POLICY 7-5.3 ADMINISTERING MEDICINES TO STUDENTS

Policy

The Fauquier County School Board affirms its position that in order to prevent possible harm to students and possible liability on the part of the School Board and its employees, all school personnel are prohibited from administering to students treatments for injuries or medication for illnesses with exceptions as noted in this policy. For purposes of this policy, "medication" shall mean any drug including all prescription and over-the-counter drugs. The only exception to this policy is non-medicated lip balm, sunscreen, hand sanitizer, and saline solution, which can be carried by students without parental permission.

Administration of Epinephrine

Pursuant to an order or standing protocol issued by the prescriber within the course of his professional practice, a school nurse, or any School Board employee, employee of a local governing body, or employee of a local health department who is authorized by a prescriber and trained in the administration of epinephrine, may possess and administer epinephrine to any student believed to be having an anaphylactic reaction, in accordance with the "Virginia School Health Guidelines." Any school nurse, School Board employee, employee of a local governing body, or employee of a local health department authorized by a prescriber and trained in the administration of epinephrine, who provides, administers, or assists in the administration of epinephrine to a student believed in good faith to be having an anaphylactic reaction, or is the prescriber of the epinephrine, shall not be liable for any civil damages for ordinary negligence in acts or omissions resulting from the rendering of such treatment.

Policy Limitations

Parents of students with known life threatening allergies and/or anaphylaxis must provide the school with written instructions from the students' health care provider for handling anaphylaxis and all necessary medications for implementing the student specific order on an annual basis. The anaphylaxis policy is not intended to replace student specific orders or parent provided individual medications. This policy **does not** extend to activities off school grounds (including transportation to and from school, field trips, etc.) or outside of the academic day (sporting events, extra-curricular activities, etc.).

Generally

School personnel may administer first aid, but only in accordance with the items and procedures contained in the First Aid Guide for School Emergencies (Virginia Department of Education and Virginia Department of Health), the American Red Cross Manual, American Heart Association, Heart Saver and AED Manual, and the Virginia School Health Guidelines 2nd Edition, which are on file in the school clinic.

When medication or first aid is administered by school personnel, procedures will be followed which protect the health and safety of the student (Virginia School Health Guidelines 2nd Edition, Manual for the Training of Public School Employees in the Administration of Medication). Physician's orders must be provided annually for (i) individualized health plans and procedures; (ii) medication administration; and (iii) emergency transportation plans.

To maintain awareness on the part of professional staff members, the Fauquier County School Division will provide annual training on the subject of administering medication consistent with guidelines established by the State Department of Education as well as staff development on the subject of temporary aid according to local policy and procedures.

Each school building shall have a school health room equipped to treat students (Virginia School Health Guidelines 2nd Edition, pages 136 – 140).

Emergencies

Emergency information shall be on file at each school for every pupil. The emergency card should be returned to the student's school no later than five (5) days after student's enrollment. The emergency card shall be easily accessible as established by the school principal.

Bus drivers should be notified by emergency transportation plan about students with medical problems who ride their buses.

The parents or guardian shall be contacted as soon as possible in cases of emergency. If the injury is believed to be serious and the parent or guardian cannot be contacted, the pupil shall be transferred by a rescue vehicle to a hospital for treatment. School personnel should accompany the pupil and stay with them until the parent/guardian arrives.

Prescription Medications

Fauquier County Public School personnel may give prescription medication to students only with a physician's written order and written permission from the student's parent or guardian (see attached form). The order must include the name of the medicine, the dosage, the time, the amount, and the duration of the order. Such medicine must be in the original pharmacy labeled container and delivered to the principal, school nurse, clinic attendant, or School Division designee by the parent/guardian of the student unless other arrangements have been made.

Non-Prescription Medications

Fauquier County Public School personnel may give non-prescription medication to students only with the written permission of the parent or guardian (see attached form). Such permission shall include the name of the medication, the required dosage of the medication, and the reason the medicine is to be given. Such medicine must be in the original unopened container and delivered to the principal, school nurse, clinic attendant, or School Division designee by the parent/guardian of the student unless other arrangements have been made. In order for a non-prescription medication to be given to a student for more than ten (10) consecutive school days, written permission from the child's physician shall be required.

Fauquier County Public School personnel are only allowed to administer the recommended dosage. Any exceptions to the recommended dosage will require a physician's order.

Self-Administration of Medication

Self-administration of any medication is prohibited unless the self-administration adheres to the conditions set forth herein. The only exceptions are non-medicated lip balm, sunscreen, hand sanitizer and saline solution, which are not subject to this policy. Students are permitted to possess and self-administer medications in accordance with this policy during the school day, at school-sponsored activities, or while on a school bus or other school property. In order for a student to possess and self-administer medication, the following conditions must be met:

1. Written parental consent (see attached form) that the student may self-administer medications must be on file with the school;
2. Written notice from the student's primary care provider (see attached form) must be on file with the school, indicating the identity of the student, stating the diagnosis, and approving self-administration of medications that have been prescribed for the student; specifying the name and dosage of the medication, the frequency in which it is to be administered, the circumstances which may warrant its use; and attesting to the student's demonstrated ability to safely and effectively self-administer the medication; and
3. An individualized health care plan must be on file in the school health office.
4. An emergency transportation plan must be prepared for any life threatening conditions.
5. Self-administration of medications must be consistent with the Virginia School Health Guidelines 2nd Edition, and the Guidelines for Specialized Healthcare Procedures, which are jointly issued by the Virginia Department of Education and the Virginia Department of Health.

Permission granted to a student to possess and self-administer medications will be effective for a period of one (1) school year, and must be renewed annually. However, a student's right to possess and self-administer medication

may be revoked if the student violates the policy. The appropriate school personnel will consult with the principal, student's parents, the student, and the school nurse/clinic attendant, if the student violates this policy and the student may be subject to disciplinary action in accordance with the Standards of Student Conduct and the Code of Conduct.

If student-to-student exposure involving bodily fluids occurs, the school principal will notify the School Health Coordinator immediately or as soon as practicable thereafter. The School Health Coordinator shall inform each student's parents of the exposure, advise them of the importance of consulting with their family physician or the Fauquier County Health Department, and explain to them the limited legal authority of the School Division to intervene.

LEGAL REFERENCE: Code of Virginia, 1950, as amended, § 22.1-78, 22.1-274.2, 22.1-287, 22.1-289, 54.1-2957.02; Family Education Rights and Privacy Act of 1974, 20 U.S.C. § 1232(g).

Adopted: April 10, 2012

Revised: July23, 2012; July 8, 2013

ACCOMPANYING REGULATIONS/FORMS

REGULATION 7-5.3 (A)	GUIDELINES FOR ADMINISTERING MEDICINE/FIRST AID TO STUDENTS
REGULATION 7-5.3 (B)	ADMINISTRATION OF EPINEPHRINE
FORM 7-5.3(A)F1	AUTHORIZATION FOR MEDICATION ADMINISTRATION
FORM 7-5.3(A)F2	ANNUAL CONTRACT FOR SELF-ADMINISTRATION OF MEDICATION
FORM 7-5.3(A)F3	PHYSICIAN ORDER/HEALTH CARE PLAN FOR SEVERE ALLERGY
FORM 7-5.3(A)F4	PHYSICIAN ORDER/HEALTH CARE PLAN FOR DIABETES
FORM 7-5.3(A)F5	PHYSICIAN ORDER/HEALTH CARE PLAN FOR ASTHMA
FORM 7-5.3(B)F1	REPORT OF ANAPHYLACTIC REACTION

REGULATION 7-5.3(A) GUIDELINES FOR ADMINISTERING MEDICINE/FIRST AID TO STUDENTS

1. **Generally**

The Superintendent is authorized to promulgate regulations and forms for the implementation of policy 7-5.3, Administering Medicine/First Aid.

2. **Procedures for Administering Medication and Temporary Aid to Students**
    a. School personnel who administer medication to students shall review School Board policy 7-5.3 regarding this subject.
    b. A copy of the American Heart Association First Aid, CPR and AED Manual as well as First Aid Guide for School Emergencies (Virginia Department of Education) shall be kept readily available.
    c. A minimum of three (3) employees at each school shall be trained in first aid procedures.
    d. The principal shall make known to the staff and students the identity and location of these individuals.
    e. All prescribed medications should be pharmacy labeled with the following: (1) the student's name, (2) name of the drug, (3) instructions for administration in lay language, (4) the time of administration and (5) the expiration date of the drug. Parents should provide instrument for measuring liquid medications.
    f. Records shall be kept by school personnel of the prescribed medication, date, time, and person administering the medication.
    g. It is the parent's and/or guardian's responsibility to provide prescribed medication, which has not exceeded the expiration date.
    h. The principal shall be responsible for informing parents who request that medication be administered of the procedures for administering such medications by school personnel.
    i. A summary of this policy shall be included in the Fauquier County Public Schools Student/Parent Information Handbook, as well as in the handbooks or information packets provided to students and parents by the schools.
    j. Adequate accommodations shall be provided in order to safeguard all medication in a locked, centrally located, clean, dry area.

3. **Procedures for Special Health Services to Students**
    a. Health Services – Intermittent Catheterization
        i. When a student's physician prescribes a bladder training program which utilizes this technique, and the catheterization procedure must be carried out during school hours to complement the home program, then it shall be one under the following conditions:
            1. Two (2) persons in the school shall learn the procedure. These persons shall be trained by the family physician who ordered the procedure to be done in school, or other medical personnel as approved by the child's physician. Principals should contact the Director of Student Services and Special Education who will provide direction regarding scheduling the training session.
            2. These persons must be regular members of the school staff that would basically ensure at least one (1) of the two (2) being present during school hours. Any school staff member may, without prejudice, decline to accept responsibility for administering intermittent catheterization.
            3. Parents shall furnish written requests for the school staff to administer the procedure prescribed by the physician, including a statement of informed consent, signed and executed by the pupil's parents (form available in school clinic).
            4. A copy of the physician's orders and their procedural guidelines for the catheterization procedure being administered by laypersons must be filed with the school (form available in school clinic). The prescription must state: Name of procedure to be administered, time intervals between applications of procedure, and reason for procedure.
    b. Health Services for Students with Non-food Allergies
        i. When a student's physician prescribes emergency allergy injections and related medication and there is the possibility that a student might need this treatment during regular school hours, the following procedure shall be implemented:
            1. Two (2) employees in the school shall learn the procedure. These two (2) employees shall be trained in proper administration procedures.

2. These employees must be regular members of the school staff that would basically ensure at least one (1) of the two (2) being present during school hours.
3. Parents shall furnish written request (see attached form) for the school staff to administer the procedure prescribed by the physician, including a statement of informed consent, signed and executed by the pupil's parent.
4. A copy of the doctor's orders and the procedural guidelines to be followed (forms available in school health office) must be filed with the school. The prescription must state: Name of procedure, statement of dosage for injection, and reason for procedure.

ii. All medications should be stored together in an appropriate central, clean, dry area. Parents shall be responsible for ensuring that the medication has not exceeded the expiration date.

c. Health Services for Students with Food Allergies
   i. When a student's physician prescribes emergency allergy injections and related medication for a student with a food allergy that may be life threatening and there is the possibility that a student might need this treatment during regular school hours or on field trips, the following procedures shall be implemented:
      1. Family Responsibilities
         a. Notify school personnel of the student's food allergy during annual registration;
         b. With school personnel, identify a core team to develop the Severe Allergy Health Care Plan, which accommodates the student's needs throughout the school day, including transportation and field trips;
         c. Include written Physician's Orders, medication(s) to be administered, and instructions in the Severe Allergy Health Care Plan;
         d. Instruct the student in self-management of his/her food allergy including:
            i. Safe and unsafe foods;
            ii. Strategies for avoiding exposure to unsafe foods;
            iii. Symptoms of allergic reactions;
            iv. How and when to tell an adult that they are experiencing an allergy-related problem;
            v. How to read food labels (if age-appropriate); and
            vi. The proper use of an epinephrine automatic injector (if age appropriate);
         e. Notify school personnel of any changes which occur that impact the student's Health Care Plan;
         f. Review the Health Care Plan with the core team, physician, and student (if age appropriate) after a reaction has occurred; and
         g. Replace medications after use or upon expiration.
      2. School Personnel Responsibilities;
         a. Review the student's health records submitted by the parent/guardian and physician;
         b. At registration, identify a core team to develop Health Care Plan. Revise Plan with core team's recommendations;
         c. Provide copy of Health Care Plan to all staff who interact with student;
         d. Attempt to eliminate the use of the student's food allergy during the school day;
         e. Ensure peanut-free table is available and is cleaned according to specific guidelines in custodian's manual;
         f. Ensure proper storage of medications by clinic attendant/school nurse, unless otherwise noted in Health Care Plan;
         g. Designate school personnel to be trained to administer medications;
         h. Ensure school bus driver training includes recognition of allergic reaction symptoms and proper procedures if allergic reaction occurs;
         i. Ensure that school buses are equipped with communication devices for use in emergencies;
         j. Establish "no eating or drinking" policy on school buses, except for medical necessities or to accommodate field trips;
         k. Implement field trip procedures as outlined in Health Care Plan;

l. Ensure that students are not excluded from activities because of food allergies; and
m. Take all threats or harassment against an allergic student seriously.

3. Student Responsibilities
   a. Should not trade food with others;
   b. Should not eat any food with unknown ingredients or foods known to contain an allergen;
   c. Should be proactive in the care and management of his/her food allergy based on developmental level;
   d. Should immediately notify an adult if he/she eats something believed to contain the food allergen and/or becomes symptomatic;
   e. Should immediately inform an adult if he/she self-medicates for a food allergy reaction; and
   f. Should inform adult if threats or harassment occur.

d. Health Services for Students with Diabetes

i. Upon receiving written notification (on form available in school health office) from a licensed physician that a student attending Fauquier County Public Schools is currently diagnosed as having diabetes mellitus, the principal shall ensure that at least two (2) employees assigned to the building have been trained in the administration of insulin and glucagon.
   1. The training shall be consistent with guidelines established by the State Department of Education.
   2. Should the school building have an instructional and administrative staff of fewer than ten (10), then only one (1) such employee shall need to have been trained.

ii. Such employees shall be designated as the "Diabetes Care Providers" ("DCP's"), and such designation shall be communicated to the student with diabetes, the student's parent, and all staff in the school.
   1. No licensed instructional employee shall be required to serve or otherwise be coerced into serving as the designated DCP, although the principal may permit a licensed instructional employee to serve voluntarily.
   2. A licensed instructional employee who has volunteered to serve as a DCP may withdraw with notice reasonable under the circumstances, and the principal shall ensure that a sufficient number of employees assigned to the school are trained as specified above and designated DCP's.

iii. Subject to the conditions provided below, a currently designated DCP will assist with the administration of insulin or will administer glucagon when, in the opinion of the DCP, the need arises and a registered nurse, nurse practitioner, physician, or physician assistant is not present to administer such procedures.

iv. Administration of medication services shall be provided for students attending the Fauquier County Public Schools who have a current diagnosis of diabetes mellitus, on the condition that a physician's order has been filed with the school specifically authorizing and prescribing such administration by a DCP, and on the further condition that the parent has furnished a written request and consent to the administration of the medication in accordance with the physician's order.
   1. The written order must be from a licensed physician.
   2. The administration of medication services will be provided only during school hours during which scheduled classes take place.
   3. At the request and consent of the parent, and pursuant to written physician's order, special provision may be made by the principal for administration of medication services for a student who is participating in school-sponsored field trips, or for a student who has been assigned or selected to participate in school-sponsored extracurricular or co-curricular activities occurring outside of regular school hours. The Fauquier County Public Schools shall not be responsible for providing a DCP or for administration of medication services during activities that occur outside regular school hours if they are sponsored by a group other than the Fauquier County Public Schools, even if they occur on school grounds.
   4. The administration of medication services provided in the Fauquier County Public Schools shall include only those services necessary to afford the student with diabetes an opportunity to participate in or benefit from the program of free public education that is afforded to others, and, except as may be otherwise

specifically provided in the student's Individualized Education Plan or Section 504 Accommodation Plan, shall be limited to:

a. Assistance in the administration of insulin as prescribed; and
b. Administration of glucagon when the student with diabetes is believed to be suffering life-threatening hypoglycemia.

5. A student's written diagnosis, physician's order, and parent request and consent will be filed annually with the principal on or before the first day of school, and will be updated by the parent as necessary and appropriate during the school year. Copies will be maintained in the student's records, and in the clinic or other area of the school designated for delivery of health services.
6. The designated DCP will receive written notification whenever the above documentation has been filed for a student with diabetes. Upon receiving such notification, the DCP will arrange to meet with the student as soon as may be practicable. Should the physician's order provide for injections of insulin during regular school hours, the DCP will arrange a schedule and a procedure for assisting with such administration, and advise the student.
7. All medications shall be furnished to the school by the parent, and shall be stored in an appropriate central, clean, dry area. Parents shall be responsible for ensuring that the medication prescribed in the physician's order and furnished to the school has not exceeded the expiration date.
8. Following the administration of glucagon, emergency services will be contacted and/or the student will be transported to the hospital.

v. The principal will ensure that there is a suitable location provided in the school building for the monitoring of blood glucose levels, and for the administration of insulin for students with diabetes, taking into consideration the student's privacy, the prevention of disruption to the education programs in the building, and the need to provide for appropriate procedures for the prevention of infection and contamination by blood borne pathogens, such as hand-washing and the proper disposal of sharps and other blood-contaminated materials.

vi. For students for whom the physician's order prescribes the emergency administration of glucagon, upon written request and consent of the parent and unless a DCP is assigned to be present during transportation, the employee assigned to provide transportation for the student with diabetes shall be trained in recognizing symptoms indicating that there is a need for care for a student with diabetes, symptoms of hypoglycemia and hyperglycemia, and appropriate steps to take when glucose levels are creating emergency conditions as described in the physician's order for the student. Under such circumstances, the student will be permitted to maintain in the vehicle appropriate snacks for other food substances that are recommended by the physician for mitigating the effects of hypoglycemia or hyperglycemia, and will be permitted to eat or drink them as needed. In addition, the employee assigned to provide such transportation shall be provided with a device capable of establishing contact with emergency medical assistance from the vehicle.

ACCOMPANYING REGULATION

REGULATION 7-5.3(B): ADMINISTRATION OF EPINEPHRINE
(Severe Allergic Reaction)

Generally

Fauquier County Public Schools Public Schools (FCPS) anaphylaxis regulation is developed to meet the Code of Virginia Section 22.1-274.2. FCPS will provide at least two (2) doses of auto-injectable epinephrine (hereinafter called 'unassigned or stock epinephrine') in each school, to be administered by a school nurse or employee of the school board who is authorized and trained in the administration of epinephrine to any student believed to be having an anaphylactic reaction on school premises, during the academic day. The *Code of Virginia* (§8.01-225) provides civil protection for employees of a school board who are appropriately trained to administer epinephrine.

Regulation Limitations:

Parents of students with known life threatening allergies and/or anaphylaxis must provide the school with written instructions from the students' health care provider for handling anaphylaxis and all necessary medications for implementing the student specific order on an annual basis. The anaphylaxis policy is not intended to replace student specific orders or parent provided individual medications. This regulation **does not** extend to activities off school grounds (including transportation to and from school, field trips, etc.) or outside of the academic day (sporting events, extra-curricular activities, etc.).

Definitions:

Anaphylaxis: is a severe systemic allergic reaction from exposure to allergens that is rapid in onset and can cause death. Common allergens include animal dander, fish, latex, milk, shellfish, tree nuts, eggs, insect venom, medications, peanuts, soy, and wheat. A severe allergic reaction usually occurs quickly; death has been reported to occur within minutes. An anaphylactic reaction can occur up to one to two hours after exposure to the allergen.

Symptoms of Anaphylaxis

- Shortness of breath or tightness of chest; difficulty in or absence of breathing
- Sneezing, wheezing or coughing
- Difficulty swallowing
- Swelling of lips, eyes, face, tongue, throat or elsewhere
- Low blood pressure, dizziness and/or fainting
- Heart beat complaints: rapid or decreased
- Blueness around lips, inside lips, eyelids
- Sweating and anxiety
- Itching, with or without hives; raised red rash in any area of the body
- Skin flushing or color becomes pale
- Hoarseness
- Sense of impending disaster or approaching death
- Loss of bowel or bladder control
- Nausea, abdominal pain, vomiting and diarrhea
- Burning sensation, especially face or chest
- Loss of consciousness

Although anaphylactic reactions typically result in multiple symptoms, reactions may vary. A single symptom may indicate anaphylaxis. **Epinephrine should be administered promptly at the first sign of anaphylaxis. It is safer to administer epinephrine than to delay treatment for anaphylaxis. (See Anaphylaxis Flow Sheet Form)**

Training

Building level administration shall be responsible for identifying at least two employees, in addition to the school nurse (RN or LPN), to be trained in the administration of epinephrine by auto-injector. Only trained personnel should administer epinephrine to a student believed to be having an anaphylactic reaction. Training shall be conducted in accordance with the most current edition of the Virginia Department of Education's *Manual for Training Public School Employees in the Administration of Medication.* Training shall be conducted annually or more often as needed. (Emergency Anaphylaxis Skills Training Checklist Form) (Epinephrine Auto Injector Pen Training Checklist Form)

Standing Orders:

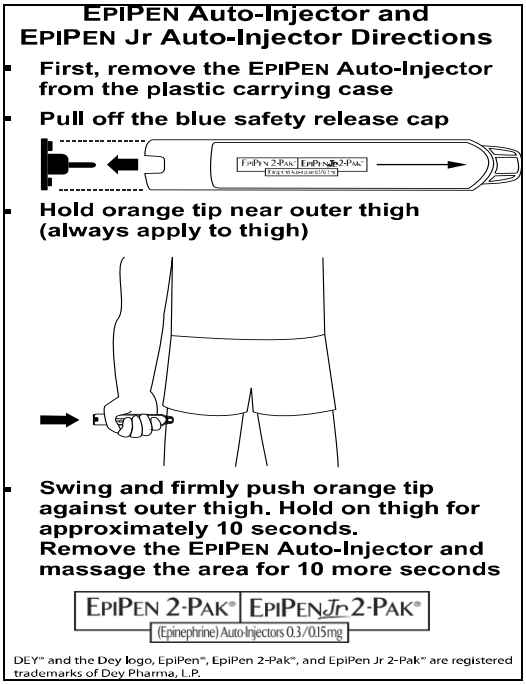
Standing orders are written to cover multiple people as opposed to individual-specific orders, which are written for one person. FCPS shall designate an authorized medical provider (MD, DO, PA, or NP with prescriptive authority) to prescribe non-student specific epinephrine for the school division, to be administered to any student believed to be having an anaphylactic reaction on school grounds, during the academic day. Standing orders must be renewed annually and with any change in prescriber. Standing orders will be kept with the stock epi-pens and in the School Health Manual. (See Standing Order Form)

Responding to Anaphylaxis:

If student-specific orders are on file they should be followed for students with known life threatening allergies and/or anaphylaxis.

For suspected anaphylaxis without specific orders:

1. Based on symptoms, determine that an anaphylactic reaction is occurring.
2. Act quickly. It is safer to give epinephrine than to delay treatment. **This is a life and death decision**.
3. Determine the proper dose and administer epinephrine. Note the time.
4. Direct someone to call 911 and request medical assistance. Advise the 911 operator that anaphylaxis is suspected and that epinephrine has been given.
5. Stay with the person until emergency medical services (EMS) arrives.
6. Monitor their airway and breathing.
7. Reassure and calm person as needed.
8. Call School Nurse/Front Office school personnel and advise of situation.
9. Direct someone to call parent/guardian
10. If symptoms continue and EMS is not on the scene, administer a second dose of epinephrine 5 to 15 minutes after the initial injection. Note the time.
11. Administer CPR if needed.
12. EMS to transport individual to the emergency room. Document individual's name, date, and time the epinephrine was administered on the used epinephrine auto-injector and give to EMS to accompany individual to the emergency room.
13. Even if symptoms subside, 911 must still respond and individual must be evaluated by a physician. A delayed or secondary reaction may occur.
14. Document the incident and complete the incident report. (Form)
15. Replace epinephrine stock medication as appropriate.



Courtesy of FAAN, 2012

Post Event Actions:

- Once epinephrine is administered, local Emergency Medical Services (911) shall be activated and the student transported to the emergency room for follow care. In some reactions, the symptoms go away, only to return one to three hours later. This is called a "biphasic reaction." Often these second-phase symptoms occur in the respiratory tract and may be more severe than the first-phase symptoms. Therefore, follow up care with a health care provider is necessary. The student will not be allowed to remain at school or return to school on the day epinephrine is administered.

- Document the event
- Complete incident report (Form)
- Replace epinephrine stock medication immediately

Storage, Access and Maintenance:

Epinephrine should be stored in a safe, unlocked cabinet marked "Emergency Epinephrine" in an accessible location, at room temperature (between 59-86 degrees F). Epinephrine should **not** be maintained in a locked cabinet or behind locked doors. Staff should be made aware of the storage location in each school. It should be protected from exposure to heat, cold or freezing temperatures. Exposure to sunlight will hasten deterioration of epinephrine more rapidly than exposure to room temperatures. The expiration date of epinephrine solutions should be periodically checked; the drug should be replaced if it is approaching the expiration date. The contents should periodically be inspected through the clear window of the auto-injector. The solution should be clear; if it is discolored or contains solid particles, replace the unit.

Each school should maintain documentation that stock epinephrine has been checked on a monthly basis to ensure proper storage, expiration date, and medication stability.

The school division shall maintain a sufficient number of extra doses of epinephrine for replacement of used or expired school stock on the day it is used or discarded. Expired auto-injectors or those with discolored solution or solid particles should not be used. Discard them in a sharps container.

FAUQUIER COUNTY PUBLIC SCHOOLS

AUTHORIZATION FOR MEDICATION ADMINISTRATION **BUS #_____**

PARENT/GUARDIAN SECTION

Student_____DOB_____Age_____Grade_____
School_____Homeroom Teacher_____
Parent/Guardian Signature_____Date_____
Parent/Guardian Printed Name_____
Signature gives permission for principal's designee to administer prescribed medicine and gives principal's designee permission to contact physician/dentist if necessary. For Over-the-Counter medicine, parent's signature gives principal's designee permission to administer medicine.

PHYSICIAN/DENTIST SECTION
(Must be completed by Physician/Dentist)

PRESCRIPTION MEDICATIONS:
Name of Medication:_____

Reason medication is needed, unless confidential:_____

Dosage:_____Length of Time:_____

Time to be given:_____
If potentially serious side effects exist, please outline any necessary emergency response on a separate sheet.

Physician/Dentist Signature_____Date_____

Physician/Dentist PRINTED Name_____

Physician/Dentist Phone_____Fax_____

Physician/Dentist Address_____

OVER-THE-COUNTER MEDICATIONS:

Name of Medication:_____

Dosage/Length of Time:_____

Time of Day to be given:_____

Side effects:_____

Received by_____**Date**_____

FAUQUIER COUNTY PUBLIC SCHOOLS
ANNUAL CONTRACT FOR SELF-ADMINISTRATION OF MEDICATION

PHYSICIAN OR PRESCRIBER

Name of Student_____Grade/Room_____

Name of Medication_____

Frequency of Use_____

Duration of Order_____

Health Care Plan specific for the student is provided for the school.

Yes_____ No_____

Please list any directions or comments specific to the student and include any recommended emergency response.

_____

_____

_____

Physician's

Signature_____Phone_____Date_____

PARENT/GUARDIAN

I have provided the school with the orders and health care plan from the physician. I understand that I will not hold the school board or its employees responsible for any negative outcomes from the self-administration of medication. In the event an individual is exposed to my child's bodily fluids, I will have my child's blood tested for HIV, Hepatitis B and Hepatitis C or other organisms. Furthermore, I understand that the principal may revoke the permission to possess and self administer the medication for the remainder of the school year, if it is determined that my student is not safely and effectively self-administering the medication.

_____ _____ _____

Parent/Guardian's Signature **Phone Number** **Date**

TO BE COMPLETED BY THE SCHOOL HEALTH STAFF

CHECKLIST: Documentation of this agreement is on file in the school clinic.

_____Physician Prescribed Orders _____Demonstrated ability by the student

_____Individualized Health Care Plan _____Parent Signature

_____Emergency Transportation Plan _____Teacher(s) Informed

Fauquier County Public Schools Health Care Plan for Severe Allergy-Page 1

Student Name: _____DOB:_____Date:_____Grade/Homeroom:_____

PHYSICIAN ORDERS/PLAN OF CARE

Health Care Provider_____ / _____ / _____
Printed Name Signature Date

_____ / _____
Provider Phone Provider Fax

ALLERGY TO: _____High risk for severe reaction: ☐ YES ☐ NO
History of Asthma: ☐ YES ☐ NO Asthma Action Plan: ☐ YES ☐ NO

MEDICATION ORDERED FOR ALLERGY SYMPTOMS (please complete symptom checklist below)

1. **Antihistamine: Benadryl/Diphenhydramine HCL: _____mg/Other:_____**
2. **Inhaler: Medication _____Dose_____/Follow Asthma Action Plan ☐ YES ☐ NO**
3. **Epinephrine Auto Injector (Junior) 0.15mg Epinephrine Auto Injector 0.30mg**
4. **Repeat Epinephrine Auto Injector: ☐ NO ☐ YES, when_____**
5. **Other:_____**

Symptoms	Give Checked Medication	
--If insect stings, but NO SYMPTOMS	☐Epi pen	☐Antihistamine
--If a food allergen has been ingested, but NO SYMPTOMS	☐Epi pen	☐Antihistamine
--MOUTH: itching/tingling/swelling of lips, tongue, mouth	☐Epi pen	☐Antihistamine
--SKIN: hives, itching, swelling about the extremities	☐Epi pen	☐Antihistamine
--GI: nausea, abdominal cramps, vomiting and/or diarrhea	☐Epi pen	☐Antihistamine
--LUNGS: shortness of breath, repetitive cough, wheezing	☐Epi pen	☐Antihistamine
--HEART: thready pulse, low blood pressure, fainting	☐Epi pen	☐Antihistamine
--OTHER: _____	☐Epi pen	☐Antihistamine

Student Photo Here

*****The severity of these symptoms can change quickly and progress rapidly to a life-threatening situation**

1. **Give medications as ordered above. Note time medications given.**
2. **Monitor student and instruct someone to CALL 911 (if Epinephrine is given, or as needed).**
3. **Notify parent/guardian and school administrator.**
4. **Additional instructions/orders: _____**

PERMISSION TO CARRY AND/OR SELF-ADMINISTER EPINEPHRINE/ANTIHISTAMINE

I, as the Health Care Provider, certify that this child has a medical history of severe allergic reaction. I further certify that this student has been judged to be capable of carrying and self-administering these medication(s) for allergic reaction. The student must notify the nurse or appropriate school staff if any of this ordered medication(s) is used. This child understands the hazards of sharing medications and has agreed to refrain from this practice.

_____ / _____ / _____
Health Care Provider Signature Printed Name Date

As the parent/guardian of _____, I give consent for my student to carry and self-administer the above ordered medication(s). My student has been instructed on the recognition of severe allergy symptoms and the safe and effective use of the ordered medication(s). I will not hold the school board or any of its employees liable for any negative outcomes resulting from the self-carrying or self-administration of the ordered medication(s) by the student. Furthermore, I understand that the principal may revoke this permission if it is determined that my student is not safely and effectively carrying or administering the medication(s).

_____ / _____ / _____
Parent/Guardian Signature Printed Name Date

Fauquier County Public Schools Health Care Plan for Severe Allergy-Part 2

ıdent Name _____DOB:_____Date:_____
te/Description of Last Reaction: _____
s Epinephrine Been Used in the Past/Explain: _____

IERGENCY CONTACTS
ıther (home) _____ (work) _____(cell)_____
ther (home) _____(work)_____(cell)_____
her Contact_ _____Other Contact_____

S PROCEDURES-Transportation will be alerted to student's allergy.
1. **Emergency Transportation Plan: Given to Parent Completed by Parent**
2. **Student will sit at the front of the bus: ☐ YES ☐ NO**
3. **Other (specify)_____**

ELD TRIP PROCEDURES
1. **The teacher/nurse will discuss field trips with parent in advance. Parent is encouraged to accompany the student on the trip. If parent unavailable and student does not have orders to self-carry and administer ordered medication(s), the responsible teacher will carry the ordered medication(s). The teacher will administer the medication(s) as ordered after receiving instructions on use of the medication(s) from the nurse. Teachers will be notified of all students with self-administration orders**
2. **The student will remain with the teacher or parent during the entire trip: ☐ YES ☐ NO**
3. **Other (specify)_____**

ASSROOM
1. **Teachers will be notified of severe allergy history. Classroom projects will be reviewed by the teacher to avoid specified allergens.**
2. **Other(specify)_____**

THLETICS/EXTRACURRICULAR ACTIVITIES
1. **Student/parent will notify nurse of student's participation in athletics/extracurricular activities so tha nurse may share allergy plan with coach/activity sponsor.**
2. **Parent/student/nurse/coach/sponsor will coordinate plan to have ordered medication(s) available to student during activity. Nurse will instruct coach/sponsor on use of the ordered medication(s).**
3. **Other(specify)_____**

TUDENTS WITH FOOD ALLERGIES-Cafeteria Manager will be alerted to the student's allergy.
1. **_____Student will only eat food provided by parent.**
2. **_____Student allowed to eat from school menu.**
3. **_____Student will make own food choices and will seek assistance from cafeteria/clinic staff as needed.**
4. **_____Alternative snacks will be provided by parent to be kept in classroom/clinic.**
5. **_____Parents will be told of planned parties/activities involving food as early as possible.**
6. **_____Student will have NO SEATING RESTRICTIONS in cafeteria.**
7. **_____Student requires following cafeteria seating:_____**
8. **_____Student requires following cafeteria table cleaning:_____**
9. **Other(specify)_____**

ARENT SIGNATURE_____PRINTED NAME_____DATE_____
gnature gives permission for the principal's designee to administer the prescribed medication(s) as ordered ı Part 1 of this Health Care Plan. It further gives principal's designee permission to contact the ordering ealth care provider if necessary.

RDERS RECEIVED/REVIEWED BY:_____DATE_____
otification(initial/date): Admin_____Transport_____Teacher(s)_____Cafeteria_____Other_____

Virginia School Diabetes Medical Management Forms

Student _____ **School** _____ **Effective Date** _____

Date of Birth _____ **Grade** _____ **Homeroom Teacher** _____

Instructions:

1. **Part 1**- **Contact Information and Diabetes Medical History** . To be completed by parent/guardian and returned to school nurse (prior to beginning of each school year or upon diagnosis).
   ►Includes: Parent authorization for trained school designees to administer insulin and/or glucagon (required by Virginia Law).
2. **Part 2***- **Diabetes Medical Management Plan (DMMP)**. Student's physician/provider to complete Intensive Therapy or Conventional Therapy/Type 2 version of DMMP.
   Please note that physician authorization for treatment by trained school designees must be included in the Diabetes Medical Management Plan or a separate form must be provided.
3. **Part 3***- **Insulin Pump Supplement** . Have the physician/provider, diabetes educator, and parent/guardian collaborate to complete appropriate portions if your child wears an insulin pump.
4. **Part 4**- **Permission to Self-Carry and Self-Administer Diabetes Care** . To be completed by the physician/provider, school nurse and the parent/guardian if your child is going to carry and self administer insulin and/or perform blood glucose checks in the classroom.
5. **Virginia Diabetes Council School Diabetes Care Practice and Protocol** provides guidelines, accepted accommodations and references applicable to all students with diabetes. This document is available from your school nurse, the Department of Education Office of Student Services, or the Virginia Diabetes Council.

***Other Diabetes Medical Management Plans may be used for **Parts 2, 3 & 4** as long as all components are represented.

Return completed forms to the school nurse as quickly as possible. Thank you for your cooperation.

School nurse_____ Phone_____ Date_____

Part 1: Contact Information and Diabetes Medical History

To be completed by Parent/Guardian:

Parent/Guardian #1:_____

Address: _____

Telephone-Home: _____Work: _____ Cell: _____

Parent/Guardian #2:_____

Address: _____

Telephone-Home: _____Work: _____ Cell: _____

Other emergency contact: _____

Address: _____ Relationship: _____

Telephone-Home: _____Work: _____ Cell: _____

Physician managing diabetes: _____

Address: _____

Main Office #_____ Fax #_____ Emergency Phone #_____

Nurse/Diabetes Educator: _____ Office # _____

Student:

Medical History	Parent/Guardian Response (check appropriate boxes and complete blanks)
Diagnosis information	At what age? Type of diabetes?
How often is child seen by diabetes physician?	Frequency: Date of last visit:
Nutritional needs	♦ Snacks ❑ ____AM ❑ ____PM ❑ _____Prior to Exercise/Activity ❑ Only in case of low blood glucose ❑ Student may determine if CHO counting ❑ In the event of a class party may eat the treat (include insulin coverage if indicated in medical orders) ❑ student able to determine whether to eat the treat ❑ replace with parent supplied treat ❑ may NOT eat the treat ◆ Other _____
Child's most common signs of low blood glucose	❑ trembling ❑ tingling ❑ loss of coordination ❑ dizziness ❑ moist skin/sweating ❑ slurred speech ❑ heart pounding ❑ hunger ❑ confusion ❑ weakness ❑ fatigue ❑ seizure ❑ pale skin ❑ headache ❑ unconsciousness ❑ change in mood or behavior ❑ other _____
How often does child experience low blood glucose and how severe?	**Mild/Moderate** ❑ once a day ❑ once a week ❑ once a month Indicate date(s) of last mild/moderate episode(s) _____ What time of day is most common for hypoglycemia to occur? _____ **Severe** (i.e. unconscious, unable to swallow, seizure, or needed Glucagon) Include date(s) of recent episode(s) _____
Episode(s) of ketoacidosis	Include date(s) of recent episode(s)
Field trips	Parent/guardian will accompany child during field trips? ❑ YES ❑ NO ❑ Yes, if available
Serious illness, injuries or hospitalizations this past year	Date(s) and describe
List any other medications currently being taken	
Allergies (include foods, medications, etc):	
Other concerns and comments	

I give permission to the school nurse and designated school personnel*, who have been trained and are under the supervision of the school nurse to perform and carry out the diabetes care tasks as outlined in my child's *Diabetes Medical Management Plan* as ordered by the physician. I give permission to the designated school personnel, who have been trained to perform the following diabetes care tasks for my child. (Code of Virginia§ 22.1-274).

Insulin Administration ☐ YES ☐ NO Glucagon Administration ☐ YES ☐ NO

I understand that I am to provide all supplies to the school necessary for the treatment of my child's diabetes. I also consent to the release of information contained in the Diabetes Medical Management Plan to staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I also give permission to contact the above named physician and members of the diabetes management team regarding my child's diabetes should the need arise.

Parent/Guardian Name _____ **Date** _____

Parent/Guardian Signature_____

School Nurse's Name _____ **Date** _____

School Nurse's Signature _____

*Note: If at any time you would like to have the names of the designated school personnel that have been trained, please contact the school nurse. Names and training records are kept in the school clinic.

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

Part 2: Virginia Diabetes Medical Management Plan (DMMP)

To be completed by physician/provider.

Notice to Parents: Medication(s) **MUST** be brought to school by the PARENT/GUARDIAN in a container that is appropriately labeled by the pharmacy or physician/practitioner.

In order for schools to safely administer medication during school hours, the following regulations should be observed:

- A new copy of the DMMP must be completed at the beginning of each school year. This form, an Authorization for Medication Administration form, or MD prescription must be received in order to change diabetes care at school during the school year.

Student Name (Last, First, MI)	Student's Date of Birth	
School	Student's Grade	Home Phone
Parent Name	Work/Cell Phone	
Home Address	City	State, Zip code
Student's Diagnosis: **DIABETES:** ☐ **Type 1** ☐ **Type 2** ☐ **Other**	Today's Date	

MONITORING		
BLOOD GLUCOSE (BG) MONITORING with meter, lancets, lancing device, and test strips	☐ Yes ☐ No ☐ Student requires supervision ☐ To be performed by school personnel ☐ Student is independent ☐ Permission to self-carry	☐ Before meals ☐ For symptoms of hypo/hyperglycemia & anytime the student does not feel well ☐ Before PE/Activity ☐ After PE/Activity ☐ Prior to dismissal ☐ Additional BG monitoring may be performed at parent's request
CONTINUOUS GLUCOSE MONITORING (CGM) **Brand/Model:** _____	☐ Yes ☐ No Alarms set for: Low:_____ (mg/dL) High: _____ (mg/dL)	Always confirm CGM results with finger stick check before taking action on sensor blood glucose level. If student has symptoms or signs of hypoglycemia, check finger stick blood glucose level regardless of CGM.
☐ **URINE KETONE TESTING** ☐ **BLOOD KETONE TESTING**	Anytime the BG **>** _____ mg/dL or when student complains of nausea, vomiting, abdominal pain. See page 3 for further instructions under hyperglycemia management.	

NAME OF MEDICATION	**DOSE/ROUTE**		**TIME**	
☒ **GLUCAGON** - INJECTABLE	☐ 0.5 mg subq/IM ☐ 1.0 mg subq/IM		Immediately for severe hypoglycemia: unconscious, semi-conscious (unable to control his/her airway or unable to swallow), or seizing	
	DOSAGE	**TIME**	**POSSIBLE SIDE EFFECTS**	**TREATMENT OF SIDE EFFECTS**
☐ Glucophage® (Metformin) ☐ to be administered at school	_____ mg po	_____ AM or PM	Nausea/vomiting, diarrhea	Clear liquids
☐ Other: _____® ☐ to be administered at school				

Additional Instructions:

Specific duration of order: **2013 - 2014** **SCHOOL YEAR**	Physician/Provider Signature: Provider Printed Name:	Office Phone: XXX-XXX-XXXX Office Fax: XXX-XXX-XXXX **Emergency # XXX-XXX-XXXX**

Patient Label or MRN, Acct#, Patient name, DOB, Date of Service

SCHOOL YEAR 2013-2014 DIABETES SCHOOL CARE PLAN
Intensive Therapy/Multiple Daily Injections

Student:
Effective date:

Definitions

Insulin-to-Carbohydrate Ratio (CHO Ratio)	Insulin Sensitivity (Correction Factor)	Target Blood Glucose
• the amount of insulin necessary to prevent hyperglycemia after ingestion of a specified amount of carbohydrate • usually expressed as "1 unit for every ____ grams of carbohydrate"	• the predicted drop in blood glucose concentration after administration of 1 unit of regular or rapid-acting insulin • usually expressed as "1 unit for every ____mg/dl blood glucose is > target"	• a specific blood glucose value used to determine the correction dose of insulin administered with a meal

INSULIN

Insulin to be given during school hours: ☐ Yes ☐ No ☐ May calculate/give own injections with supervision

☒ Rapid-acting Insulin Type: _____®
(all doses to be administered subcutaneously)

☐ _____® _____units at _____am or pm
☐ may mix with rapid-acting insulin
(all doses to be administered subcutaneously)

Timing of Insulin Dose:
Rapid-acting Insulin should always be given prior to
☐ meals ☐ snacks
if CHO intake can be predetermined.
- If CHO intake cannot be predetermined insulin should be given no more than 30 minutes after completion of meal/snack.
- Treat hypoglycemia before administration of meal or snack insulin.

CALCULATING INSULIN DOSES: According to CHO ratio and Insulin Sensitivity/Correction Factor (if needed) - the student requires meal time coverage with rapid-acting insulin based on the amount of carbohydrates in the meal and may require additional insulin to correct blood glucose to the desired range according to the following formula:

Insulin Dose = [(Actual BG – Target pre-meal BG) divided by Insulin Sensitivity] + [# carbohydrates consumed/CHO Ratio]

- Fractional amounts of insulin from correction and carbohydrate calculation, when added together, may yield an even amount of insulin
- If uneven, then round to the nearest **half or whole unit** (May use clinical discretion; if physical activity follows meal, then may round down).

Target pre-meal BG: _____ mg/dL

Insulin Sensitivity/Correction Factor:
__ unit for every _____ > target

CHO Ratio:

☐ Parent has permission to adjust CHO ratio in a range from 1:_____ to 1:_____

Exercise/PE CHO Ratio: _____ ☐ Not Applicable
- Less insulin may be required with meals prior to physical activity in order to prevent hypoglycemia. If so, the Exercise/PE CHO Ratio should be used instead of the CHO Ratio.

☐ Correction insulin to be administered for elevated blood glucose if 3 hours or more after last insulin dose

Snacks

- In general, children with diabetes managed using Intensive Therapy/MDI do not require snacks.
- Scheduled snacks may be required prior to or after exercise in order to prevent hypoglycemia. Insulin is not administered with these snacks.

☐ Before Exercise ☐ After Exercise

- Foods may be eaten at unscheduled times. Insulin may be ordered for these snacks in order to prevent post-meal hyperglycemia (see above).
- Snack time insulin = # carbohydrates consumed/CHO Ratio.
- Never provide insulin coverage for carbohydrate/glucose being used to treat hypoglycemia.

Exercise and Sports

- In general, there are no restrictions on activity unless specifically noted.
- A student should not exercise if his/her blood glucose is < _____ mg/dL or > 300 mg/dL (with positive ketones) immediately prior to exercise or until hypoglycemia/hyperglycemia is resolved.
- A source of fast-acting glucose & glucagon should be available in case of hypoglycemia.

Specific duration of order: **2013 - 2014 SCHOOL YEAR**	Physician/Provider Signature: Provider Printed Name:	Office Phone: xxx-xxx-xxxx Office Fax: xxx-xxx-xxxx **Emergency # xxx-xxx-xxxx**

Patient Label or MRN, Acct#, Patient name, DOB, Date of Service

SCHOOL YEAR 2013-2014 DIABETES SCHOOL CARE PLAN

Student:
Effective date:

Hypoglycemia (Low Blood Glucose)

Hypoglycemia is defined as a blood glucose **<**_____ mg/dL

Signs of hypoglycemia:

Hunger	Sweating	Shakiness	Paleness	Dizziness
Confusion	Loss of coordination	Fatique	Fighting	Crying
Day-dreaming	Inability to concentrate	Anger	Passing-out	Seizure

- If hypoglycemia is suspected, check the blood glucose level.

Hypoglycemia Management (Low Blood Glucose)	**Severe Hypoglycemia: If student unconscious, semi-conscious (unable to control his/her airway or unable to swallow) or seizing, administer glucagon.** • Place student in the "recovery position." • If glucagon is administered, call 911 for emergency assistance, and call Parents/Legal Guardian.
	Mild or Moderate Hypoglycemia: If conscious & able to swallow, immediately give 15 grams fast-acting glucose: • 3-4 glucose tablets or • 6 Life Saver® Candies or • 4 ounces of regular soda/juice or • 1 small tube Glucose/Cake gel
	Repeat BG check in 15 minutes • If BG still low, then re-treat with 15 gram CHO • If BG in acceptable range and at lunch or snack time, let student eat and cover CHO per orders • If BG in acceptable range and not lunch or snack time, provide student slowly-released CHO snack (Example: 3-4 peanut butter or cheese crackers or ½ sandwich)
	If unable to raise the BG > 70 mg/dL despite fast-acting glucose sources, call **xxx-xxx-xxxx.**

Hyperglycemia (High Blood Glucose)

Signs of hyperglycemia:

Extreme thirst	Frequent urination	Blurry Vision	Hunger	Headache
Nausea	Hyperactivity	Dry Skin	Dizziness	Stomach ache

- If hyperglycemia is suspected, check the blood glucose level.

Hyperglycemia Management (High Blood Glucose)	**If BG > 300 mg/dL, or when child complains of nausea, vomiting, and/or abdominal pain, ask the student to check his/her urine for ketones**
	• If urine ketones are trace to small (blood ketones 0 - 1.0 mmol/L), give 8-16 ounces of sugar-free fluid (water), return to classroom • If correction insulin has not been administered within 3 hours, provide correction insulin according to student's Correction Factor and Target pre-meal BG • Recheck BG and ketones 2 hours after administering insulin
	• If urine ketones are moderate/large (blood ketones >1.0 mmol/L), give 8-16 ounces of sugar-free fluid (water) and call **xxx-xxx-xxxx** for instructions concerning insulin administration. • Contact the Parent/Legal Guardian. • Recheck BG and ketones 2 hours after administering insulin

My signature below provides authorization for the above written orders. I/We understand that all treatments and procedures may be performed by the school nurse, the student and / or trained unlicensed designated school personnel under the training and supervision provided by the school nurse (or by EMS in the event of loss of consciousness or seizure) in accordance with state laws & regulations. I also give permission for the school to contact the health care provider regarding these orders and administration of these medications.

School plan ordered by:	Physician/Provider Signature: Provider Printed Name:	Date:
Acknowledged and received by:	Parent/Legal Guardian:	Date:
Acknowledged and received by:	School Representative:	Date:

Institution Name and Address:

DIABETES MEDICAL MANAGEMENT PLAN
CONVENTIONAL THERAPY or TYPE 2

Patient Label or MRN, Acct#, Patient name, DOB, Date of Service

Part 2: Virginia Diabetes Medical Management Plan (DMMP)

To be completed by physician/provider.

Notice to Parents: Medication(s) **MUST** be brought to school by the PARENT/GUARDIAN in a container that is appropriately labeled by the pharmacy or physician/practitioner.

In order for schools to safely administer medication during school hours, the following guidelines should be observed:

- A new copy of the DMMP must be completed at the beginning of each school year. This form, an Authorization for Medication Administration form, or MD prescription must be received in order to change diabetes care at school during the school year.

Student Name (Last, First, MI)	Student's Date of Birth	
School	Student's Grade:	Home Phone
Parent Name	Work/Cell Phone	
Home Address	City	State, Zip code
Student's Diagnosis: **DIABETES:** ☐ **Type 1** ☐ **Type 2** ☐ **Other**	Today's Date	

MONITORING		
BLOOD GLUCOSE (BG) MONITORING with meter, lancets, lancing device, and test strips	☐ Yes ☐ No ☐ Student requires supervision ☐ To be performed by school personnel ☐ Student is independent ☐ Permission to self-carry	☐ Before meals ☐ For symptoms of hypo/hyperglycemia & anytime the student does not feel well ☐ Before PE/Activity ☐ After PE/Activity ☐ Prior to dismissal ☐ Additional BG monitoring may be performed at parent's request
CONTINUOUS GLUCOSE MONITORING (CGM) **Brand/Model:** _____	☐ Yes ☐ No Alarms set for: Low:_____ (mg/dL) High: _____ (mg/dL)	Always confirm CGM results with finger stick check before taking action on sensor blood glucose level. If student has symptoms or signs of hypoglycemia, check finger stick blood glucose level regardless of CGM.
☐ **URINE KETONE TESTING** ☐ **BLOOD KETONE TESTING**	Anytime the BG **>** _____ mg/dL or when student complains of nausea, vomiting, abdominal pain. See page 3 for further instructions under hyperglycemia management.	

NAME OF MEDICATION	**DOSE/ROUTE**	**TIME**
☐ **GLUCAGON** - INJECTABLE	☐ 0.5 mg subq/IM ☐ 1.0 mg subq/IM	Immediately for severe hypoglycemia: unconscious, semi-conscious (unable to control his/her airway or unable to swallow), or seizing

ORAL MEDICATIONS	**DOSAGE**	**TIME**	**POSSIBLE SIDE EFFECTS**	**TREATMENT SIDE EFFECTS**
☐ Glucophage® (Metformin) ☐ to be administered at school	_____ mg po	_____ AM or PM	Nausea/vomiting, diarrhea	Clear liquids
☐ Other: ® ☐ to be administered at school				
☐ Additional Instructions:				

Specific duration of order: **2013 - 2014** **SCHOOL YEAR**	Physician/Provider Signature: Provider Printed Name:	Office Phone: _____ Office Fax: _____ **Emergency # _____**

Institution Form #

Institution Name and Address:

DIABETES MEDICAL MANAGEMENT PLAN
CONVENTIONAL THERAPY or TYPE 2

Patient Label or MRN, Acct#, Patient name, DOB, Date of Service

SCHOOL YEAR 2013-2014 DIABETES SCHOOL CARE PLAN
CONVENTIONAL THERAPY OR TYPE 2 DIABETES

Student: _____
Effective date: _____

INSULIN

Insulin to be given during school hours: ☐ Yes ☐ No

☐ Student can administer insulin if supervised
☐ Student can administer his/her own insulin
☐ Student can not administer insulin

Insulin Types:

☐ Rapid-acting Insulin Type: _____®
☐ Short-acting Insulin Type: **Regular**

☐ Intermediate-acting Insulin Type: **NPH**
☐ may mix with rapid or short-acting insulin

☐ Long-acting Insulin Type: _____® _____units at _____am or pm
☐ may mix with rapid-acting insulin

(all doses to be administered subcutaneously)

☐ **Meal Plan:**
☐ according to the following distribution:
Breakfast: _____ grams
AM Snack: _____ grams
Lunch: _____ grams
PM Snack: _____ grams

☐ Insulin:CHO Ratio: 1 unit for every _____ grams of CHO
☐ decrease by 1 unit if pre-lunch reading is less than 80 mg/dL or if strenuous exercise if anticipated.

☐ Pre-breakfast dose:	Regular _____ units	Humalog® or Novolog® or Apidra® _____ units	NPH _____ units
☐ Pre-lunch dose:	Regular _____ units	Humalog® or Novolog® or Apidra® _____ units	NPH _____ units
☐ Pre-dinner dose:	Regular _____ units	Humalog® or Novolog® or Apidra® _____ units	NPH _____ units

☐ **Sliding scale to be administered at _____ (times)**

If blood glucose	Units of rapid-acting Insulin subq
_____	give _____
_____	give _____
_____	give _____
_____	give _____
_____	give _____
_____	give _____

☐ **Insulin Sensitivity (Correction Factor) to be administered at _____ (times)**

- the predicted drop in blood glucose concentration after administration of 1 unit of regular or rapid-acting insulin
- usually expressed as "1 unit for every ____mg/dl blood glucose is > target"
- If uneven, then round to the nearest **half or whole unit** (May use clinical discretion; if physical activity follows meal, then may round down)

Sensitivity: _____

Target: _____

☐ Other Instructions:

Snacks

- Children using NPH insulin usually require snacks without additional insulin coverage (please, adhere to CHO amounts ordered above).
- Scheduled snacks may be required prior to or after exercise in order to prevent hypoglycemia. Insulin is not administered with these snacks.

☐ Before Exercise ☐ After Exercise

- Foods may be eaten at unscheduled times. Insulin may be ordered for these snacks in order to prevent post-meal hyperglycemia (see above).
- Snack time insulin = # carbohydrates consumed/CHO Ratio.
- Never provide insulin coverage for carbohydrate/glucose being used to treat hypoglycemia.

Exercise and Sports

- In general, there are no restrictions on activity unless specified.
- A student should not exercise if his/her blood glucose is <100 mg/dL or > 300 mg/dL and ketones are positive.
- A source of fast-acting glucose & glucagon (if ordered) should be available in case of hypoglycemia.

Specific duration of order:	Physician/Provider Signature: Provider Printed Name:	Office Phone: _____ Office Fax: _____
2013 - 2014 SCHOOL YEAR		**Emergency # _____**

Institution Name and Address:

DIABETES MEDICAL MANAGEMENT PLAN
CONVENTIONAL THERAPY or TYPE 2

Patient Label or MRN, Acct#, Patient name, DOB, Date of Service

SCHOOL YEAR 2013-2014 DIABETES SCHOOL CARE PLAN

Student: _____
Effective date: _____

Hypoglycemia (Low Blood Glucose)

Hypoglycemia is defined as a blood glucose **<** _____ mg/dL

Signs of hypoglycemia:

Hunger	Sweating	Shakiness	Paleness	Dizziness
Confusion	Loss of coordination	Fatique	Fighting	Crying
Day-dreaming	Inability to concentrate	Anger	Passing-out	Seizure

- If hypoglycemia is suspected, check the blood glucose level.

Hypoglycemia Management **(Low Blood Glucose)**	**Severe Hypoglycemia: If student unconscious, semi-conscious (unable to control his/her airway or unable to swallow), or seizing, administer glucagon.** • Place student in the "recovery position." • If glucagon is administered, call 911 for emergency assistance, and call Parents/Legal Guardian.
	Mild or Moderate Hypoglycemia: If conscious & able to swallow, immediately give 15 gram fast-acting glucose: • 3-4 glucose tablets or • 6 Life Saver® Candies or • 4 ounces of regular soda/juice or • 1 small tube Glucose/Cake gel
	Repeat BG check in 15 minutes • If BG still low, then re-treat with 15 gram CHO • If BG in acceptable range and at lunch or snack time, let student eat and cover CHO per orders • If BG in acceptable range and not lunch or snack time, provide student slowly-released CHO snack (3-4 peanut butter or cheese crackers or ½ sandwich)
	If unable to raise the BG > 70 mg/dL despite fast-acting glucose sources, call _____

Hyperglycemia (High Blood Glucose)

Signs of hyperglycemia:

Extreme thirst	Frequent urination	Blurry Vision	Hunger	Headache
Nausea	Hyperactivity	Dry Skin	Dizziness	Stomach ache

- If hyperglycemia is suspected, check the blood glucose level.

Hyperglycemia Management **(High Blood Glucose)**	**If BG > 300 mg/dL, or when child complains of nausea, vomiting, and/or abdominal pain, ask the student to check his/her urine for ketones**
	• If urine ketones are trace or negative (blood ketones 0 - 1.0 mmol/L), give 8-16 ounces of sugar-free fluid (water), return to classroom. • If correction insulin has not been administered within 3 hours, provide correction insulin according to student's Correction Factor and Target pre-meal BG • Recheck BG and ketones 2 hours after administering insulin
	• If urine ketones are moderate/large (blood ketones > 1.0 mmol/L), give 8-16 ounces of sugar-free fluid (water) and call _____ for instructions concerning insulin administration. • Contact the Parent/Legal Guardian. • Recheck BG and ketones 2 hours after administering insulin

My signature below provides authorization for the above written orders. I/We understand that all treatments and procedures may be performed by the school nurse, the student and / or trained unlicensed designated school personnel under the training and supervision provided by the school nurse (or by EMS in the event of loss of consciousness or seizure) in accordance with state laws & regulations. I also give permission for the school to contact the health care provider regarding these orders and administration of these medications.

School plan ordered by:	Physician/Provider Signature: Provider Printed Name:	Date:
Acknowledged and received by:	Parent/Legal Guardian:	Date:
Acknowledged and received by:	School Representative:	Date:

INSTITUTION NAME
Institution Address

DEPARTMENT
DIABETES MEDICAL MANAGEMENT PLAN

Patient Label or MRN, Acct#, Patient name, DOB, Date of Service

Part 3: Insulin Pump Supplement

Effective date:

To be completed by physician/provider, diabetes educator and parent/guardian.

Student Name: _____ Date of Birth: ____

Pump Brand/Model: _____™ Pump Company Technical Assistance Number: _____

Pump Trainer/Resource Person: Phone/Beeper:

Child-Lock On? ☐ Yes ☐ No Code: _17_ (applicable to Cozmo Deltec™ Pump only)

How long has student worn an insulin pump? _____ or

☐ **Patient is new to pump therapy and is to initiate use of pump on _____(date)**

INSULIN / PUMP SETTINGS

☐ Rapid-acting Insulin Type: _____®

☐ Use pump bolus calculator to determine all meal, snack and correction doses unless set or pump malfunction occurs.

Timing of Insulin Dose (Bolus Insulin):
Rapid-acting Insulin should always be given prior to
☐ meals ☐ snacks
if CHO intake can be predetermined.

- If CHO intake cannot be predetermined insulin should be given no more than 30 minutes after completion of meal/snack.
- Treat hypoglycemia before administration of meal or snack insulin.

Calculating Insulin Doses: According to CHO ratio and Correction Factor (if needed) - the student requires meal time coverage with rapid-acting insulin based on the amount of carbohydrates in meal and may require additional insulin to correct blood glucose to the desired range according to the following formula:

Insulin Dose = [(Actual BG – Target pre-meal BG) divided by Insulin Sensitivity] + [# carbohydrates consumed/CHO Ratio]

- Fractional amounts of insulin from correction and carbohydrate calculation, when added together, may yield an even amount of insulin
- If uneven, then round to the nearest **whole or half unit** (May use clinical discretion; if physical activity follows meal, then may round down).

Target pre-meal BG: _____ mg/dL

Insulin Sensitivity/Correction Factor:
__ unit for every _____ > target

CHO Ratio:

☐ Parent has permission to adjust CHO ratio in a range from 1:_____ to 1:_____

Exercise/PE CHO Ratio: _____ ☐ Not Applicable

- Less insulin may be required with meals prior to physical activity in order to prevent hypoglycemia. If so, the Exercise/PE CHO Ratio should be used instead of the CHO Ratio.

Extra pump supplies to be furnished by parent/guardian: ☐ infusion sets ☐ reservoirs ☐ pods for OmniPod™ ☐ dressings/tape ☐ insulin ☐ syringes/insulin pen ☐ pump manufacturer instructions

STUDENT PUMP SKILLS		Comments/Additional Instructions:
1. Count carbohydrates	☐ Independent ☐ Needs Assistance	
2. Bolus for carbohydrates consumed	☐ Independent ☐ Needs Assistance	
3. Calculate and administer correction bolus	☐ Independent ☐ Needs Assistance	
4. Disconnect pump	☐ Independent ☐ Needs Assistance	
5. Reconnect pump at infusion set	☐ Independent ☐ Needs Assistance	**School nurses/personnel are not routinely trained on use of specific insulin pumps. School personnel will not perform pump operation without training (to be coordinated with school by caregiver and healthcare provider). If child is not independent and trained RN/personnel are not available, parent/guardian to be contacted for set change. Insulin by injection until set is changed per DMMP orders. If administering via injection, pump must be suspended or disconnected unless ordered otherwise.**
6. Access bolus history on pump	☐ Independent ☐ Needs Assistance	
7. Prepare reservoir and tubing	☐ Independent	
8. Insert infusion set	☐ Independent	
9. Use & programming of square/extended/dual/combo bolus features	☐ Independent ☐ Needs Assistance	
10. Use and programming of temporary basals for exercise and illness	☐ Independent ☐ Needs Assistance	
11. Give injection with syringe or pen, if needed	☐ Independent ☐ Needs Assistance	
12. Re-program pump settings if needed	☐ Independent ☐ Needs Assistance	
13. Trouble shoot alarms and malfunctions	☐ Independent ☐ Needs Assistance	

Specific duration of order: **2013 - 2014 SCHOOL YEAR**	Physician/Provider Signature: : Provider Printed Name:	Office Phone: xxx-xxx-xxxx Office Fax: xxx-xxx-xxxx **Emergency # xxx-xxx-xxxx**

Patient Label or MRN, Acct#, Patient name, DOB, Date of Service

Part 3: Insulin Pump Supplement (continued)

Student Name: _____

HYPOGLYCEMIA MANAGEMENT (Low Blood Glucose):

Follow instructions in DMMP, but in addition:

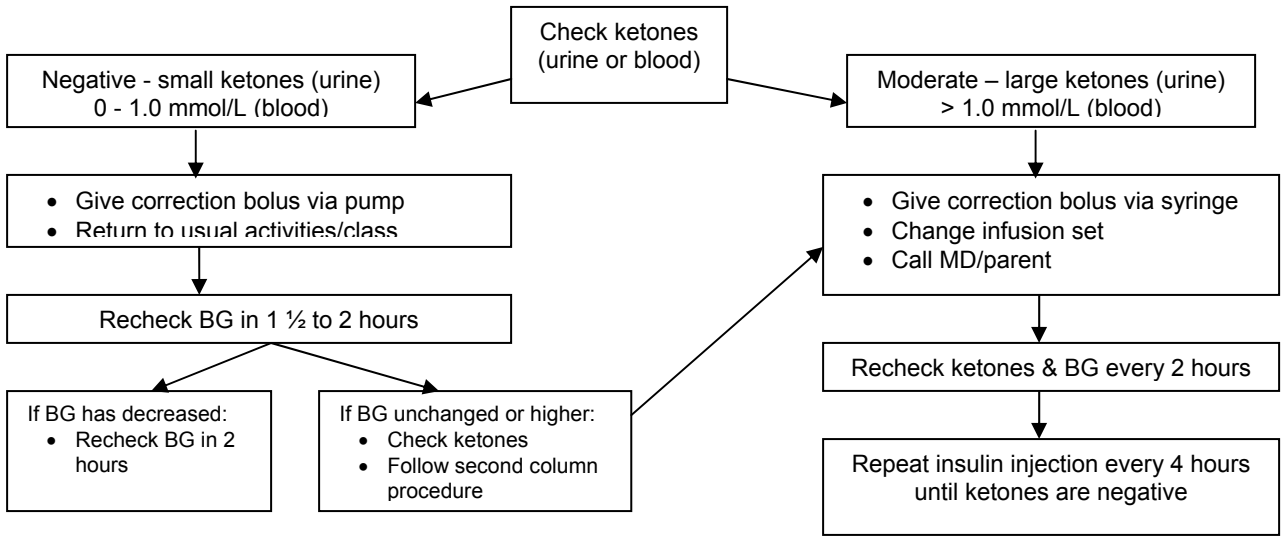
If seizure or unresponsiveness occurs:

1. **Treat with Glucagon** (See Diabetes Medical Management Plan)
2. **Call 911** (or designate another individual to do so)
3. **Stop insulin pump** by any of the following methods (Send pump with EMS to hospital):
   - Placing in "suspend" or stop mode (See manufacturer's instructions)
   - Disconnecting at site, pigtail or clip
   - Cutting tubing
4. Notify parent
5. If pump was removed, send with EMS to hospital

HYPERGLYCEMIA MANAGEMENT (High Blood Glucose)

Follow instructions in diabetes medical management plan (DMMP), but in addition:

Prevention of DKA (Diabetic Ketoacidosis)
If Blood Glucose (BG) is >250 mg/dL two times in a row, drink 8-16 oz. of water/hour and follow below:



ADDITIONAL TIMES TO CONTACT PARENT/GUARDIAN

- Soreness, redness or bleeding at infusion site
- Leakage of insulin at connection to pump or infusion site
- Insulin injection given for high BG/ketones
- Dislodged infusion set
- Pump malfunction
- Repeated Alarms

Other Instructions:

My signature below provides authorization for the above written orders. I/We understand that all treatments and procedures may be performed by the school nurse, the student and / or trained unlicensed designated school personnel under the training and supervision provided by the school nurse (or by EMS in the event of loss of consciousness or seizure) in accordance with state laws & regulations.

School plan reviewed by:	Physician/Provider Signature: Provider Printed Name:	Date:
Acknowledged and received by:	Parent/Legal Guardian:	Date:
Acknowledged and received by:	School Representative:	Date:

INSTITUTION NAME
Institution Address

DEPARTMENT
DIABETES MEDICAL MANAGEMENT PLAN

Patient Label or MRN, Acct#, Patient name, DOB, Date of Service

Part 4: Permission to Self-Carry and Self Administer Diabetes Care

To be completed by physician/provider, parent/guardian and student. This form is not required by law, but serves to inform everyone of expectations and responsibilities.

Student Name: _____ Birthdate: _____

Student's physician or licensed nurse practitioner confirms that the student has a diagnosis of diabetes, is independent and can perform diabetes care, and has approval to self-administer his/her diabetes care including:

☐ glucose monitoring

☐ insulin calculation and administration (including pump operation & pump equipment)

The student understands that he/she is to promptly report to the school nurse or adult as soon as symptoms of high or low blood glucose appear or when not feeling well.

I agree to prepare a written Diabetes Medical Management Plan in consultation with student's parents and appropriate school personnel.

Specific duration of order: **2013 - 2014** **SCHOOL YEAR**	Physician/Provider Signature: Provider Printed Name:	Office Phone: xxx-xxx-xxxx Office Fax: xxx-xxx-xxxx Date: _____

My child has been instructed in and understands his/her diabetic self-management. My child understands that he/she is responsible and accountable for carrying and using his/her medication and equipment.

I will provide the school nurse/school administrator with a copy of my child's Diabetes Medical Management Plan signed by his/her physician.

I hereby give permission for the school to administer the medications as prescribed in the care plan, if indicated (ie. Student requests assistance or becomes unable to perform self-care).

I also give permission for the school to contact the above physician/nurse practitioner regarding my child's diabetes care (authorization required if contact is other than the school nurse).

I will not hold the school board or any of its employees liable for any negative outcomes resulting from the self-administration of diabetes medication by my child.

I understand that the school nurse, after consultation with the parent/guardian and school administrator, may impose reasonable limitations or restrictions upon my child's possession and self-administration of diabetes medications relative to his/her age and maturity or other relevant considerations.

I understand that the school administration may revoke permission to possess and self-administer said diabetes medication at any point during the school year if it is determined that my child has abused the privilege of possession and self-administration or he/she is not safely and effectively self-administering the medication. In addition, my child could be subject to further disciplinary action.

_____ _____

Parent/Guardian Signature *Date*

_____ _____

Student Signature *Date*

Report of Anaphylactic Reaction

Demographics and Health History

1. Name: _____ Name of School: _____

2. DOB:_____ Status of Person: Student ☐ Staff ☐ Visitor ☐ Gender: M ☐ F ☐

3. History of allergy: Yes ☐ No ☐ Unknown ☐ If known, specify type of allergy: _____

If yes, was allergy action plan available? Yes ☐ No ☐ Unknown ☐ History of prior anaphylaxis: Yes ☐ No ☐ Unknown ☐

Diagnosis/History of asthma: Yes ☐ No ☐ Unknown ☐

School Plans and Medical Orders

4. Individual Health Care Plan (IHCP) in place? Yes ☐ No ☐ Unknown ☐

5. Does the student have a student specific order for epinephrine? Yes ☐ No ☐ Unknown ☐

6. Source of epinephrine (ex. student provided, stock epinephrine)_____Expiration date of epinephrine _____Unknown ☐

Epinephrine Administration Incident Reporting

7. Date/Time of occurrence: _____Vital signs: BP____/____ Temp _____ Pulse _____ Respiration _____

8. Specify suspected trigger that precipitated this allergic episode:

Food ☐ Insect Sting ☐ Exercise ☐ Medication ☐ Latex ☐ Other ☐ _____ Unknown ☐

If food was a trigger, please specify suspected food _____

Please check: Ingested ☐ Touched ☐ Inhaled ☐ Other ☐ specify _____

9. Did reaction begin prior to start of school day? Yes ☐ No ☐ Unknown ☐

10. Location where symptoms developed:

Classroom ☐ Cafeteria ☐ Health Office ☐ Playground ☐ Bus ☐ Other ☐ specify _____

11. How did exposure occur?

_____

_____

12. Symptoms: (Check all that apply)

Respiratory	GI	Skin	Cardiac/Vascular	Other
☐ Cough	☐ Abdominal discomfort	☐ Angioedema	☐ Chest discomfort	☐ Sweating
☐ Difficulty breathing	☐ Diarrhea	☐ Flushing	☐ Cyanosis	☐ Irritability
☐ Hoarse voice	☐ Difficulty swallowing	☐ General itching	☐ Dizziness	☐ Loss of consciousness
☐ Stuffy or runny nose	☐ Oral Itching	☐ General rash	☐ Faint/Weak pulse	☐ Metallic taste
☐ Swollen throat or tongue	☐ Nausea	☐ Hives	☐ Headache	☐ Red eyes
☐ Shortness of Breath	☐ Vomiting	☐ Lip swelling	☐ Low blood pressure	☐ Sneezing
☐ Stridor		☐ Localized rash	☐ Rapid heartbeat	☐ Uterine cramping
☐ Tightness (chest, throat)		☐ Paleness		
☐ Wheezing				

13. First Epinephrine Dose (amt.)_____Site (ex. upper left thigh)_____Time:_____Initials:_____

Second Epinephrine Dose (amt.)_____ Site _____Time:_____Initials:_____

14. Location where epinephrine administered: Health Office ☐ Other ☐ specify _____

15. Location of epinephrine storage: Health Office ☐ Other ☐ specify _____

16. Epinephrine administered by: RN ☐ Self ☐ Other ☐ (print name) _____

17. Parent or guardian notified of epinephrine administration: Yes ☐ No ☐ Time: _____

By whom: _____

18. Biphasic reaction: Yes ☐ No ☐ Don't know ☐

Disposition

19. EMS notified at: (time) _____ By whom _____

Transported to hospital emergency department: Yes ☐ No ☐ If "No", reason _____

If yes, transferred via ambulance ☐ Parent/Guardian ☐ Other ☐

20. Student/Staff/Visitor outcome: _____

School Follow-up

21. Were parents or guardians advised to follow up with student's medical provider? Yes ☐ No ☐

22. Were arrangements made to restock epinephrine? Yes ☐ No ☐

.NOTES: _____

_____

_____

24. Form completed by: _____ Date: _____

(please print)

Signature: _____ Title: _____