Emergency Action Plan

Student _____Year_____

Diagnosis _____Teacher/ Grade: _____

Contact Numbers: Call _____at _____-
___

OR _____ at _____

If you see this: **Do this:**

Watch for possible emergency situations:

I have reviewed this plan and agree to it being shared with my Provider and School Staff to ensure the safety of my child.

Parent's Signature: _____ Date: _____

Nurse's Signature: _____ Date: _____

File: JHCD (1)

MEDICATION ADMINISTRATION AUTHORIZATION FOR SCHOOL PERSONNEL

CLEAR FORK VALLEY LOCAL SCHOOLS

Licensed Prescriber Section

It is necessary that _____ have medication during school hours.

He/She is in _____ grade at the _____ building. He/She must take:

MEDICATION: _____ Dosage_____

Time_____ Beginning date_____ End date_____

Possible reactions to be reported to Physician_____

_____

Special instructions to be followed in the administration of this drug, e.g. sterile conditions, special storage ect._____

_____ _____

Physician's Name (printed) Physician' signature

_____ _____ _____

Phone Address Date

Parent Permission

I, the parent/guardian of _____ give permission for the medication ordered by the above physician to be given at school.

1. Parent must deliver the medication to school in the original prescription container properly labeled by physician or pharmacist.
2. Parent must notify the school if I change physicians.
3. Parent must notify school if the medication or dosage is changed or eliminated.

_____ _____ _____

Parent/guardian signature Phone Date

_____

Address

Administrative Approval – office use only

_____ _____

Principal/Assistant Principal Signature Nurse Signature

Person(s) authorized to administer medication

Principal_____ Nurse_____

Secretary_____ Substitute_____

CLEAR FORK VALLEY LOCAL SCHOOLS

MEDICATION ADMINISTRATION AT SCHOOL

Dear Parents:

We receive many requests to administer medication at school. To assure that all students take their medication safely, in the appropriate dosages and at the appropriate time, please review the following steps required before school personnel administer medication (over the counter or Prescribed).

1. If at all possible, all medication should be given at home.
2. This form (reverse side) must be completed by both the physician/licensed prescriber and the parent/guardian.
3. All medication must be brought to the school office by the parent/guardian. Medication that is not picked up at the end of the school year will be disposed of.
4. Medication must be kept in the student's labeled prescription bottle. The prescription label must match instructions from the prescriber. If it is a non-prescription medication, it must be in the original container
5. New forms must be submitted each school year and for each new medication, dose or time occurs.

Item #1 above is very important. When possible, please attempt to give your child medication outside of school operation hours. Physicians can approve appropriate dosages of the medication so that it is possible to administer three doses to the child that would occur before school, immediately after school, and before bedtime.

Please contact the school nurse if you have any question.

We appreciate your help with this process.

Thank You,

Clear Fork Valley Local Schools

EMERGENCY CARE PLAN
ASTHMA

Student:_____ Grade_____ DOB:_____

Asthma Triggers:_____ Best Peak Flow:_____

Mother:_____ Home #_____ Cell#_____

Father:_____ Home #_____ Cell#_____

Emergency Contact:_____ Phone:_____

Symptoms of an Asthma episode may include any / all of these:

- **Changes in Breathing:** coughing, wheezing, breathing through mouth, shortness of breath
- **Verbal Reports of:** chest tightness, chest pain, cannot catch breath, dry mouth, "neck feels funny", doesn't feel well, speak's quietly.
- **Appears:** anxious, sweating,, nauseous, fatigued, stands with shoulders hunched over and cannot straighten up easily.

SIGNS OF AN ASTHMA EMERGENCY:

Breathing with chest and / or neck pulled in, sits hunched over, nose opens wide when inhaling. Difficulty in walking and talking.

- Blue-gray discoloration of lips and/or fingernails.
- Failure of medication to reduce worsening symptoms with no improvement 15 – 20 minutes after initial treatment.
- Peak Flow of _____ or below.
- Respirations greater than 30/minute
- Pulse greater than 120/minute

STAFF MEMBER INSTRUCTED: ☐Classroom Teacher ☐Special Area Teacher ☐Administration ☐Support Staff ☐Transportation Staff

TREATMENT:

- **Stop activity immediately**
- **Help student assume a comfortable position. Sitting up is usually more comfortable.**
- **Encourage purse lipped breathing. Like blowing through a straw**
- **Encourage fluids to decrease thickness of lung secretions**
- **Give medication as ordered**
- **Observe for relief of symptoms. If no relief noted in 15 – 20 minutes, follow steps below for an Asthma emergency.**
- **Other specific instructions**_____

STEPS TO FOLLOW FOR AN ASTHMA EMERGENCY:

- **CALL 911 AND INFORM THEM THAT YOU HAVE AN ASTHMA EMERGENCY. They will ask the student's age, physical symptoms, and what medications he/she has taken and usually takes.**
- **A staff member should accompany the student to the emergency room if the parent, guardian or emergence contact is not present and adequate supervision for other students if present.**

HealthcareProvider:_____ **Phone:**_____

Parent/Guardian Signature:_____ **Date:**_____

ASTHMA INHALER - SELF MEDICATION AUTHORIZATION FORM

Student Name _____ Date _____

Address _____

Medication Name _____

Dosage _____

Date the administration is to begin _____

Date the administration is to cease _____

Adverse reactions that should be reported to the physician _____

_____

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack _____

_____

Other special instructions _____

_____

Physician and parent/guardian names, signatures and emergency phone numbers:

Physician Name (printed)_____ Phone _____

Physician Signature _____ Date _____

Parent/guardian name (printed) _____

Home Phone _____ Work Phone

_____

Cell Phone _____

Parent/guardian signature _____ Date _____

(Adoption date: November 15, 2012)

Clear Fork Valley Local School District, Bellville, Ohio

EMERGENCY CARE PLAN

BEE STING ALLERGY

Student:_____Grade:_____DOB:_____

Asthmatic: ☐ Yes ☐ No (increased risk for sever reaction) severity of reaction:_____

Mother:_____Home#_____Cell#_____

Father:_____Home#_____Cell#_____

Emergency Contact:_____Phone:_____

SYMPTOMS OF AN ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:

- Mouth — Itching & swelling of lips, tongue or mouth
- Throat — Itching, tightness in throat, hoarseness, cough
- Skin — Hives, itchy rash, swelling of face and extremities
- Stomach — Nausea, abdominal cramps, vomiting diarrhea
- Lung — Shortness of breath, repetitive cough, wheezing
- Heart — "Thready Pulse", "passing out"
  - **The severity of symptoms can change quickly – it is important that treatment is given immediately**

STAFF MEMBERS INSTRUCTED: ☐ **CLASSROOM TEACHER** ☐ **SPECIAL AREA TEACHER**

☐ **ADMINISTRATION** ☐ **SUPPORT STAFF** ☐ **TRANSPORTATION STAFF**

TREATMENT: Remove stinger if visible, apply ice to area Rinse contact area with water

Treatment should be initiated ☐ with symptoms as noted above ☐ Without waiting for symptoms

Benadryl ordered ☐ Yes, give as ordered ☐ No ☐ Call 911 ☐ Call Parent only

Epinephrine ordered: Yes, give as ordered No Call 911 whenever epinephrine given

Other/Special Instructions:_____

_____

Send a runner to contact: ☐ School Nurse if there ☐ Secretary to call parent/guardian

IF ANY SYMPTOMS BEYOND REDNESS OR SWELLING AT THE SITE OF THE STING ARE PRESENT AND EPINEPHRINE IS ORDERED, GIVE EPINEPHRINE IMMEDIATELY AND CALL 911.

Epinephrine provides a 20 minute response window. After epinephrine, a student may feel dizzy or have an increased heart rate, this is a normal response. Students receiving epinephrine should be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present.

Healthcare Provider:_____Phone:_____

Parent/Guardian Signature:_____Date:_____

Ohio Department of Health

Authorization for Student Possession and Use of an Epinephrine Auto Injector

In accordance with ORC 3313.78/3313.141

A completed form must be provided to the school principal and/or nurse before the student may possess and use an epinephrine autoinjector to treat anaphylaxis in school.

Student name:
Student Address:

This section must be completed and signed by the student's parent or guardian.
As the Parent/Guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school, and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will **provide a backup dose of the medication to the school principal or nurse as required by law.**

Parent/Guardian signature_____ Date_____

Parent/Guardian name_____ Phone:_____

This section must be completed and signed by the medication prescriber.

Name and dosage of medication:	
Date medication administration begins:	Date medication administration ends:

Circumstances for use of the epinephrine autoinjector:_____

Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief:

_____

_____

Possible severe adverse reactions

To the student for which it is prescribed (that should be reported to the prescriber)_____

_____

To a student for which it is not prescribed who receives a dose_____

Special instructions:_____

_____

As the prescriber, I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

Prescriber signature:_____ Date:_____

Prescriber name:_____ Phone:_____

Developed in collaboration with the Ohio Association of School Nurses. HEA 4222 3/07

DIABETES MEDICAL MANAGEMENT PLAN FOR SCHOOL

Student:_____ **DOB:**_____

School:_____ **Building:**_____

Type of Diabetes: ☐ **Type 1** ☐ **Type 2** ☐ **Pre Diabetes** **Date of diagnosis**_____

☐ **Other:**_____

Blood Glucose Monitoring

☐ Meter type:_____ ☐ Blood glucose target _____ - _____

☐ Blood glucose testing times: _____ _____ _____ _____ _____

☐ For suspected hypoglycemia ☐ At student's discretion excluding suspected hypoglycemia

☐ Only at student's discretion ☐ No blood glucose testing at school

☐ Permission to test independently ☐ Supervision of testing/results

☐ Student will need assistance with testing and blood glucose management

☐ Test blood glucose 10 to 20 minutes before boarding bus.

Diabetes Medication

☐ No insulin at school: Current insulin at home:_____

☐ Oral diabetes medication at school:_____

☐ Insulin at school: ☐ Humalog ☐ Novolog ☐ Lantus ☐ Other:_____

☐ Insulin delivery device: ☐ Syringe and vial ☐ Insulin Pen ☐ Insulin Pump

Insulin dose for school:_____

Standard lunchtime dose:_____

☐ Meal Bolus:_____ units of insulin per _____ grams of carbohydrate

☐ Correction for blood glucose: _____units of insulin for every _____md/dl above _____mg/dl
(correction bolus can be given with meals or every 3 hours if blood glucose levels are high)

Blood Glucose Value (mg/dl)	Units of Insulin
< 100	
100 - 150	
151 - 200	
201 - 250	
251 - 300	
301 - 350	
352 - 400	
More than 400	

Note: insulin dose is a total of meal bolus and correction bolus.

☐ Parent may adjust insulin doses as needed. ☐ Student may self-manage

DIABETES MEDICAL MANAGEMENT PLAN FOR SCHOOL (cont.)

MEAL PLAN

☐ Meal plan prescribed (see below)
Breakfast Time:_____
Morning Snack Time: _____
Lunch Time:_____
Afternoon Snack Time:_____

☐ Meal plan variable
# of carb choices = _____
# of carb choices = _____
# of carb choices = _____
# of carb choices = _____

☐ Plan for pre-activity:_____
☐ Plan for after school activities:_____
☐ Plan for class parties:_____
☐ Extra food allowed: ☐ Parent/guardian's discretion ☐ Student's discretion

HYPOGLYCEMIA

LOW BLOOD GLUCOSE < _____MG/DL

☐ Self- treatment of mild lows ☐ Assistance for all lows
☐ Immediately treat with 15 gm of fast-action carbohydrate (e.g.; 4 oz juice, 3 – 4 glucose tabs, 4 oz regular pop, 8 oz of Skim milk.
☐ Recheck blood glucose in 15 minutes and repeat 15 gm of carbohydrate if blood glucose remains low.
☐ If more than 1 hour until next meal or snack student should have another 15 gm of carbohydrate.
☐ If child will be participating in additional exercise or activity before the next meal, provide an additional carbohydrate Choice.
☐ If student is using an insulin pump, suspend pump until blood glucose is back in normal range.

SEVERE HYPOGLYCEMIA

☐ If the child is unconscious or having seizures due to low blood glucose immediately administer injection of:
GLUCAGON _____MG (GLUCAGON EMERGENCY KIT)

- Immediately after administering the Glucagon, turn child onto their side. Vomiting is a common side effect Of Glucagon.
- Notify parent and EMS per protocol

HYPERGLYCEMIA

High Blood Glucose > = _____mg/dl

☐ Check ketones when blood glucose > _____mg/dl or student is sick.
☐ Use correction scale insulin orders when blood glucose is _____mg/dl
☐ Unlimited bathroom pass.
☐ Notify parent immediately of blood glucose > _____mg/dl or if student is vomiting.
☐ If student is using an insulin pump, follow DKA prevention protocol

SPECIAL OCCASIONS

☐ Arrange for appropriate monitoring and access to supplies on all field trips.

_____ _____
Signature of Physician/Licensed Prescriber Date

_____
Print name of Physician/Licensed Prescriber

Returned to:_____ _____
RN, School Nurse Signature Date

FOOD ALLERGY ACTION PLAN

Name:_____D.O.B._____

Allergy to :_____

Weight:_____lbs. Asthma ☐ Yes (higher risk for a severe reaction ☐ No

Extremely reactive to the following foods:_____

THEREFORE:

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

☐ If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms

Any SEVERE SYMPTOMS after suspected or known Ingestion

LUNG: SHORT OF BREATH, WHEEZE, REPETIVIE COUGH
HEART: Pale, blue, faint, weak pulse, dizzy, confused
Throat: Tight, hoarse, trouble breathing/swallowing
Mouth: Obstructive swelling (tongue and/or lips)
Stomach: Vomiting, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. **CALL 911**
3. Begin monitoring (See Box Below)
4. Give additional medications
   Antihistamine, inhaler if asthma

*Antihistamines & Inhalers/bronchodilators are not to
Be depended upon to treat a severe reaction (ANAPHYLAXIS)
USE EPINEPHRINE

MILD SYMPTOMS ONLY:
MOUTH: ITCHY MOUTH
SKIN: A FEW HIVES AROUND MOUTH/FACE, MILD ITCH
STOMACH: MILD NAUSEA/DISCOMFORT

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent.
3. If symptoms progress (see above) GIVE EPINEPHRINE
4. Begin monitoring

MEDICATIONS/DOSES

Epinephrine (brand and dose):_____
Antihistamine (brand and dose):_____
Other (e.g. Inhaler-Bronchodilator if Asthmatic):_____

MONITORING

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request and ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached.

_____ _____
Parent/Guardian Signature Date

_____ _____
Physician/Healthcare Provider Signature Date

MIGRAINE HEALTH CARE PLAN

NAME _____ SCHOOL YEAR _____
DOB _____ SCHOOL _____
PRACTITIONER _____ GRADE _____
PHONE _____ FAX _____

☐ **Migraine symptom are no longer an issue for my child. (Please sign and return Care Plan)**

The above student has been diagnosed with migraine headaches. Migraines in this child are often identified by the following characteristics:

_____ Moderate to severe pain intensity
_____ Throbbing pain
_____ Disabling pain
_____ Nausea and/or vomiting
_____ Photophobia
_____ Phonophobia

This child has been prescribed: Give medication(s) at onset of migraine, without delay.

Medication	Dosage	Time(s)	Route	Taken at Home or School	

Potential side effects to watch for include:_____

If needed, please allow the child to rest for_____. After this time, the child may return to the classroom if pain relief is achieved or if the child feels they can continue to function.

Please notify the Parent if:

- Headache does not respond to given treatment within 2 hours
- Headaches have a sudden change in characteristics or features
- Headaches seem to be increasing in frequency

Other notes:_____

Please supply the school with the needed medication(s) on or prior to the first day of school

_____

Parent/Guardian Signature **Date**

_____

'ractitioner Signature **Date**

SEIZURE ACTION PLAN (SAP)

EPILEPSY FOUNDATION END EPILEPSY

ıme: _____ Birth Date: _____

Address: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Emergency Contact/Relationship _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

Protocol for seizure during school (check all that apply) ☑

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify parent/emergency contact
- ☐ Contact school nurse at _____
- ☐ Call 911 for transport to _____
- ☐ Other _____

First aid for any seizure

- ☐ **STAY** calm, keep calm, **begin timing seizure**
- ☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe magnet for VNS
- ☐ Write down what happens _____
- ☐ Other _____

When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked

When **rescue therapy** may be needed:

WHEN AND WHAT TO DO

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

ame of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

Care after seizure

What type of help is needed? (describe) _____

When is student able to resume usual activity? _____

Special instructions

First Responders: _____

_____

Emergency Department: _____

_____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: _____

Important Medical History _____

Allergies _____

Epilepsy Surgery (type, date, side effects) _____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted _____

Diet Therapy ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) _____

Special Instructions: _____

_____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature _____ Date _____

Provider signature _____ Date _____

EPILEPSY FOUNDATION | END EPILEPSY