

<u>Medicine</u>	<u>How much to take</u>	<u>When to take it</u>
Albuterol	<input type="checkbox"/> 2 puffs by inhaler	<input type="checkbox"/> May repeat every
or	<input type="checkbox"/> 4 puffs by inhaler	20 min up to 3 doses
_____	<input type="checkbox"/> with spacer, if available	in first hour, if needed
	<input type="checkbox"/> by nebulizer	

If symptoms **DO NOT** improve after first hour of treatment, then go to **red zone**.

If symptoms **DO** improve after first hour of treatment, then continue:

Albuterol	<input type="checkbox"/> 2 puffs by inhaler	<input type="checkbox"/> Every 4 - 8 hours
or	<input type="checkbox"/> 4 puffs by inhaler	for _____ days
_____	<input type="checkbox"/> with spacer, if available	
	<input type="checkbox"/> by nebulizer	

Or Peak Flow \_\_\_\_\_ to \_\_\_\_\_ (50-80%)

\_\_\_\_\_, \_\_\_\_\_ times a day for \_\_\_\_\_ days  Home  School

(oral corticosteroid) (how much)

**Call your doctor if still having some symptoms for more than 24 hours!**

**3. Red – Stop – Danger**

- Medicine is not helping.
- Breathing is hard and fast.
- Nose opens wide.
- Can't walk.
- Ribs show.
- Can't talk well.



**Call your doctor and/or parent/guardian NOW!**

**Take these medicines until you talk with a doctor or parent/guardian:**

<u>Medicine:</u>	<u>How much to take:</u>	<u>When to take it:</u>
Albuterol	<input type="checkbox"/> 2 puffs by inhaler	<input type="checkbox"/> May repeat every
or	<input type="checkbox"/> 4 puffs by inhaler	20 minutes until
_____	<input type="checkbox"/> with spacer, if available	you get help
	<input type="checkbox"/> by nebulizer	
_____, _____ times a day for _____ days		<input type="checkbox"/> Home <input type="checkbox"/> School
(oral corticosteroid)	(how much)	

**Call 911 for severe symptoms, if symptoms don't improve, or you can't reach your doctor and/or parent/guardian.**

Or Peak Flow \_\_\_\_\_ (Less than 50%)

\_\_\_\_\_ Student is capable and has been instructed in self-administration of these medications.

\_\_\_\_\_ Student is not approved to self-medicate.

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

# EMERGENCY ACTION PLAN

## SEIZURES

**Student's Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **School** \_\_\_\_\_

**Grade** \_\_\_\_\_ **Teacher** \_\_\_\_\_ **Bus #** \_\_\_\_\_ **Daycare?** \_\_\_\_\_

PARENT/GUARDIAN \_\_\_\_\_ PHONE \_\_\_\_\_

\_\_\_\_\_ PHONE \_\_\_\_\_

HEALTH CARE PROVIDER \_\_\_\_\_ PHONE \_\_\_\_\_

1. What type of seizures does your child have and how often do they occur?

\_\_\_\_\_

2. Does your child have an aura or warning of a seizure coming? Is she/he able to notify anyone that a seizure is coming?

\_\_\_\_\_

3. Name of seizure medications: How often are they taken?

At home \_\_\_\_\_

At school \_\_\_\_\_

4. Does your child have any side effects from these medications? Please list:

\_\_\_\_\_

5. Are there any sports/activities in which your child CANNOT fully participate?

\_\_\_\_\_

PLEASE NOTE: If medication is to be taken at school, a medication authorization form must be completed by a parent AND a physician and kept at the school. These forms are obtained from your school office staff or school nurse. These forms are completed on a yearly basis.

PLEASE READ THE EMERGENCY ACITON PLAN FOR SEIZURES ON THE REVERSE SIDE, AND ADD ANY FURTHER INSTRUCTIONS WE NEED TO BE MADE AWARE OF.

**\*\* If Diastat is prescribed by the child's physician, please complete a medication administration form.**

# EMERGENCY ACTION PLAN

## SEIZURES

\_\_\_\_\_  
**Student's Name**

\_\_\_\_\_  
**Teacher**

What type of seizure does your child have? What are his/her symptoms?

**Petit Mal (absence seizure)**

- brief loss of consciousness
- minimal or no alteration in muscle tone
- usually able to maintain postural control
- frequently has minor movements or twitches
- often mistaken for inattention
- stares blankly into space
- Other: \_\_\_\_\_

**Grand Mal (tonic-clonic seizure)**

- loss of consciousness
- child falls to floor or ground
- breathing may stop for a moment
- arms and legs may become rigid and move in rhythm with face
- may be incontinent of urine and/or feces
- may last several minutes
- may want to sleep afterwards
- Other: \_\_\_\_\_

**EMERGENCY PLAN:**

- 1) Stay with child during and after seizure. Note duration of seizure and type of body movements.
- 2) Clear area around student to prevent injury.
- 3) Assist to horizontal position if loss of consciousness occurs. Remove student's glasses, loosen clothing around neck.
- 4) Turn on side as soon as able.
- 5) DO NOT RESTRAIN MOVEMENT OR PLACE ANYTHING IN MOUTH.
- 6) Monitor breathing and begin artificial respiration if breathing does not resume spontaneously.
- 7) If seizure lasts more than 5 minutes or student has one seizure after another without waking, call 911 and transport to \_\_\_\_\_ Hospital.
- 8) When seizure is over, allow child to rest and always notify parents.
- 9) Notify school nurse if she is in the building.
- 10) Additional instructions: \_\_\_\_\_

This medical information needs to be shared with your child's teachers, office personnel and bus drivers, if necessary. By signing below, the school nurse has your permission to share this Emergency Action Plan with school personnel mentioned above.

PARENT/GUARDIAN'S

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

NURSE \_\_\_\_\_ DATE \_\_\_\_\_ page 2 of 2

**EMERGENCY ACTION PLAN**  
**VARIOUS HEALTH ISSUES**

**Student's**  
**Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **School** \_\_\_\_\_  
**Grade** \_\_\_\_\_ **Teacher** \_\_\_\_\_ **Bus #** \_\_\_\_\_ **Daycare?** \_\_\_\_\_

**HEALTH CONCERN:** \_\_\_\_\_

Is exercise or activity limited? \_\_\_\_\_yes \_\_\_\_\_no If yes, please describe limitations:

\_\_\_\_\_

**Is student on medication for this problem?** \_\_\_\_\_yes \_\_\_\_\_no

Please list below:

At home? \_\_\_\_\_

At school? \_\_\_\_\_

Briefly describe symptoms: \_\_\_\_\_

\_\_\_\_\_

**OTHER HEALTH PROBLEMS:**

Briefly describe: \_\_\_\_\_

\_\_\_\_\_

**PLEASE NOTE:** If medications are to be taken at school, a medication authorization form must be completed by parent and physician and kept at school. These are obtained from your office staff or school nurse and must be completed on a yearly basis for each medication.

**PLEASE READ THE EMERGENCY ACTION PLAN ON THE REVERSE SIDE AND COMPLETE IT, SIGN IT, AND RETURN IT TO THE SCHOOL NURSE.**

**Student's**  
**Name** \_\_\_\_\_ **Teacher** \_\_\_\_\_

**Emergency contact:** \_\_\_\_\_ **Ph:** \_\_\_\_\_

**Healthcare Provider:** \_\_\_\_\_ **Ph:** \_\_\_\_\_

**SIGNS OF EMERGENCY:** \_\_\_\_\_

**ACTIONS AND TREATMENT FOR SCHOOL PERSONNEL TO TAKE:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**ADDITIONAL INSTRUCTIONS:** \_\_\_\_\_

Healthcare provider's signature \_\_\_\_\_ Date \_\_\_\_\_

This medical information needs to be shared with your child's teachers, office personnel, and bus drivers, if necessary. By signing below, the school nurse has your permission to share the above Emergency Action Plan with the school personnel mentioned above.

PARENT/GUARDIAN  
SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

NURSE \_\_\_\_\_ DATE \_\_\_\_\_

EMERGENCY ACTION PLAN

**PREGNANCY**

**Date:** \_\_\_\_\_

**Grade:** \_\_\_\_\_

Student's Name: \_\_\_\_\_

Home phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Home phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Due Date: \_\_\_\_\_

Symptoms: Nausea and vomiting

Treatment: Provide soft drink and crackers, if available. Student is responsible for providing snacks.

**Signs of Emergency:**

- Bright red vaginal bleeding
- Leaking bag of water (may be sudden gush or slow leak)
- Sharp abdominal pain in abdomen or side that does not go away
- Headache/dizziness
- Blurred vision
- Epigastric discomfort
- Chills, fever
- Pain when passing urine

**Actions for School Personnel To Take During An Emergency:**

**Stay with student at all times!**

- Call 911
- Call parents
- Call or page school nurse,  
If school nurse is in the building, notify her immediately
- Move student to office area if possible
- Have student lie on left side
- Provide comfort measures (pillow, blanket, reassurance, etc.)

Additional Instructions: \_\_\_\_\_

Healthcare provider's signature \_\_\_\_\_ Date \_\_\_\_\_

This medical information needs to be shared with your daughter's teachers, office personnel, and bus drivers, if necessary. By signing below, the school nurse has your permission to share the above Emergency Action Plan with the school staff involved with your daughter.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_



## Diabetes Management in the School Setting

North Carolina passed Senate Bill 911 in September 2002 to ensure each diabetic student's needs are safely met while attending school. The school must reasonably accommodate all diabetic students in the usual school setting with as little disruption as possible and allow full participation in all school activities. The student with diabetes should have immediate access to their supplies at all times, with supervision as needed. Provisions must be available

### Procedure

#### **Parent/Guardian's Responsibility**

The parent/guardian will provide the school with a written request for a Diabetes Care Plan and will work with student's health care provider and school personnel in preparing the Diabetes Care Plan. The parent/guardian will provide the school with the following materials, equipment, and information needed for student's diabetes care:

#### **1. Diabetes Care Plan**

- Provide a written request for a diabetes care plan for your child, using form provided.
- Work with the health care provider and school personnel to complete the Diabetes Care Plan form with the information needed to take care of your child's diabetes at school.
- Obtain signatures needed for Diabetes Care Plan. If physician has not completed a care plan, the parent must bring insulin orders and diabetic care recommendations for treatment signed by the physician.
- Return the doctor's orders and any other forms as soon as possible. Without doctor's orders, school personnel will be limited in the help that they can provide.
- Provide school with diabetes supplies and snacks needed for student's care.

#### **2. Emergency phone numbers for the parent/guardian and student's diabetes care team**

- Provide school staff with names and phone numbers of appropriate individuals to contact for routine care and emergencies and update as needed.

#### **3. Blood sugar testing supplies**

- Parent/guardian is responsible for the maintenance of the blood sugar testing equipment (i.e., cleaning and performing controlled testing per the manufacturer's instructions).
- Provide written instructions about student's blood sugar testing schedule and assistance when needed.

#### **4. Insulin administration supplies and back-up supplies for insulin pump users, if needed.**

- Provide written instructions about student's insulin requirements and assistance needed.

#### **5. Ketone testing supplies to check urine, if needed.**

- Provide written instructions about when to check for ketones.
- Provide written instructions about measures to take if ketones are present.

#### **6. Supplies and instructions about treating low blood sugar (hypoglycemia) and high blood sugar (hyperglycemia).**

- Provide written instructions about how to manage student's low/high blood sugar levels.
- Provide snacks, a source of fast sugar, and a glucagon emergency kit, if ordered by health care provider.
- Provide recent photo of student for emergency identification purposes.
- Encourage student to wear medic alert I.D. at school.

#### **7. Information about student's self care capabilities. Parents must state what diabetes care their children may do themselves.**

#### **8. Information about the student's meal/snack schedule**

- Work with school staff to coordinate meal and snack schedule.
- Provide instructions for food during school parties and other activities.
- Provide carbohydrate content information for snacks and meals brought from home.
- Provide snacks that can be used to prevent or correct low blood sugars.

## **9. Information about diabetes and the performance of diabetes-related tasks.**

- Provide general diabetes information, as well as information specific to the student.

## **10. Replacement supplies needed for diabetes care**

- Check diabetes supplies and snacks on hand at school on a regular basis.
- Provide additional supplies before existing ones run out.

## **11. Information about changes in student's health status or medical management.**

- Provide school staff with updates involving student's condition or diabetes care as soon as possible. A new Diabetes Care Plan may have to be completed and filed, depending on changes.
- A new Diabetes Care Plan must be completed and filed before the start of each new school year to ensure that student receives appropriate diabetes care at school.
- Any insulin adjustments to the diabetes care that have been requested by the physician must be written down and given to the DCM. Understand that you are responsible for all written changes to the diabetes care provided. Insulin adjustments at school should not be made to the basal rate.
- All written insulin adjustments to the diabetes care plan made by the parent or guardian must be reviewed by the school nurse before the DCM can carry out to assure the safest possible care is provided to your child.

## **12. Note signed by student's health care provider to obtain an excused absence for health care appointments.**

- Follow up with teacher(s) to obtain make-up assignments for excused absences.
- Make sure that student completes missed work within the time frame allowed by school policy or that has been negotiated with teacher.

## **School Responsibilities**

### **1. Diabetes Care Plan:**

- Will be developed each year by the parent/guardian, the student, the student's healthcare provider, the school nurse, and the Diabetic Care Manager (DCM).
- Will be reviewed by the DCM and school nurse whenever parent informs school (in writing) of changes that have occurred in the student's health status or medical treatment, with a new plan developed if necessary.
- Specify the roles and expectations of the parent/guardian, the student, and school personnel in providing assistance to the student during school and extracurricular activities and any special arrangements that be necessary.

### **2. The school nurse will assure training is provided to all school personnel who provide education or care for the student about:**

- General information about diabetes.
- Symptoms and treatment of low blood sugar (hypoglycemia), high blood sugar (hyperglycemia), and emergency procedures.

### **3. The school nurse will assess, plan and evaluate diabetic care provided in the schools.**

#### **The school nurse will:**

- Oversee the school staff to assure safe and competent diabetes care is provided at school and will clarify any questions or concerns with the parent and/or physician.
- Train school staff members to be Diabetic Care Managers (DCMs) in diabetes management and have them successfully demonstrate the administration of insulin or other diabetes medications (which for pump users includes programming and troubleshooting the student's insulin pump), blood glucose monitoring, ketone checks, and responding to hyperglycemia and hypoglycemia including administering glucagon. Develop a plan for follow-up to continually evaluate competencies and successful execution of the care plan.
- Train any staff that has primary care for the student at any time during school hours, extracurricular activities, or during field trips. Training will include a general overview of diabetes and typical health care needs of a student with diabetes, recognition of high and low blood glucose levels, and informing staff how and when to immediately contact either the parent, the school nurse, DCM or 911. Provide them with a copy of the student's Emergency Action Plan.
- Provide bus drivers, who transport the student, with written information about symptoms of high and low blood glucose levels and provide them with a copy of the student's Emergency Action Plan.
- The school nurse is the only staff member who may facilitate diabetic education and deem staff competent to deliver diabetic care.

**4. The DCMs will ensure that at least one DCM is present to perform these procedures and maintain documentation in a timely manner while the student is at school, on field trips, and during extracurricular activities or other school sponsored events. The DCM will:**

- Ensure the student has immediate access to supplies and the assistance of a DCM in the treatment of hypoglycemia (low blood sugar).
- Provide an appropriate location in the school that is private and/or convenient, as requested by the student or parent/guardian, for all needed diabetic care.
- Make treatment for hypoglycemia (low blood sugar) available as close as possible to the student's location.
- Supervise the student until appropriate treatment has been administered. Student should not be left unattended or sent through school hallways alone with a low blood sugar.
- Perform or supervise finger-stick blood sugar monitoring and record the results in the student's logbook unless independent contract on file.
- Perform or supervise insulin administration or other diabetes medications and record amount given on log unless independent contract on file.
- Administer glucose for hypoglycemia (low blood sugar) or Glucagon for severe hypoglycemic reactions.
- Assist with insulin pump operation and insulin administration unless independent contract on file.
- Take appropriate actions for blood sugar levels outside of the target ranges according to students' diabetes care plan.
- If the parents provide written insulin adjustments (and has an MD order to do so), the DCM will contact the school nurse to review the adjustments. If the DCM cannot get in touch with the school nurse, the DCM will request the parent come make the adjustment until the revision can be reviewed by the school nurse.
- The school nurse is the only staff member who may contact a healthcare provider and receive orders for change in treatment.

**5. Notify parents/guardian immediately in the following situations:**

- Symptoms of severe low blood sugar such as continuous crying, extreme tiredness, seizure, or loss of consciousness.
- Symptoms of severe high blood sugar such as frequent urination, presence of ketones, vomiting or elevated blood glucose.
- The student refuses to eat or take insulin injections or bolus.
- Insulin pump malfunctions that cannot be remedied.

**6. The student's teacher will be responsible for knowing the schedule of the student's meals, snacks, and activities and will:**

- Work with the parent/guardian to coordinate this schedule with that of other students as closely as possible.
- Notify the parent/guardian in advance of any expected changes in the school schedule that affect the student's meal times or exercise routine including field trips.
- Remind young children of snack times, including designated snack times or those in conjunction with physical activity.

**7. The school will give permission for the student to:**

- See school medical personnel upon request.
- Eat a snack anywhere, including the classroom or the school bus, to prevent or treat low blood sugar.
- Test blood sugar levels wherever and whenever necessary and to take immediate corrective actions if student has independent contract on file.
- Test and treat blood sugar levels during school testing to ensure optimal academic performance.
- Miss school for required medical appointments to monitor the student's diabetes management. This should be an excused absence with a doctor's note.
- Use the restroom and have access to fluids (i.e. water) as necessary.
- Have immediate access to diabetes supplies at all times, with supervision as needed. Immediate access includes permission for student to carry his/her supplies in book bag or on person.

- 8. As needed the school will incorporate the following attachments into the student's Diabetes Care Plan and will make them available to parent/guardian and appropriate school personnel:**
- Request for diabetes care plan
  - Healthcare Provider's Orders for Students with Diabetes
  - Release of medical information
  - The Emergency Action Plan
  - Information sheet "What School Personnel Should Know About the Student with Diabetes"
  - Request for modified diet
  - Log sheets to record blood sugar levels and insulin given
  - Insulin pump information
  - Other instructions or information necessary for student's diabetes care

MEDICAL ORDER FOR INSULIN INJECTIONS or OTHER MEDICINES

Student \_\_\_\_\_ DOB \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Doctor \_\_\_\_\_ Phone \_\_\_\_\_ Diabetes Educator \_\_\_\_\_ Phone \_\_\_\_\_

Monitor Blood Glucose [ ] Before lunch [ ] After lunch [ ] Before PE [ ] After PE [ ] Before snack [ ] Before getting on bus/going home [ ] As needed for signs/symptoms of low or high blood glucose

Blood glucose at which parent should be notified Low < \_\_\_\_\_ mg/dl and High > \_\_\_\_\_ mg/dl.

Target range for blood glucose > \_\_\_\_\_ mg/dl to < \_\_\_\_\_ mg/dl.

Hypoglycemia Student should not be sent to office unaccompanied if symptomatic or BS less than \_\_\_\_\_ mg/dl.

- Check blood glucose - if blood glucose meter is not available, treat symptoms.
Blood glucose below \_\_\_\_\_ mg/dl and/or symptomatic Treat with 10 to 15 grams carbohydrate snack.
Mild symptoms: Treat with juice, glucose tabs, etc. until above \_\_\_\_\_ mg/dl, then snack or lunch.
Moderate symptoms if unable to drink juice: Administer glucose gel. Retreat until above \_\_\_\_\_ mg/dl, then snack or lunch.
Severe symptoms which may include seizures, unconscious, unable or unwilling to take gel or juice: Administer Glucagon \_\_\_\_\_ mg(s) [ ] IM and call 911.

Hyperglycemia

- Check urine ketones if blood glucose is over \_\_\_\_\_ mg/dl or with symptoms of illness/vomiting. If ketones present, call parents, provide water and student should not exercise. Student may need insulin via injection.
Use insulin orders (see below) when blood glucose is over \_\_\_\_\_ mg/dl
Recommend student be released from school when ketones are moderate/large or symptoms of illness in order to be treated and monitored more closely by parent/guardian.

Medication

Student is on [ ] oral diabetes medication(s) Dose: \_\_\_\_\_ Times to be given \_\_\_\_\_.

Student is on [ ] insulin. Type: \_\_\_\_\_ Dose: \_\_\_\_\_ Times to be given \_\_\_\_\_.

Blood Glucose Correction and Insulin Dosage using (Rapid Acting) Insulin: \_\_\_\_\_

- Blood Glucose Range \_\_\_\_\_ mg/dl Administer \_\_\_\_\_ units
Blood Glucose Range \_\_\_\_\_ mg/dl Administer \_\_\_\_\_ units
Blood Glucose Range \_\_\_\_\_ mg/dl Administer \_\_\_\_\_ units
Blood Glucose Range \_\_\_\_\_ mg/dl Administer \_\_\_\_\_ units and check ketones
Blood Glucose Range \_\_\_\_\_ mg/dl Administer \_\_\_\_\_ units and check ketones
Blood Glucose Range \_\_\_\_\_ mg/dl Administer \_\_\_\_\_ units and check ketones
Blood Glucose Range \_\_\_\_\_ mg/dl Administer \_\_\_\_\_ units and check ketones

If ketones present, call parents, provide water and student should not exercise.

Carbohydrate counting \_\_\_\_\_ unit(s) of insulin per \_\_\_\_\_ grams of carbohydrate with lunch.

\*Other Provider instructions are: \_\_\_\_\_

- Parent/guardian authorized to increase or decrease correction within the following range: +/- 2 units of insulin.
Parent/guardian authorized to increase or decrease insulin to carbohydrate ratio within the following range: 1 unit per prescribed grams of carbohydrates +/- 5 grams of carbohydrates.

Student's Self Care (ability level to be determined by school nurse and parent with input from healthcare provider)

- Totally independent management. [ ] Yes [ ] No Self injects with trained staff supervision. [ ] Yes [ ] No
(if independent, complete Self-Management Agreement) Injections to be done by trained staff. [ ] Yes [ ] No
Needs verification of blood glucose by staff. [ ] Yes [ ] No Self treats mild hypoglycemia. [ ] Yes [ ] No
Assist/testing to be done by trained staff. [ ] Yes [ ] No Monitors own snacks and meals. [ ] Yes [ ] No
Administers insulin independently. [ ] Yes [ ] No Independently counts carbohydrates. [ ] Yes [ ] No
Self injects with verification of dose. [ ] Yes [ ] No Monitors and interprets urine ketones. [ ] Yes [ ] No

SIGNATURES

My signature below provides authorization for the above written orders and exchange of health information to assist the school nurse in developing an Individualized Health Plan. I understand that all procedures will be implemented in accordance with state laws and regulations and may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This order is effective for the current school year only.

Physician \_\_\_\_\_

Date \_\_\_\_\_

Parent \_\_\_\_\_

Date \_\_\_\_\_

School Nurse \_\_\_\_\_

Date \_\_\_\_\_

**MEDICAL ORDER FOR INSULIN PUMP**

Student \_\_\_\_\_ DOB \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_  
Doctor \_\_\_\_\_ Phone \_\_\_\_\_ Diabetes Educator \_\_\_\_\_ Phone \_\_\_\_\_

**Pump settings are established by the student’s healthcare provider and should not be changed by school staff.**

**Monitor Blood Glucose**

- Before lunch  After lunch  Before PE  After PE  Before snack  Before getting on bus/driving home
- As needed for signs/symptoms of low or high blood glucose
- All blood sugars should be entered into pump to determine need for bolus correction.

Notify parent when blood sugar < \_\_\_\_\_ or > \_\_\_\_\_. Target range for blood sugar > \_\_\_\_\_ mg/dl to < \_\_\_\_\_.

**Hypoglycemia**

Student **should not** be sent to office unaccompanied if symptomatic or BS < \_\_\_\_\_ mg/dl.

- Check blood glucose - if blood glucose meters not available, treat symptoms.
- Blood glucose between \_\_\_\_\_ mg/dl and/or symptomatic: Treat with 10 to 15 gm carbohydrate (juice, glucose tabs, etc).
- Mild symptoms: Treat with 10 – 15 gms carbs. (juice, glucose tabs, etc). until above \_\_\_\_\_ mg/dl, then snack or lunch.
- Moderate symptoms if unable to drink juice: Administer glucose gel. Retreat until above \_\_\_\_\_ mg/dl, then snack or lunch.
- Severe symptoms which may include seizures, unconscious, unable or unwilling to take gel or juice:

Administer Glucagon \_\_\_\_\_ mg(s) IM and call 911. Disconnect pump.

**Do not bolus for carbohydrates given to treat low blood glucose until blood glucose is > \_\_\_\_\_ mg/dl.**

**Hyperglycemia**

- If BS > \_\_\_\_\_ mg/dl

In the event of pump failure contact parent, if not available then call healthcare provider for further instructions. May need insulin via syringe.

**Insulin – Type:** \_\_\_\_\_

**Correction Ratio:** \_\_\_\_\_ unit of insulin for every \_\_\_\_\_ mg/dl in blood glucose over: \_\_\_\_\_

Check urine ketones if blood glucose > \_\_\_\_\_ mg/dl

- √ If ketones present, call parents, provide water and student should not exercise.
- √ Recommend student be released from school when ketones are moderate/large or symptoms of illness in order to be treated and monitored more closely by parent/guardian.

**Insulin to Carbohydrate ratio** \_\_\_\_\_ units of insulin per \_\_\_\_\_ grams of carbohydrate.

Carbohydrate ratio for snack \_\_\_\_\_ units per \_\_\_\_\_ gm of carbs \_\_\_\_\_ am \_\_\_\_\_ pm

**Bolus for carbohydrates (or to be) eaten should occur immediately**  Before meal  After meal  ½ bolus before & ½ bolus after

- Parent/guardian authorized to increase or decrease sliding scale within the following range: +/- 2 units of insulin
- Parent/guardian authorized to increase or decrease insulin to carbohydrate ratio within the following range: 1 unit per prescribed \_\_\_\_\_ grams of carbohydrates +/- 5 grams of carbohydrates.

**Comments:**

**Student’s Self Care:** (ability level determined by parent and healthcare provider)

- Independently monitors blood glucose.  Yes  No
- Independently counts carbohydrates.  Yes  No
- (if independent, complete Self-Management Agreement)
- Inserts new infusion set.  Yes  No
- Self injects with verification of dosage.  Yes  No
- Tests and interprets urine ketones.  Yes  No
- Needs assistance with pump management.  Yes  No
- Injection to be done by trained staff  Yes  No
- Independently manages pump boluses.  Yes  No
- Self treats mild hypoglycemia.  Yes  No

**SIGNATURES**

My signature below provides authorization for the above written orders and exchange of health information to assist the school nurse in developing an Individualized Health Plan. I understand that all procedures will be implemented in accordance with state laws and regulations and may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This order is effective for the current school year only.

Physician \_\_\_\_\_  
Parent \_\_\_\_\_  
School Nurse \_\_\_\_\_

Date \_\_\_\_\_  
Date \_\_\_\_\_  
Date \_\_\_\_\_

**Burke County Public Schools**

**Independent Management Health Plan  
DIABETES Type 1 Type 2**

Student	_____	DOB	_____			
School	_____					
Nurse	_____	Phone	_____	Grade	_____	Teacher
Parent/ Guardian	_____	Home Phone	_____	Work Phone	_____	Cell Phone
Physician	_____	Phone	_____	Diabetes Educator	_____	504 Plan <input type="checkbox"/> Yes <input type="checkbox"/> No

**Student is independent with daily diabetes management and self-care**

Blood Glucose Monitoring: Student is able to check as needed during the school day.

Target range \_\_\_\_\_ mg/dl to \_\_\_\_\_ mg/dl.

**Health Concern #1: Low Blood Glucose (Hypoglycemia)**

*Emergency situations may occur with low blood glucose.*

*Symptoms: shaky, feels low, feels hungry, confused*

- Student should treat when blood glucose is below \_\_\_\_\_ mg/dl or if symptomatic.
- Contact DCM to come to the classroom to monitor student if needed.
- Follow directions on Emergency Action Plan.

**Health Concern #2: High Blood Glucose (Hyperglycemia)**

*Symptoms: increased thirst, increase in urination, headache, stomachache*

- Student should treat when blood glucose is above \_\_\_\_\_ mg/dl.
- Follow directions on Emergency Action Plan.

**Call 911 for:**

1. Student is unable to cooperate to eat or drink anything.
2. Decreasing alertness or loss of consciousness.
3. Seizure – never put anything into the mouth of a person who is unconscious or having a seizure. Roll student onto side and protect from injury.
4. If Glucagon is prescribed and available, immediately contact DCM to administer.

**Medication at School:** Insulin via: Pump Syringe Pen None  
 Glucagon: Yes No Location in School \_\_\_\_\_

Staff delegated to administer Glucagon \_\_\_\_\_

**Additional Information:**

1. Student is allowed access to fast acting glucose and test blood glucose as needed.
2. Student will be allowed to carry a water bottle and have unrestricted bathroom privileges.
3. Substitute teachers must be aware of the student's health situation.
4. Be aware that blood glucose levels can affect ability to concentrate and perform properly on tests.
5. Prior to and during timed tests have student monitor their blood glucose. If blood glucose is out of range during test, treat per care plan. Allow for student to continue taking test after treatment and asymptomatic.
6. Notify Parent(s) when blood glucose is below \_\_\_\_\_ mg/dl or above \_\_\_\_\_ mg/dl and for emergencies.

**FIELD TRIPS AND SPECIAL EVENTS Notify** parents of all field trips and special events. Supervising staff will review Student Health Plan. Trained and delegated staff will provide necessary interventions for daily management and emergency care. All necessary supplies will accompany student during the trip and may include: blood glucose meter, snack and drinks, fast acting glucose, Glucagon.

*As Parent/Guardian of the above named student, I give my permission to the school nurse and other designated staff to perform and carry out the diabetes tasks as outlined in this School Health Plan and for my child's health care provider to share information with the school nurse for the completion of this plan. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis.*

Parent \_\_\_\_\_ Date \_\_\_\_\_

School Nurse \_\_\_\_\_ Date \_\_\_\_\_

# AGREEMENT FOR STUDENTS INDEPENDENTLY MANAGING THEIR DIABETES

Student \_\_\_\_\_ School/Grade \_\_\_\_\_

## STUDENT

- I agree to dispose of any sharps either by keeping them in my kit and disposing at home, or placing them in the sharps container provided at school.
- I will notify the health office if my blood sugar is below \_\_\_\_\_ mg/dl or above \_\_\_\_\_ mg/dl.
- I will not allow any other person to use my diabetes supplies.
- I plan to keep my diabetes supplies: \_\_\_\_\_ with me \_\_\_\_\_ in the school health office \_\_\_\_\_ in an accessible and secure location (located in \_\_\_\_\_)
- I understand that the freedom to manage my diabetes independently is a privilege and I agree to abide by this contract.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

## PARENT/GUARDIAN

- I agree that my child can self manage his/her diabetes and can recognize when he/she needs to seek the help of a staff member.
- It has been recommended to me that back up supplies be provided to the health office for emergencies.
- I understand that this contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contingencies.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

## SCHOOL NURSE

- School staff that have the need to know about the student's condition and the need to carry their diabetes supplies have been notified.

School Nurse's Signature \_\_\_\_\_ Date \_\_\_\_\_

# DIET ORDER

## Medical Statement for Student with Special Needs

---

### Part I (to be filled out by Parent or Guardian)

Name of Student: \_\_\_\_\_  
Last First MI

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

School attended by Student: \_\_\_\_\_

Parent/Guardian's daytime Phone Number (s): \_\_\_\_\_

Name of Parent/Guardian (s): \_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

---

### Part II (to be filled out by physician)

Patient Diagnosis:

\_\_\_\_\_

Describe the patient's condition and the major life activity affected by the condition related to the need for dietary modifications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Indicate which dietary modification the patient needs and specify what changes need to be made.

Texture modification:  pureed  ground  chopped  other

Specify foods: \_\_\_\_\_

Tube feeding: Formula Name: \_\_\_\_\_

Administering Instructions: \_\_\_\_\_

Oral feeding:  No  Yes If yes, specify foods: \_\_\_\_\_

Nutrient Modifications:  Increase Calories Description: \_\_\_\_\_

Supplement Name: \_\_\_\_\_

Decrease Calories Description: \_\_\_\_\_

Nutrient Restriction Description: \_\_\_\_\_

Special Mealtime Equipment: \_\_\_\_\_

Other: \_\_\_\_\_

Dietitian's Name (if available) \_\_\_\_\_ Phone: \_\_\_\_\_

Physician: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**PHYSICIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

---

## Emergency Action Plans

The purpose of an Emergency Action Plan (EAP) is to provide a plan of care for students that have the potential to experience a medical emergency while at school or on school sponsored trips. Individual health plans for chronically ill children should address potential emergency situations based on each student’s health condition. EAPs are written protocols with precise instructions signed by the child’s parent and if indicated, by the physician. If a student has a health condition, which requires special treatment in a certain defined emergency circumstance, an EAP must be on record and appropriate school staff must be trained to administer the emergency steps to keep a child safe at school. Without an EAP, the school’s only alternative in an emergency situation is to call parents and /or EMS.

### Emergency Action Plan Procedure

1. The school nurse should review the student health questionnaire (SHQ) completed by parents/guardians at the beginning of each school year. An EAP should be sent home for the parent/guardian to complete if they indicated on the SHQ that the student has any condition that could potentially lead to the student experiencing a life-threatening emergency at school.
  
2. The following are standard EAPs:
  - Asthma
  - Allergies
  - Diabetes
  - Pregnancy
  - Seizures
  - Various Health Issues – a blank form for other emergencies, such as heart conditions or bleeding disorders
  
3. It is the responsibility of the parent/guardian to have EAP completed. If the parent/guardian does not believe emergency action is required at school for the condition identified on the SHQ, they may sign a form to waive an EAP. If an EAP is warranted, the parent must complete sections indicated and if necessary, the child’s physician will be required to complete sections pertaining to medical treatment including self-medication or medication administration at school. The physician orders listed on the EAP takes the place of the prescription medication authorization request form.
  
4. Once the parent/guardian has returned the EAP to the school, the school nurse should copy the completed EAP and distribute to all teachers/staff the student comes in contact with during the school day. The main office should have a copy of all EAPs readily accessible as a part of the Safe School Plan. Teachers should be reminded to make EAPs available to substitute teachers, to complete the Substitute Information sheet regarding health concerns, and include all papers in a substitute folder.

5. EAPs must also be distributed to day care and bus drivers if appropriate.
6. Faculty/staff must be aware of students with EAPs and appropriate emergency action to take in case of a crisis.
7. The school nurse should retain the original EAP in an easily accessible file.
8. EAPs are valid for one school year. A new EAP must be formulated at the beginning of each school year. If necessary, a new plan should be formulated for any changes in the child's condition during the school year.
9. Faculty/staff will be trained by the school nurse. Training will include knowledge, medication administration, and deemed competent to deliver emergency treatment. The school nurse is the only employee that can train and approve faculty/staff to administer medications and emergency procedures.
10. EAPs should be taken on field trips accompanied by necessary medication and equipment. All these materials must be stored for confidentiality and security.

**EMERGENCY ACTION PLAN**  
**SEVERE ALLERGIES**

Place  
Child's  
Picture  
Here

Student's Name \_\_\_\_\_ DOB \_\_\_\_\_ School \_\_\_\_\_

Grade \_\_\_\_\_ Teacher \_\_\_\_\_ Bus # \_\_\_\_\_ Daycare? \_\_\_\_\_

ALLERGY TO \_\_\_\_\_

**Physician to complete:**

Asthmatic Yes\*  No  \*Higher risk for severe reaction

**STEP 1: TREATMENT**

Symptoms:

Give Checked Medication:

- |  |                                 |  |
|--|---------------------------------|--|
| * If a food allergen has been ingested, but no symptoms:                 | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| * Mouth Itching, tingling, or swelling lips, tongue, mouth               | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| * Skin Hives, itchy rash, swelling of the face or extremities            | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| * Gut Nausea, abdominal cramps, vomiting, diarrhea                       | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| * Throat** Tightening of throat, hoarseness, hacking cough               | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| * Lung** Shortness of breath, repetitive coughing, wheezing              | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| * Heart** Thready pulse, low blood pressure, fainting, pale              | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| * Other** _____  | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| * If reaction is progressing (several of the above areas affected), give | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |

The severity of symptoms can quickly change. \*\*potentially life-threatening

**DOSAGE:**

Epinephrine: EpiPen EpiPen Jr. (circle one) Inject Intramuscularly

Antihistamine/Dose: \_\_\_\_\_ **By mouth**

Special Instructions: \_\_\_\_\_

School to administer.

Student may self-administer antihistamine or epi-pen. I have provided education and they are knowledgeable

\_\_\_\_\_  
Doctor's Signature Date Phone Number

\_\_\_\_\_  
Address

## Step 2: EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Notify parent. Encourage parent to notify child's physician.
3. Emergency Contacts:

Name/Relationship

Phone Number(s)

a. \_\_\_\_\_ a. \_\_\_\_\_ a. \_\_\_\_\_

b. \_\_\_\_\_ b. \_\_\_\_\_ b. \_\_\_\_\_

c. \_\_\_\_\_ c. \_\_\_\_\_ c. \_\_\_\_\_

### TRAINED STAFF MEMBERS

1. \_\_\_\_\_ Phone Extension \_\_\_\_\_  
 2. \_\_\_\_\_ Phone Extension \_\_\_\_\_

\* NOTIFY YOUR 911 AND YOUR SCHOOL NURSE IF EPI-PENS ARE ADMINISTERED

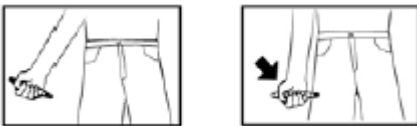
### EPIPEN® AND EPIPEN® JR. DIRECTIONS

Expiration Date: \_\_\_\_\_

- 1) Grasp unit, with the black tip pointing downward.
- 2) Form a fist around the auto-injector (black tip down).
- 3) With your other hand, pull off the gray activation cap.



- 4) Swing and jab firmly into outer thigh so that auto-injector is perpendicular (at a 90° angle) to the thigh.



- 5) Hold firmly in thigh for 10 seconds. Remove unit, massage injection area for 10 seconds.
- 6) Student must remain lying down, preferable on side, until Emergency Management arrives.
- 7) Once Epi-Pen is used, call 911. Additional epinephrine may be needed. Take the used Epi-Pen with child to the Emergency Room.

\_\_\_\_\_  
 Parent/Guardian's Signature

\_\_\_\_\_  
 Date

- School Nurse has verified that child is competent to self-administer medication, if trained by physician.

\_\_\_\_\_  
 School Nurse

\_\_\_\_\_  
 Date

page 2 of 2 (2-06)

# EMERGENCY ACTION PLAN

## SEIZURES

**Student's**

**Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **School** \_\_\_\_\_

**Grade** \_\_\_\_\_ **Teacher** \_\_\_\_\_ **Bus #** \_\_\_\_\_ **Daycare?**

PARENT/GUARDIAN \_\_\_\_\_ PHONE \_\_\_\_\_

\_\_\_\_\_ PHONE \_\_\_\_\_

HEALTH CARE PROVIDER \_\_\_\_\_ PHONE \_\_\_\_\_

1. What type of seizures does your child have and how often do they occur?

\_\_\_\_\_

2. Does your child have an aura or warning of a seizure coming? Is she/he able to notify anyone that a seizure is coming?

\_\_\_\_\_

3. Name of seizure medications: How often are they taken?

At home \_\_\_\_\_

At school \_\_\_\_\_

4. Does your child have any side effects from these medications? Please list:

\_\_\_\_\_

5. Are there any sports/activities in which your child CANNOT fully participate?

\_\_\_\_\_

PLEASE NOTE: If medication is to be taken at school, a medication authorization form must be completed by a parent AND a physician and kept at the school. These forms are obtained from your school office staff or school nurse. These forms are completed on a yearly basis.

PLEASE READ THE EMERGENCY ACTION PLAN FOR SEIZURES ON THE REVERSE SIDE, AND ADD ANY FURTHER INSTRUCTIONS WE NEED TO BE MADE AWARE OF.

**\*\* If Diastat is prescribed by the child's physician, please complete a medication administration form.**

# EMERGENCY ACTION PLAN\SEIZURES

\_\_\_\_\_  
**Student's Name**

\_\_\_\_\_  
**Teacher**

What type of seizure does your child have? What are his/her symptoms?

**Petit Mal (absence seizure)**

- brief loss of consciousness
- minimal or no alteration in muscle tone
- usually able to maintain postural control
- frequently has minor movements or twitches
- often mistaken for inattention
- stares blankly into space
- Other: \_\_\_\_\_

**Grand Mal (tonic-clinic seizure)**

- loss of consciousness
- child falls to floor or ground
- breathing may stop for a moment
- arms and legs may become rigid and move in rhythm with face
- may be incontinent of urine and/or feces
- may last several minutes
- may want to sleep afterwards
- Other: \_\_\_\_\_

## **EMERGENCY PLAN:**

- 1) Stay with child during and after seizure. Note duration of seizure and type of body movements.
- 2) Clear area around student to prevent injury.
- 3) Assist to horizontal position if loss of consciousness occurs. Remove student's glasses, loosen clothing around neck.
- 4) Turn on side as soon as able.
- 5) DO NOT RESTRAIN MOVEMENT OR PLACE ANYTHING IN MOUTH.
- 6) Monitor breathing and begin artificial respiration if breathing does not resume spontaneously.
- 7) If seizure lasts more than 5 minutes or student has one seizure after another without waking, call 911 and transport to \_\_\_\_\_ Hospital.
- 8) When seizure is over, allow child to rest and always notify parents.
- 9) Notify school nurse if she is in the building.
- 10) Additional instructions: \_\_\_\_\_

This medical information needs to be shared with your child's teachers, office personnel and bus drivers, if necessary. By signing below, the school nurse has your permission to share this Emergency Action Plan with school personnel mentioned above.

PARENT/GUARDIAN'S

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

NURSE \_\_\_\_\_ DATE \_\_\_\_\_ page 2 of 2

**EMERGENCY ACTION PLAN**  
**VARIOUS HEALTH ISSUES**

**Student's**

**Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **School** \_\_\_\_\_

**Grade** \_\_\_\_\_ **Teacher** \_\_\_\_\_ **Bus #** \_\_\_\_\_ **Daycare?**

\_\_\_\_\_

**HEALTH CONCERN:** \_\_\_\_\_

Is exercise or activity limited? \_\_\_\_\_ yes \_\_\_\_\_ no If yes, please describe limitations:

\_\_\_\_\_

**Is student on medication for this problem?** \_\_\_\_\_ yes \_\_\_\_\_ no

Please list below:

At home? \_\_\_\_\_

At school? \_\_\_\_\_

Briefly describe symptoms: \_\_\_\_\_

\_\_\_\_\_

**OTHER HEALTH PROBLEMS:**

Briefly describe: \_\_\_\_\_

\_\_\_\_\_

PLEASE NOTE: If medications are to be taken at school, a medication authorization form must be completed by parent and physician and kept at school. These are obtained from your office staff or school nurse and must be completed on a yearly basis for each medication.

PLEASE READ THE EMERGENCY ACTION PLAN ON THE REVERSE SIDE AND COMPLETE IT, SIGN IT, AND RETURN IT TO THE SCHOOL NURSE.

**EMERGENCY PLAN/VARIOUS HEALTH ISSUES**

**Student's**  
**Name** \_\_\_\_\_ **Teacher** \_\_\_\_\_

**Emergency contact:** \_\_\_\_\_ **Ph:** \_\_\_\_\_

**Healthcare Provider:** \_\_\_\_\_ **Ph:** \_\_\_\_\_

**SIGNS OF EMERGENCY:** \_\_\_\_\_

**ACTIONS AND TREATMENT FOR SCHOOL PERSONNEL TO TAKE:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**ADDITIONAL INSTRUCTIONS:** \_\_\_\_\_

Healthcare provider's signature \_\_\_\_\_ Date \_\_\_\_\_

This medical information needs to be shared with your child's teachers, office personnel, and bus drivers, if necessary. By signing below, the school nurse has your permission to share the above Emergency Action Plan with the school personnel mentioned above.

**PARENT/GUARDIAN**  
**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**NURSE** \_\_\_\_\_ **DATE** \_\_\_\_\_

# EMERGENCY ACTION PLAN

## PREGNANCY

Date: \_\_\_\_\_

Grade: \_\_\_\_\_

Student's Name: \_\_\_\_\_

Home phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Home phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Due Date: \_\_\_\_\_

Symptoms: Nausea and vomiting

Treatment: Provide soft drink and crackers, if available. Student is responsible for providing snacks.

### Signs of Emergency:

- Bright red vaginal bleeding
- Leaking bag of water (may be sudden gush or slow leak)
- Sharp abdominal pain in abdomen or side that does not go away
- Headache/dizziness
- Blurred vision
- Epigastric discomfort
- Chills, fever
- Pain when passing urine

### Actions for School Personnel To Take During An Emergency:

#### Stay with student at all times!

- Call 911
- Call parents
- Call or page school nurse,  
If school nurse is in the building, notify her immediately
- Move student to office area if possible
- Have student lie on left side
- Provide comfort measures (pillow, blanket, reassurance, etc.)

Additional Instructions: \_\_\_\_\_

Healthcare provider's signature \_\_\_\_\_ Date \_\_\_\_\_

This medical information needs to be shared with your daughter's teachers, office personnel, and bus drivers, if necessary. By signing below, the school nurse has your permission to share the above Emergency Action Plan with the school staff involved with your daughter.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

**EMERGENCY ACTION PLAN  
ASTHMA**

**Student's Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **School** \_\_\_\_\_

**Grade** \_\_\_\_\_ **Teacher** \_\_\_\_\_ **Bus #** \_\_\_\_\_ **Daycare?** \_\_\_\_\_

**Emergency contact:** \_\_\_\_\_ **Ph:** \_\_\_\_\_

**Physician treating student for asthma:** \_\_\_\_\_ **Ph:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

Asthma medication may be used on school property during the school day, at school-sponsored activities, or while in transit to or from school-sponsored events.

**\*\*EMERGENCY PLAN:\*\***

**Emergency Action is necessary when the student has symptoms such as:**

**Coughing**

**Tight chest**

**Difficulty breathing**

**Wheezing**

**Nose opens wide**

**Difficulty talking**

1. Attempt to calm student. Stay with student.
2. Have student take prescribed medication as ordered by health care provider and parent (see back of form).
3. Have student sit in a resting position, breathing slowly through the mouth, exhaling slowly through pursed lips.
4. Offer fluids.
5. Notify school nurse if in the building.
6. Notify parent for severe breathing difficulty or if medication is not effective after 15 minutes.
7. If parent is unavailable or student is having extreme difficulty breathing, call 911 and transport to closest hospital.

**Parents are responsible for providing back-up medications to the school in a location that the student has immediate access to if needed for an asthma or anaphylaxis emergency.**

**Back-up medication will be located** \_\_\_\_\_.

**If a student uses asthma medication prescribed for the student in a manner other than as prescribed, a school may impose on the student disciplinary action according to the school's disciplinary policy. A school may not impose disciplinary action that limits or restricts the student's immediate access to the asthma medication.**

**By signing below, the school nurse has your permission to share this Emergency Action Plan with appropriate school personnel.**

\*BCPS and its employees/agents are not liable for an injury arising from a student's possession and self-administration of asthma medication.

**PARENT/GUARDIAN'S SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PLEASE NOTE: All inhalers/nebulizers MUST be registered with the school nurse. Exp date:** \_\_\_\_\_

- Student has demonstrated ability to the school nurse to use the asthma medication and any device that is necessary to administer the medication appropriately.**

**SCHOOL NURSE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**\*\*If your child requires medicine at school, their doctor must complete the back of this form.\*\***

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Doctor: \_\_\_\_\_ Date: \_\_\_\_\_

Phone for Doctor or Clinic: \_\_\_\_\_

Predicted/Personal Best Peak Flow Reading: \_\_\_\_\_

**Asthma Triggers**

*Try to stay away from or control these things:*

- Exercise
- Mold
- Chalk dust/dust
- Pollen
- Animals
- Tobacco smoke
- Food
- Smoke, strong odors or spray
- Colds/Respiratory infections
- Carpet
- Change in temperature
- Dust mites
- Cockroaches
- Other \_\_\_\_\_

**1. Green – Go**

- Breathing is good.
- No cough or wheeze.
- Can work and play.



Or Peak Flow \_\_\_\_\_ to \_\_\_\_\_ (80-100%)

Use these controller medicines *every day* to keep you in the green zone:

Medicine: \_\_\_\_\_ How much to take: \_\_\_\_\_ When to take it: \_\_\_\_\_  Home  School

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5-15 minutes before very active exercise, use  Albuterol \_\_\_\_\_ puffs.

**2. Yellow – Caution**



Coughing



Wheezing



Tight Chest



Wakes up at night

Or Peak Flow \_\_\_\_\_ to \_\_\_\_\_ (50-80%)

Keep using controller green zone medicines everyday.

Add these medicines to keep an asthma attack from getting bad:

Medicine	How much to take	When to take it
Albuterol	<input type="checkbox"/> 2 puffs by inhaler	<input type="checkbox"/> May repeat every
or	<input type="checkbox"/> 4 puffs by inhaler	20 min up to 3 doses
_____	<input type="checkbox"/> with spacer, if available	in first hour, if needed
	<input type="checkbox"/> by nebulizer	

If symptoms **DO NOT** improve after first hour of treatment, then go to **red zone**.

If symptoms **DO** improve after first hour of treatment, then continue:

Albuterol	<input type="checkbox"/> 2 puffs by inhaler	<input type="checkbox"/> Every 4 - 8 hours
or	<input type="checkbox"/> 4 puffs by inhaler	for _____ days
_____	<input type="checkbox"/> with spacer, if available	
	<input type="checkbox"/> by nebulizer	

\_\_\_\_\_, \_\_\_\_\_ times a day for \_\_\_\_\_ days  Home  School

(oral corticosteroid) (how much)

Call your doctor if still having some symptoms for more than 24 hours!

Call your doctor and/or parent/guardian **NOW!**

Take these medicines until you talk with a doctor or parent/guardian:

Medicine:	How much to take:	When to take it:
Albuterol	<input type="checkbox"/> 2 puffs by inhaler	<input type="checkbox"/> May repeat every
or	<input type="checkbox"/> 4 puffs by inhaler	20 minutes until
_____	<input type="checkbox"/> with spacer, if available	you get help
	<input type="checkbox"/> by nebulizer	
_____, _____ times a day for _____ days		<input type="checkbox"/> Home <input type="checkbox"/> School
(oral corticosteroid)	(how much)	

Call 911 for severe symptoms, if symptoms don't improve, or you can't reach your doctor and/or parent/guardian.

**3. Red – Stop – Danger**

- Medicine is not helping.
- Breathing is hard and fast.
- Nose opens wide.
- Can't walk.
- Ribs show.
- Can't talk well.



Or Peak Flow \_\_\_\_\_ (Less than 50%)

\_\_\_\_\_ Student is capable and has been instructed in self-administration of these medications.

\_\_\_\_\_ Student is not approved to self-medicate.

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_