1. **Policy**

1.1. 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.

2. **Medication Recommendations by School Personnel**

2.1. School personnel are prohibited from recommending the use of psychotropic medications for any student.

2.1.1. This policy shall not prohibit school health staff, classroom teachers or other school professionals from recommending that a student be evaluated by an appropriate medical practitioner, or prohibit school personnel from consulting with such practitioner, with the written consent of the student’s parent.

2.1.2. For the purposes of section 4.1., “psychotropic medications” means those medications the prescribed intention of which is to alter mental activity or state, including, but not limited to antipsychotic, antidepressant, and anxiolytic medication and behavior-altering medication.

3. **Administration of Epinephrine**

3.1. 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.

4. **Policy Limitations**

4.1. 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.)

5. **Generally**

5.2. 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.

5.3. 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.

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

6. Emergencies

6.1. 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.

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

6.3. 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.

7. Prescription Medications

7.1. 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.

8. Non-Prescription Medications

8.1. 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.

8.2. 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.
9. Self-Administration of Medication

9.1. 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:

9.1.1. Written parental consent (see attached form) that the student may self-administer medications must be on file with the school;

9.1.2. 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

9.1.3. An individualized health care plan must be on file in the school health office.

9.1.4. An emergency transportation plan must be prepared for any life threatening conditions.


9.2. 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.

9.2.1. 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.

9.3. 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.

9.3.1. 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.

10. Self-care of Students Diagnosed with Diabetes

10.1. Fauquier County Public Schools students with a diagnosis of diabetes may, with parental consent and the written approval of a prescriber, as defined in Virginia Code § 54.1-3401, (i) carry with them and use supplies, including a reasonable and appropriate short-term supply of carbohydrates, an insulin pump, and equipment for immediate treatment of high and low blood glucose levels, and (ii) self-check their own blood glucose levels on a school bus, on school property, and at a school-sponsored activity.

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

2.1. School personnel who administer medication to students shall review School Board policy 7-5.3 regarding this subject.

2.2. 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.

2.3. A minimum of three (3) employees at each school shall be trained in first aid procedures.

2.4. The principal shall make known to the staff and students the identity and location of these individuals.

2.5. All prescribed medications should be pharmacy labeled with the following:

2.5.1. Student’s name

2.5.2. Name of the drug

2.5.3. Instructions for administration in lay language

2.5.4. Time of administration and

2.5.5. Expiration date of the drug.

2.6. Parents should provide instrument for measuring liquid medications.

2.7. Records shall be kept by school personnel of the prescribed medication, date, time, and person administering the medication.

2.8. It is the parent’s and/or guardian’s responsibility to provide prescribed medication, which has not exceeded the expiration date.

2.8.1. The principal shall be responsible for informing parents who request that medication be administered of the procedures for administering such medications by school personnel.

2.8.2. 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.

2.8.3. 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

3.1. Health Services – Intermittent Catheterization

3.1.1. 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:

3.1.1.1. 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.

3.1.1.2. 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.

3.1.1.3. 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).

3.1.1.4. 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.

3.2. Health Services for Students with Non-food Allergies

3.2.1. 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:

3.2.1.1. Two (2) employees in the school shall learn the procedure. These two (2) employees shall be trained in proper administration procedures.

3.2.1.2. 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.

3.2.1.3. 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.

3.2.1.4. 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.

3.2.1.5. 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.
3.3. Health Services for Students with Food Allergies

3.3.1. 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:

3.3.1.1. Family Responsibilities

3.3.1.1.1. Notify school personnel of the student’s food allergy during annual registration;

3.3.1.1.2. 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;

3.3.1.1.3. Include written Physician’s Orders, medication(s) to be administered, and instructions in the Severe Allergy Health Care Plan;

3.3.1.1.4. Instruct the student in self-management of his/her food allergy including:

3.3.1.1.4.1. Safe and unsafe foods;

3.3.1.1.4.2. Strategies for avoiding exposure to unsafe foods;

3.3.1.1.4.3. Symptoms of allergic reactions;

3.3.1.1.4.4. How and when to tell an adult that they are experiencing an allergy-related problem;

3.3.1.1.4.5. How to read food labels (if age-appropriate); and

3.3.1.1.4.6. The proper use of an epinephrine automatic injector (if age appropriate);

3.3.1.1.5. Notify school personnel of any changes which occur that impact the student’s Health Care Plan;

3.3.1.1.6. Review the Health Care Plan with the core team, physician, and student (if age appropriate) after a reaction has occurred; and

3.3.1.1.7. Replace medications after use or upon expiration.

3.3.1.2. School Personnel Responsibilities;

3.3.1.2.1. Review the student’s health records submitted by the parent/guardian and physician;
3.3.1.2.2. At registration, identify a core team to develop Health Care Plan. Revise Plan with core team’s recommendations;

3.3.1.2.3. Provide copy of Health Care Plan to all staff who interact with student;

3.3.1.2.4. Attempt to eliminate the use of the student’s food allergy during the school day;

3.3.1.2.5. Ensure peanut-free table is available and is cleaned according to specific guidelines in custodian’s manual;

3.3.1.2.6. Ensure proper storage of medications by clinic attendant/school nurse, unless otherwise noted in Health Care Plan;

3.3.1.2.7. Designate school personnel to be trained to administer medications;

3.3.1.2.8. Ensure school bus driver training includes recognition of allergic reaction symptoms and proper procedures if allergic reaction occurs;

3.3.1.2.9. Ensure that school buses are equipped with communication devices for use in emergencies;

3.3.1.2.10. Establish “no eating or drinking” policy on school buses, except for medical necessities or to accommodate field trips;

3.3.1.2.11. Implement field trip procedures as outlined in Health Care Plan;

3.3.1.2.12. Ensure that students are not excluded from activities because of food allergies; and

3.3.1.2.13. Take all threats or harassment against an allergic student seriously.

3.3.1.3. Student Responsibilities

3.3.1.3.1. Should not trade food with others;

3.3.1.3.2. Should not eat any food with unknown ingredients or foods known to contain an allergen;

3.3.1.3.3. Should be proactive in the care and management of his/her food allergy based on developmental level;

3.3.1.3.4. Should immediately notify an adult if he/she eats something believed to contain the food allergen and/or becomes symptomatic;

3.3.1.3.5. Should immediately inform an adult if he/she self-medicates for a food allergy reaction; and

3.3.1.3.6. Should inform adult if threats or harassment occur.
3.4. Health Services for Students with Diabetes

3.4.1. 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.

3.4.1.1. The training shall be consistent with guidelines established by the State Department of Education.

3.4.1.2. 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.

3.4.2. 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.

3.4.2.1. 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.

3.4.2.2. 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.

3.4.3. 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.

3.4.4. 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.

3.4.4.1. The written order must be from a licensed physician.

3.4.4.2. The administration of medication services will be provided only during school hours during which scheduled classes take place.

3.4.4.3. 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.
3.4.4. 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:

3.4.4.1. Assistance in the administration of insulin as prescribed; and

3.4.4.2. Administration of glucagon when the student with diabetes is believed to be suffering life-threatening hypoglycemia.

3.4.4.5. 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.

3.4.4.6. 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.

3.4.4.7. 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.

3.4.4.8. Following the administration of glucagon, emergency services will be contacted and/or the student will be transported to the hospital.

3.4.5. 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.

3.4.6. 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.
ADMINISTERING MEDICINES TO STUDENTS

ACCOMPANYING REGULATION

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

1. Generally

1.1. 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.

2. Regulation Limitations:

2.1. 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.).

3. Definitions:

3.1. “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.

4. Symptoms of Anaphylaxis

4.1. Shortness of breath or tightness of chest; difficulty in or absence of breathing
4.2. Sneezing, wheezing or coughing
4.3. Difficulty swallowing
4.4. Swelling of lips, eyes, face, tongue, throat or elsewhere
4.5. Low blood pressure, dizziness and/or fainting
4.6. Heart beat complaints: rapid or decreased
ADMINISTERING MEDICINES TO STUDENTS

4.7. Blueness around lips, inside lips, eyelids
4.8. Sweating and anxiety
4.9. Itching, with or without hives; raised red rash in any area of the body
4.10. Skin flushing or color becomes pale
4.11. Hoarseness
4.12. Sense of impending disaster or approaching death
4.13. Loss of bowel or bladder control
4.14. Nausea, abdominal pain, vomiting and diarrhea
4.15. Burning sensation, especially face or chest
4.16. Loss of consciousness

5. Anaphylactic Reaction and Action

5.1. 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)

6. Training

6.1 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)

7. Standing Orders:

7.1. 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)
8. **Responding to Anaphylaxis:**

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

8.2. For suspected anaphylaxis without specific orders:

   8.2.1. Based on symptoms, determine that an anaphylactic reaction is occurring.

   8.2.2. Act quickly. It is safer to give epinephrine than to delay treatment. **This is a life and death decision.**

   8.2.3. Determine the proper dose and administer epinephrine. Note the time.

   8.2.4. Direct someone to call 911 and request medical assistance. Advise the 911 operator that anaphylaxis is suspected and that epinephrine has been given.

   8.2.5. Stay with the person until emergency medical services (EMS) arrives.

   8.2.6. Monitor their airway and breathing.

   8.2.7. Reassure and calm person as needed.

   8.2.8. Call School Nurse/Front Office school personnel and advise of situation.

   8.2.9. Direct someone to call parent/guardian.

   8.2.10. 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.

   8.2.11. Administer CPR if needed.

   8.2.12. 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.

   8.2.13. Even if symptoms subside, 911 must still respond and individual must be evaluated by a physician. A delayed or secondary reaction may occur.

   8.2.14. Document the incident and complete the incident report. (Form)

   8.2.15. Replace epinephrine stock medication as appropriate.

(See illustration below)
9. Post Event Actions:

9.1. 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.

9.2. Document the event

9.3. Complete incident report (Form)

9.4. Replace epinephrine stock medication immediately

10. Storage, Access and Maintenance:

10.1. 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
ADMINISTERING MEDICINES TO STUDENTS

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.

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

10.3. 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

PARENT/GUARDIAN SECTION

Student__________________________________DOB________________Age_____Grade____
School____________________________Homeroom Teacher____________________Bus_____
Allergies______________________________________________________________________
Parent/Guardian Signature_______________________________Date_____________________
Parent/Guardian Printed Name_____________________________________________________Signature gives permission for principal’s designee to administer prescribed medicine and to contact the physician/dentist if necessary to discuss. For Over-the-Counter medicine, parent’s signature gives principal’s designee permission to administer medicine.

PHYSICIAN/DENTIST SECTION
(Required for all prescription medicines and for over-the-counter medicines that exceed manufacturer’s recommended dose. Must be in original pharmacy labeled container.)

Name of Medication_____________________________________________________________
Dosage_____________________Frequency__________________Length of Time____________
Time Medication to be Given______________________________________________________
Reason Prescribed, Unless Confidential____________________________________________
Physician/Dentist Signature______________________________Date_____________________
Physician/Dentist Printed Name___________________________________________________
Physician/Dentist Phone_____________________________Fax__________________________
Physician/Dentist Address________________________________________________________

OVER-THE-COUNTER MEDICATIONS
(Must be in original, unopened container. Does not require physician signature if given in manufacturer’s recommended dosages or given for less than 11 consecutive days.)

Name of Medication_________________________________Dosage_________________________________
How Often_________________________________Reason for Medication_________________________________
Additional Instructions______________________________________________________________________
Received by_____________________________________Date________________________________

INSTRUCTIONS FOR HALF-DAYS

Above ordered daily medication should be given at school on half days YES □ NO □
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 CAREPLAN FOR SEVERE ALLERGY PART 1

STUDENT NAME:________________________________________DOB:_______________DATE:_______________

ALLERGIC TO:__________________________________________________________________________________

**PHYSICIAN ORDERED MEDICATIONS**

1. **Antihistamine:**
   - NONE OR
   - Benadryl/Diphenhydramine HCL:__________mg/Other:_________________

2. **Inhaler:**
   - NONE OR
   - Medication__________________________Dose______________________________

3. **Epinephrine Auto Injector (Epi-pen) 0.30mg** OR **Epinephrine Auto Injector JUNIOR 0.15mg**

4. **Repeat Epi-pen:**
   - NO or YES, specify when repeat dose to be given_________________________________

**SYMPTOM**

**SEVERE SYMPTOMS** following allergen exposure
- MOUTH: swelling lips/tongue/throat
- LUNGS: shortness of breath/wheezing/repetitive cough
- CIRC: weak pulse/low BP/fainting/dizziness/confusion
- SKIN: widespread hives/fainting or pale/blue skin
- GUT: severe/repetitive vomiting/diarrhea

**MILD SYMPTOMS** from SINGLE SYSTEM
- MOUTH/NOSE: itchy mouth or itchy/runny nose
- SKIN: a few hives, mild itch
- GUT: mild nausea/discomfort

**MILD SYMPTOMS** from MULTIPLE SYSTEMS

<table>
<thead>
<tr>
<th>SYMPTOMS</th>
<th>GIVE CHECKED MEDICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epi-pen</td>
<td>Antihistamine</td>
</tr>
</tbody>
</table>

**SPECIAL CIRCUMSTANCE:** Due to severity of allergy history, give Epi-pen upon allergen exposure (allergen confirmed eaten/student stung if bee allergy) even if NO ALLERGY SYMPTOMS PRESENT. YES ☐ NO ☐

**PHYSICIAN:**_______________________/______________________/____________________/_________________

Printed Name Signature Phone Date

1. Note time medications given. **CALL 911** if Epi-pen given. Notify guardian and school administrator.
2. If Antihistamine given for mild symptom only, remain with student and notify guardian. Watch closely for changes as symptoms may worsen and become severe.
3. If symptoms severe, lay student flat, raise legs, and keep warm. Sitting up may help student with breathing difficulties.

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

I certify that this child has potential for severe allergic reaction and that child has been judged capable of carrying and self-administering the above medications for allergic reaction.

**PHYSICIAN SIGNATURE_____________________Self-carry/administration permission granted YES ☐ NO ☐

I give consent for my child to carry and self-administer the above ordered medications. My child has been instructed on the recognition of symptoms and the safe/effective use of the ordered medications. My child understands the hazards of sharing medications and has agreed to refrain from doing so. My child knows to notify school staff if medications are used. I will not hold the school board or its employees liable for any negative outcome from my child self-carrying or administering the medications. I understand that this permission may be revoked by the principal to maintain safety.

**GUARDIAN SIGNATURE______________________PRINTED NAME______________________DATE________**

**NURSE:** ORDER/MEDICATION RECEIPT_________________________DATE________
Fauquier County Public Schools Health Care Plan for Severe Allergy - Part 2

STUDENT NAME: ______________________ DOB: __________________ DATE: __________________

Date/Description of Last Reaction: ______________________________________________________

Has Epinephrine Been Used in the Past/Explain ____________________________________________

PARENT/GUARDIAN PHONE (H) __________________ (W) __________________ (C) _____________

PARENT/GUARDIAN PHONE (H) __________________ (W) __________________ (C) _____________

BUS PROCEDURES

1. Emergency Transportation Plan: ☐ Given to Guardian ☐ Completed/Returned by Guardian
2. Student will sit at the front of the bus: ☐ YES ☐ NO

FIELD TRIP PROCEDURES

1. The teacher/nurse will discuss field trips with guardian in advance. Guardian encouraged to accompany student on the trip. If cannot attend and student does not have self-administration permission, responsible teacher will carry/administer medications as ordered, after receiving instruction on the use of the medications from the nurse.
2. The student will remain with the teacher or guardian during the entire trip: ☐ YES ☐ NO

CLASSROOM

1. Teachers will be notified of allergy. Teacher will review classroom projects to avoid specified allergens.
2. Other: ___________________________________________________________________________

ATHLETICS / EXTRA-CURRICULAR ACTIVITIES

1. Parents are responsible for notifying coach/activity sponsor of student’s allergy if student stays after school for athletics extra-curricular activities/clubs. School nurses are only available during regular school hours.

STUDENTS WITH FOOD ALLERGIES - PLEASE CHECK ALL BOXES THAT APPLY

1. ☐ Student will only eat food provided by guardian.
2. ☐ Student allowed to eat from school menu, make own food choices, and will seek assistance from cafeteria/clinic staff as needed.
3. ☐ Alternative snacks will be provided by guardian to be kept in classroom/clinic.
4. ☐ Guardians will be told of planned lessons/parties/activities involving food as early as possible.
5. ☐ Student will have NO SEATING RESTRICTIONS in cafeteria.
6. ☐ Student requires following cafeteria seating___________________________________________
7. Other: __________________________________________________________________________

Signature gives permission for the principal’s designee to administer the ordered medications on Part 1 of this Health Care Plan and to contact the ordering health care provider if necessary to discuss this allergy plan.

PARENT/GUARDIAN SIGNATURE __________________ PRINTED NAME __________________ DATE____

ORDERS RECEIVED/REVIEWED BY _____________________________ DATE__

Notification (initial/date): Admin_________ Transport_________ Teachers_________ Cafeteria_________
Virginia Diabetes Medical Management Plan (DMMP)

Adapted from the National Diabetes Education Program DMMP (2016)

This plan should be completed by the student’s personal diabetes health care team, including the parents/guardians. It should be reviewed with relevant school staff and copies should be kept in a place that can be accessed easily by the school nurse, trained diabetes personnel, and other authorized personnel.

### Student information

<table>
<thead>
<tr>
<th>Student’s name: ____________________________</th>
<th>Date of birth: ______________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of diabetes diagnosis: ________________</td>
<td>□ Type 1 □ Type 2 □ Other: __________</td>
</tr>
<tr>
<td>School name: _____________________________</td>
<td>School phone number: __________</td>
</tr>
<tr>
<td>Grade: ____________________________</td>
<td>Homeroom teacher: ______________________________</td>
</tr>
<tr>
<td>School nurse: ____________________________</td>
<td>Phone: ______________________________</td>
</tr>
</tbody>
</table>

### Contact information

**Parent/guardian 1:**

<table>
<thead>
<tr>
<th>Address: ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone: Home: ______________ Work: ______________ Cell: ______________</td>
</tr>
<tr>
<td>Email address: ____________________</td>
</tr>
</tbody>
</table>

**Parent/guardian 2:**

<table>
<thead>
<tr>
<th>Address: ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone: Home: ______________ Work: ______________ Cell: ______________</td>
</tr>
<tr>
<td>Email address: ____________________</td>
</tr>
</tbody>
</table>

**Student’s physician / health care provider:**

<table>
<thead>
<tr>
<th>Address: ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone: ______________ Emergency Number: ____________________</td>
</tr>
<tr>
<td>Email Address: ____________________</td>
</tr>
</tbody>
</table>

**Other emergency contacts:**

| Name: ____________________________ Relationship: ____________________ |
|----------------------------------|-----------------------------|
| Telephone: Home: ______________ Work: ______________ Cell: ______________ |
Checking blood glucose

Target range of blood glucose:  

- Before Meal  ______ - _______ mg / dL  
- Other: ________________

Check blood glucose level:  

- Before breakfast  ______ Hours after breakfast  
- Before lunch  ______ Hours after lunch  ______ Hours after correction dose  
- Before PE  After PE  Before dismissal  As needed for signs/symptoms of illness  
- As needed for signs/symptoms of high/low blood glucose  
- Other: ____________________

Student’s self-care blood glucose checking skills:

- Independently checks own blood glucose
- May check blood glucose with supervision
- Requires a school nurse or trained diabetes personnel to check blood glucose
- Uses a smartphone or other monitoring technology to track blood glucose values

Continuous Glucose Monitoring (CGM):  

- Yes  
- No  

Brand/model: ____________________

Alarms set for:  

- Severe Low: ______  
- Low: ______  
- High: ______

Predictive alarm:  

- Low: ______  
- High: ______  

Rate of change:  

- Low: ______  
- High: ______

Threshold suspend setting:  

Additional information for student with CGM

- Confirm CGM results with a blood glucose meter check before taking action on the sensor blood glucose level.
- If the student has signs or symptoms of hypoglycemia, check fingertip blood glucose level regardless of the CGM.
- Insulin injections should be given at least three inches away from the CGM insertion site.
- Do not disconnect from the CGM for sports activities.
- If the adhesive is peeling, reinforce it with any medical adhesive or tape the parent / guardian has provided.
- If the CGM becomes dislodged, remove, and return everything to the parents/guardian. Do not throw anything away.
- Refer to the manufacturer’s instructions on how to use the student’s device.

Student’s Self-care CGM Skills

<table>
<thead>
<tr>
<th>The student is able to troubleshoot alarms and malfunctions.</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>The student is able to respond to HIGH alarm.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>The student is able to respond to LOW alarm.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>The student is able to adjust alarms.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>The student is able to calibrate the CGM.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>The student is able to respond when the CGM indicates a rapid trending rise or fall in the blood glucose level.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>The student should be escorted to the nurse if the CGM alarms</td>
<td>High</td>
<td>Low</td>
</tr>
</tbody>
</table>

Other instructions for the school health team:
Hypoglycemia (Low Blood Glucose)

**Hypoglycemia:** Any blood glucose below _____ mg / dL checked by blood glucose meter.

**Student’s usual symptoms of hypoglycemia (circled):**

<table>
<thead>
<tr>
<th>Hunger</th>
<th>Sweating</th>
<th>Shakiness</th>
<th>Paleness</th>
<th>Dizziness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confusion</td>
<td>Loss of coordination</td>
<td>Fatigue</td>
<td>Irritable</td>
<td>Crying</td>
</tr>
<tr>
<td>Headache</td>
<td>Inability to concentrate</td>
<td>Anger</td>
<td>Passing-out</td>
<td>Seizure</td>
</tr>
</tbody>
</table>

**Mild to Moderate Hypoglycemia:**
Student is exhibiting symptoms of hypoglycemia AND blood glucose level is less than _____ mg/dL

1. Give a quick acting glucose product equal to 15 grams fast-actingcarbohydrate such as: glucose tablets, juice, glucose gel, gummies, skittles, starbursts
2. Recheck blood glucose in 15 minutes
3. If blood glucose level is < _____, repeat treatment with 15 grams of fast-acting carbohydrates.
4. **Additional Treatment:**

**Severe Hypoglycemia:**
Student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movement)

1. Position the student on his or her side to prevent choking
2. Administer glucagon
   - **Dose:**  [ ] 1 mg  [ ] 0.5 mg  [ ] Other ________________
   - **Route:**  [ ] Subcutaneous (SC)  [ ] Intramuscular (IM)
   - **Site:**  [ ] Buttocks  [ ] Arm  [ ] Thigh  [ ] Other: ________________
3. **Call 911** (Emergency Medical Services)
   - AND the student’s parents / guardians.
   - AND the health care provider.
4. **If on INSULIN PUMP,** Stop insulin pump by any of the following methods:
   - Place pump in “suspend” or “stop mode” (See manufacturer’s instructions)
   - Disconnect at site
   - Cut tubing

**ALWAYS** send pump with EMS to hospital

Hyperglycemia (High Blood Glucose)
Hyperglycemia: Any blood glucose above ______ mg/dL checked by blood glucose meter.

Student’s usual symptoms of hyperglycemia (circled):

<table>
<thead>
<tr>
<th>Extreme thirst</th>
<th>Frequent urination</th>
<th>Blurry Vision</th>
<th>Hunger</th>
<th>Headache</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea</td>
<td>Hyperactivity</td>
<td>Irritable</td>
<td>Dizziness</td>
<td>Stomach ache</td>
</tr>
</tbody>
</table>

Insulin Correction Dose

For blood glucose greater than _______mg/dL AND at least _____ hours since last insulin dose, give correction dose of insulin (see correction dose orders, page 5).

Notify parents/guardians if blood glucose is over _________ mg/dL.

For insulin pump users: see “Additional Information for Student with Insulin Pump”, page 6.

Ketones

If blood glucose is above ____ mg/dL, two times in a row, at least one hour apart and/or when student complains of nausea, vomiting or abdominal pain, check for ketones.

☐ Urine for ketones OR ☐ Blood for ketones

Give ____ounces of water

Allow unrestricted access to the bathroom

If urine ketones are negative to small OR blood ketones < 0.6 mmol/L - 1.0 mmol/L:

1. If insulin has not been administered within ____ hours, provide correction insulin according to student’s correction factor and target pre-meal blood glucose (refer to page 5)
2. Return student to his / her classroom
3. Recheck blood glucose and ketones in ____ hours after administering insulin

If urine ketones are moderate to large OR blood ketones >1.0 mmol/L:

1. Do NOT allow student to participate in exercise
2. Call parent / guardian, If unable to reach parent / guardian call health care provider
3. If insulin has not been administered within ____ hours, provide correction insulin according to student’s correction factor and target blood glucose. (refer page 5)
4. **IF ON INSULIN PUMP:** See “Additional Information for Student with Insulin Pump”, page 6
HYPERGLYCEMIA EMERGENCY
When large ketones are associated with the following symptoms Call 911

<table>
<thead>
<tr>
<th>Chest pain</th>
<th>Nausea and vomiting</th>
<th>Severe abdominal pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heavy breathing or shortness of breath</td>
<td>Increasing sleepiness or lethargy</td>
<td>Depressed level of consciousness</td>
</tr>
</tbody>
</table>
**Insulin therapy**

**Insulin delivery device:**  
- Insulin pen  
- Insulin syringe  
- Insulin pump (refer to page 6)

**Type of Insulin therapy at school:**  
- Adjustable (basal-bolus) insulin  
- Fixed insulin therapy  
- None

**Adjustable (Basal-Bolus) Insulin Therapy**

**Insulin Type:**  
- Apidra; Novolog; or Humalog

**Carbohydrate Coverage/ Insulin-to-carbohydrate ratio:**

- **Breakfast:**  
  - _____ unit of insulin per _____ gm of carbohydrate
- **Lunch:**  
  - _____ unit of insulin per _____ gm of carbohydrate
- **Snack:**  
  - _____ unit of insulin per _____ gm of carbohydrate
- **Dinner:**  
  - _____ unit of insulin per _____ gm of carbohydrate

<table>
<thead>
<tr>
<th>Carbohydrate Dose Calculation Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Grams of Carbohydrate to Be Eaten</td>
</tr>
<tr>
<td>Insulin-to-Carbohydrate Ratio</td>
</tr>
</tbody>
</table>

**Correction Dose:**

May be used to administer insulin for elevated blood glucose if greater than _____ hours since last insulin dose:

- Blood glucose correction factor (insulin sensitivity factor) = _____
- Target blood glucose = _____ mg/dL

<table>
<thead>
<tr>
<th>Carbohydrate Dose Calculation Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Blood Glucose – Target Blood Glucose</td>
</tr>
<tr>
<td>Correction Factor</td>
</tr>
</tbody>
</table>

**Correction dose scale** (use instead of calculation above to determine insulin correction dose):

- May be used to administer insulin for elevated blood glucose if greater than _____ hours since last insulin dose

| Blood glucose _____ to _____ mg/dL, give _____ units |
| Blood glucose _____ to _____ mg/dL, give _____ units |
| Blood glucose _____ to _____ mg/dL, give _____ units |
| Blood glucose _____ to _____ mg/dL, give _____ units |

**When to give insulin:**

**Breakfast:**

- Carbohydrate coverage only
- Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.
- Other: _____________

**Lunch:**

- Carbohydrate coverage only
- Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.
- Other: _____________

**Snack:**

- No coverage for snack
- Carbohydrate coverage only
- Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.
- Correction dose only: For blood glucose greater than _____ mg/dL AND at least _____ hours since last insulin dose.
- Other: _____________
**Insulin therapy (continued)**

**Fixed Insulin Therapy**

Name of insulin: ___________________________________________

- _____ Units of insulin given pre-breakfast daily
- _____ Units of insulin given pre-lunch daily
- _____ Units of insulin given pre-snack daily
- Other: _____________________________

**Parents/Guardians Authorization to Adjust Insulin Dose**

Parents/guardians authorization should be obtained before administering a correction dose.  

- Yes  
- No

Parents/guardians are authorized to increase or decrease correction dose scale within the following range: +/- ______ units of insulin.  

- Yes  
- No

Parents/guardians are authorized to increase or decrease insulin-to-carbohydrate ratio from:  

- _____ unit(s) for every _____ grams of carbohydrate to  
- _____ unit(s) for every _____ grams of carbohydrate  

- Yes  
- No

Parents/guardians are authorized to increase or decrease fixed insulin dose within the following range:  

- +/- ______ units of insulin.  

- Yes  
- No

**Student’s Self-Care Insulin Administration Skills**

- Independently calculates / gives own injections.  
- May calculate / give own injections with supervision.  
- Requires a school nurse or trained diabetes personnel to calculate dose and student can give own injection with supervision.  
- Requires a school nurse or trained diabetes personnel to calculate dose and give the injection.

**Additional Information for Students with Insulin Pumps**

Brand / model of pump: ___________________________  
Insulin Type: Apidra; Novolog; or Humalog

Basal rates during school:  
Time: _______ Basal rate: _______  
Time: _______ Basal rate: _______  
Time: _______ Basal rate: _______  

Other pump instructions: ___________________________  
Type of infusion set / infusion site(s): ________

- If Blood glucose greater than ______mg/dL that has not decreased within ______hours after correction and / or if student has moderate to large ketones. Notify parents/ guardians  
- Yes  
- No

- For infusion site failure: Insert new infusion set and/or replace reservoir, or give insulin by syringe or pen.  
- Yes  
- No

- For suspected pump failure: Suspend or remove pump and give insulin by syringe or pen.  
- Yes  
- No

**Adjustments for Physical Activity Using Insulin Pump**

- May disconnect from pump for sports activities:  
- Yes, for ______ hours  
- No  
- Per parent

- Set temporary basal rate:  
- Yes, ___% temporary basal for ___ hours  
- No  
- Per parent

- Suspend pump use:  
- Yes, for _____ hours  
- No  
- Per parent

**Student’s Self-care Pump Skills**

<table>
<thead>
<tr>
<th>Task</th>
<th>Independent?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counts carbohydrates</td>
<td>☐ Yes/No</td>
</tr>
<tr>
<td>Calculates correct amount of insulin for carbohydrates consumed</td>
<td>☐ Yes/No</td>
</tr>
<tr>
<td>Administers correction bolus</td>
<td>☐ Yes/No</td>
</tr>
<tr>
<td>Calculates and sets basal profiles</td>
<td>☐ Yes/No</td>
</tr>
<tr>
<td>Calculates and sets temporary basal rate</td>
<td>☐ Yes/No</td>
</tr>
<tr>
<td>Changes batteries</td>
<td>☐ Yes/No</td>
</tr>
<tr>
<td>Disconnects pump</td>
<td>☐ Yes/No</td>
</tr>
<tr>
<td>Reconnects pump to infusion set</td>
<td>☐ Yes/No</td>
</tr>
<tr>
<td>Prepares reservoir, pod, and/or tubing</td>
<td>☐ Yes/No</td>
</tr>
<tr>
<td>Inserts infusion set</td>
<td>☐ Yes/No</td>
</tr>
<tr>
<td>Troubleshoots alarms and malfunctions</td>
<td>☐ Yes/No</td>
</tr>
</tbody>
</table>

**Other diabetes medications**

Name: ____________________  
Dose: ____________  
Route: _______  
Times given: _______________

Name: ____________________  
Dose: ____________  
Route: _______  
Times given: _______________
Name: ____________________  Dose: ____________ Route: _______ Times given: _______________

**Meal plan**  
☐ Not applicable

<table>
<thead>
<tr>
<th>Meal/At Time</th>
<th>Time</th>
<th>Carbohydrate Content (grams)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast</td>
<td>______ to</td>
<td>______</td>
</tr>
<tr>
<td>Mid-morning snack</td>
<td>______ to</td>
<td>______</td>
</tr>
<tr>
<td>Lunch</td>
<td>______ to</td>
<td>______</td>
</tr>
<tr>
<td>Mid-afternoon snack</td>
<td>______ to</td>
<td>______</td>
</tr>
</tbody>
</table>

**Other times to give snacks and content/amount:**

**Instructions for when food is provided to the class** (e.g., as part of a class party or food sampling event):

**Special event/party food permitted:**  
☐ Parents'/Guardians’ discretion  ☐ Student discretion

**Student’s self-care nutrition skills:**

☐ Independently counts carbohydrates  
☐ May count carbohydrates with supervision  
☐ Requires school nurse/trained diabetes personnel to count carbohydrates

**Physical activity and sports** - A quick-acting source of glucose must be available at the site of physical education activities and sports. Examples include glucose tabs, sugar-containing juice. Student should eat:

<table>
<thead>
<tr>
<th>Carbohydrate Amount</th>
<th>Before</th>
<th>Every 30 minutes</th>
<th>Every 60 minutes</th>
<th>After activity</th>
<th>Per Parent</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 grams</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>30 grams</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

If most recent blood glucose is less than ______ mg/dL, student can participate in physical activity when blood glucose is corrected and above ______ mg/dL.

Avoid physical activity when blood glucose is greater than ______ mg/dL or if urine ketones are moderate to large / blood ketones are > 1.0 mmol/L.

(See “Adjustments for Physical Activity Using Insulin Pump”, page 6 for additional information for students on insulin pumps.)

**Disaster plan** - To prepare for an unplanned disaster or emergency (72 hours):

☐ Obtain emergency supply kit from parents/guardians.  
☐ Continue to follow orders contained in this DMMP.  
☐ Additional insulin orders as follows (e.g., dinner and nighttime): ____________________________  
☐ Other: ____________________________

---

**Authorization to Treat and Administer Medication in the School Setting as Required by Virginia Law**

This Diabetes Medical Management Plan has been approved by the undersigned Health Care Provider.

It further authorizes schools to treat and administer medication as indicated by this plan and required by Virginia Law.

**Providers:**

My signature below provides authorization for the Virginia Diabetes Medical Management Plan contained herein. I understand that all treatments and procedures may be performed by the student, the school nurse, unlicensed trained designated school personnel, as allowed by school policy, state
law or emergency services as outlined in this plan. I give permission to the school nurse and designated school personnel who have been trained to perform and carry out the diabetes care tasks for the student as outlined in the student’s Diabetes Medical Management Plan as ordered by the prescribing health care provider (Code of Virginia § 22.1-274).

Parents:

I also consent to the release of information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my student and who may need to know this information to maintain my student’s health and safety. I also give permission to the school nurse or another qualified health care professional to contact my student’s diabetes health care providers.

I give permission to the student to carry with him/her and use supplies, including a reasonable and appropriate short-term supply of carbohydrates, an insulin pump, and equipment for immediate treatment of high and low blood glucose levels, and to self-check his/her own blood glucose levels on a school bus, on school property, and at a school-sponsored activity (Code of Virginia §22.1-274.01:1).

Parent authorization for student to self-administer insulin ☐ YES ☐ NO

Parent authorization for student to self-monitor blood glucose ☐ YES ☐ NO

<table>
<thead>
<tr>
<th>Parent / Guardian Name / Signature :</th>
<th>Date:</th>
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</thead>
<tbody>
<tr>
<td>School representative Name / Signature:</td>
<td>Date:</td>
</tr>
<tr>
<td>Student’s Physician / Health Care Provider Name / Signature:</td>
<td>Date:</td>
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**Suggested Supplies to Bring to School**

- Glucose meter, testing strips, lancets, and batteries for the meter
- Insulin(s), syringes, and/or insulin pen(s) and supplies
- Insulin pump and supplies in case of failure: Reservoirs, sets, prep wipes, pump batteries / charging
- Treatment for low blood sugar (see page 3)
- Protein containing snacks: such as granola bars
- Glucagon emergency kit
- Antiseptic wipes or wet wipes
- Water
- Urine and/or blood ketone test strips and meter
- Other medication
## Virginia Asthma Action Plan

### School Division:

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Effective Dates</th>
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<thead>
<tr>
<th>Health Care Provider</th>
<th>Provider’s Phone #</th>
<th>Fax #</th>
<th>Last flu shot</th>
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<tr>
<th>Parent/Guardian</th>
<th>Parent/Guardian Phone</th>
<th>Parent/Guardian Email</th>
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<tr>
<th>Additional Emergency Contact</th>
<th>Contact Phone</th>
<th>Contact Email</th>
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**Green Zone:** Go! — **Take CONTROL (PREVENTION) Medicines EVERY Day**

- **You have ALL of these:**
  - Breathing is easy
  - No cough or wheeze
  - Can work and play
  - Can sleep all night

**Peak flow:** _______ to _______ (More than 80% of Personal Best)

**Personal best peak flow:** _______

**Always rinse your mouth after using your inhaler and remember to use a spacer with your MDI.**

- No control medicines required.
- Dulera ______ □, ___, ___ puff(s) ___ times a day
- Symbicort ______ □, ___, ___ puff(s) ___ times a day
- Advair ______ □, ___, ___ puff(s) ___ times a day
- Alvesco ______ □, ___, ___ puff(s) ___ times a day
- Flovent ______ □, ___, ___ puff(s) ___ times a day
- Pulmicort ______ □, ___, ___ puff(s) ___ times a day
- QVAR ______ □, ___, ___ puff(s) ___ times a day
- Inhaled Corticosteroid with long-acting β-agonist (LABA) ______ □, ___, ___ puff(s) ___ times a day

**Inhaled Corticosteroid/long-acting β-agonist (LABA) or Inhaled Corticosteroid Long-Acting β-agonist (LABA) with controller medication:**

- Singulair or __________________________, take ____ by mouth once daily at bedtime
- Leukotriene antagonist
- Dulera ______ □, ___, ___ puff(s) every ____ hours as needed

**Yellow Zone:** Caution! — **Continue CONTROL Medicines and ADD RESCUE Medicines**

- **You have ANY of these:**
  - Cough or mild wheeze
  - First sign of cold
  - Tight chest
  - Problems sleeping, working, or playing

**Peak flow:** _______ to _______ (60% - 80% of Personal Best)

- Albuterol or ____________________, ___ puffs with spacer every ____ hours as needed
- Albuterol or ____________________, __ puffs with spacer every ____ hours as needed
- Albuterol or ____________________, one nebulizer treatment (s) every ____ hours as needed

**Call your Healthcare Provider if you need rescue medicine for more than 24 hours or two times a week, or if your rescue medicine doesn’t work.**

**Red Zone:** DANGER! — **Continue CONTROL & RESCUE Medicines and GET HELP!**

- **You have ANY of these:**
  - Can’t talk, eat, or walk well
  - Medicine is not helping
  - Breathing hard and fast
  - Blue lips and fingernails
  - Tired or lethargic
  - Ribs show

**Peak flow:** < _______ (Less than 60% of Personal Best)

- Albuterol or _______________, ____ puffs with spacer **every 15 minutes**, for THREE treatments
- Albuterol or _______________, one nebulizer treatment (s) **every 15 minutes**, for THREE treatments

**Required Signatures:**

I give permission for school personnel to follow this plan, administer medication and care for my child and contact my provider if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Management Plan for my child.

- **Parent/Guardian:** ___________________________ Date ________
- **School Nurse/Designee:** ___________________________ Date ________
- **Other:** ___________________________ Date ________

**CC:** □ Principal □ Cafeteria Mgr □ Bus Driver/Transportation □ Coach/PE □ Office Staff □ School Staff

**SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER**

**CHECK ALL THAT APPLY:**

- Student instructed in proper use of their asthma medications, and in my opinion, CAN CARRY AND SELF-ADMINISTER INHALER AT SCHOOL.
- Student is to notify designated school health officials after using inhaler at school.
- Student needs supervision or assistance to use inhaler.
- Student should **NOT** carry inhaler while at school.

**MD/NP/PA SIGNATURE:** ___________________________ Date ________

[Virginia Asthma Action Plan approved by the Virginia Asthma Coalition (VAC) 4/11]

Based on NAEPP Guidelines and modified with permission from the D.C. Asthma Action Plan via District of Columbia Department of Health, DC Control Asthma Now, and District of Columbia Asthma Partnership.

Blank copies of this form may be reproduced or downloaded from www.virginiaasthma.org
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 (IHC) 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) __________________________ Expires date of epinephrine Unknown ☐

Epinephrine Administration Incident Reporting

7. Date/Time of occurrence: __________________________ Vital signs: BP __________ Temp ______ Pulses ________ 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 ☐ Cough ☐ Difficulty breathing ☐ Hoarse voice ☐ Stuffy or runny nose ☐ Swollen throat or tongue ☐ Shortness of Breath ☐ Stridor ☐ Tightness (chest, throat) ☐ Wheezing

GI ☐ Abdominal discomfort ☐ Diarrhea ☐ Difficulty swallowing ☐ Oral itching ☐ Nausea ☐ Vomiting

Skin ☐ Angioedema ☐ Flush ☐ General itching ☐ General rash ☐ Hives ☐ Lip swelling ☐ Localized rash ☐ Paleness

Cardio/Vascular ☐ Chest discomfort ☐ Cyanosis ☐ Dizziness ☐ Faint/Weak pulse ☐ Headache ☐ Low blood pressure ☐ Rapid heartbeat

Other ☐ Sweating ☐ Irritability ☐ Loss of consciousness ☐ Metallic taste ☐ Red eyes ☐ Sneezing ☐ Uterine cramping

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 ____________________________
   Transferred 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: ____________________________