Intervention Guides / Emergency Action Plans

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RALEIGH COUNTY SCHOOL HEALTH SERVICES
EMERGENCY ACTION PLAN/INTERVENTION GUIDE

ADD/ADHD

Student Name: ___________________ DOB: _______ Grade/Teacher: __________________

EMERGENCY CONTACT INFORMATION

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Meds student is taking at home ____________________________________________

Student will be taking __________________________ at school and should report to the __________________________ daily at ________________

<table>
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<tr>
<th>IF YOU SEE THIS:</th>
<th>DO THIS:</th>
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<tbody>
<tr>
<td>Loss of appetite, weight loss, persistent headache or stomachache, occasional motor tics &amp; nervousness</td>
<td>*Notify school nurse for monitoring, as these are common side effects, especially when initiating new meds or changing doses. *Notify parent if persists or of great concern.</td>
</tr>
<tr>
<td>Persistent and frequent motor or vocal tics: *Motor: rapid repetitive muscle movements such as eye blinking, shoulder shrugging, head jerking, facial twitching or other movements *Vocal: sniffing, snorting, throat clearing, coughing, verbal outbursts, grunting, barking, repeating words or stuttering</td>
<td>*Notify school nurse and/or parent immediately for follow up with physician. *Teacher may keep a log of occurrences of tics.</td>
</tr>
<tr>
<td>Continued signs of inattention, impulsivity, and/or hyperactivity</td>
<td>*Report specific incidents/behaviors to parents and nurse.</td>
</tr>
</tbody>
</table>

I understand and agree that per WVDE Medication Policy 2422.8:
1. I (or an adult delegate) must deliver all medication to the office and sign it in on the medication log.
2. Agree never to send the medication with my child.
3. Agree to supply refills in a prompt manner when notified, to avoid missed doses.

I understand and agree that information in this Emergency Action Plan will be shared with appropriate school staff.

Parent/Guardian Signature: ____________________________ Date: ________________

School Nurse: ____________________________ School Nurse Signature: ________________ Date: ________________

To Be Completed By School Nurse

Location of medicine: ____________________________

Revised 10/2018
Adrenal Crisis Action Plan

*Administered by Certified school nurse, or other licensed health care provider such as an RN or LPN, or designated trained personnel under the direct or indirect supervision of the certified school nurse-RN.

Student’s Name: ___________________________
Date of Birth: _______ Grade: _____ __ School: __________ Date _______

This is a letter for our patient ___________________, who has a diagnosis of threatening state caused by insufficient levels of cortisol, which is a hormone produced and released by the adrenal gland. An intramuscular injection (IM) of Solu-Cortef (an Injectable corticosteroid) must be given as soon as possible to increase the chance for a quick recovery. Risk factors for adrenal crisis include physical stress such as infection, illness, dehydration, or trauma. In situations where one or more of the risk factors are present, IM Solu-Cortef is required.

For one or more of the checked symptoms below administer Solu-Cortef ________ml, which is ________mg IM. This injection should be given immediately, and the patient should be promptly evaluated by a physician in the nearest emergency room (daily 911).

- [ ] Severe Illness
- [ ] Chills
- [ ] Fever of > or equal to 100 degrees F
- [ ] Irregular heart beat
- [ ] Shortness of breath
- [ ] Sudden confusion/unconsciousness
- [ ] Trauma
- [ ] Other: ____________________________

I, the parent or guardian of _____________________________ (student’s name), agree with his/her physician to allow school nurse or designated personnel to administer the above prescribed dose of Solu-Cortef IM to my son/daughter __________________________ (student’s name). I understand that the designated trained personnel will be trained and under direct or indirect supervision of the certified school nurse (RN).

Parent or Guardian accepts responsibility for the following:

1. Providing Solu-Cortef (un-expired vial) to the school nurse upon student enrolling in school. Medication must be properly labeled from the pharmacy.
2. Promptly communicating changes in the student’s physical condition with the school nurse and/or school staff.
3. Providing updated Action Plan yearly and for changes in emergency doses signed by physician.
4. Provide and keep current emergency numbers to be used for contacting aren’t in case of emergency.
5. Will discuss with the school nurse side effects observed from previous Solu-Cortef IM injections, if any.

Action for Major Reaction:

1. Give above prescribed dose of IM Solu-Cortef
2. Call 911
3. Call parent(s) or guardian(s) and school nurse: Contact Number(s): ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

_________________________          __________________________          ___________________________
Physicians Name          Physicians Signature          Physicians Telephone No.

_________________________          __________________________
Parent’s/Guardian’s Name          Parent’s/Guardian’s Signature

_________________________          __________________________
Parent/Guardian Telephone No.
RALEIGH COUNTY SCHOOL HEALTH SERVICES
EMERGENCY ACTION PLAN/INTERVENTION GUIDE

Severe Allergic Reaction

Student Name: ___________________ DOB: ___________ Grade: ______
Teacher: ___________________ School: ___________________
Student is allergic to: ___________________

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*If the School Nurse is in the building please notify nurse immediately!*

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<th>DO THIS:</th>
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<td><strong>Mild Symptoms:</strong></td>
<td><strong>If school nurse is in the building please notify immediately.</strong></td>
</tr>
<tr>
<td>- Nose- itchy, runny nose &amp; sneezing</td>
<td><em>Keep student calm and remain with student.</em></td>
</tr>
<tr>
<td>- Skin- a few hives, mild itch</td>
<td><em>Student has _____________________________ (Medication) at school, administer per physician order.</em></td>
</tr>
<tr>
<td>- Mouth- itchy mouth</td>
<td><em>Call Parent</em></td>
</tr>
<tr>
<td>- Gut- mild nausea/discomfort</td>
<td>*Watch student closely for changes. If symptoms worsen, give Epinephrine (if ordered). (<em>If insect sting apply ice)</em></td>
</tr>
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</table>

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<th><strong>More Severe Symptoms:</strong></th>
<th><strong>If school nurse is in the building please notify immediately.</strong></th>
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<tr>
<td>- Lung- short of breath, wheezing, repetitive cough</td>
<td><strong>Notify school nurse immediately.</strong></td>
</tr>
<tr>
<td>- Heart- pale, blue, faint, weak pulse, dizzy</td>
<td><strong>Activate Blue Team and CALL 911 and parent</strong></td>
</tr>
<tr>
<td>- Throat- tight, hoarse, trouble breathing/ Swallowing</td>
<td><strong>Student has Epinephrine ordered? □ Yes □ No</strong> If YES- then <strong>INJECT EPINEPHRINE IMMEDIATELY!</strong></td>
</tr>
<tr>
<td>- Mouth- Significant swelling of tongue &amp;/or lips</td>
<td><strong>Lay the student flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side.</strong></td>
</tr>
<tr>
<td>- Skin- many hives over body, widespread redness</td>
<td><strong>If symptoms do not improve, or symptoms return, sometimes a second dose of Epinephrine can be given</strong></td>
</tr>
<tr>
<td>- Gut- repetitive vomiting or severe diarrhea</td>
<td><strong>Transport student to ER even if symptoms resolve.</strong></td>
</tr>
<tr>
<td>- Other- feeling something bad is about to happen, anxiety, confusion</td>
<td></td>
</tr>
<tr>
<td><strong>May have a combination of mild or severe symptoms from different body areas</strong></td>
<td></td>
</tr>
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</table>

This Emergency Action Plan will be shared with appropriate school staff.

School Nurse: ___________________________ School Nurse Signature: __________________ Date: __________

*Location of medicine ___________________________*  
*To Be Completed By School Nurse*

Revised 10/2018
RALEIGH COUNTY SCHOOLS
School Health Services
Annual Health Assessment

Student: ________________________________  DOB: ___________________________  Grade: __________

School: ________________________________  Care Plan/Memo Focus: __________________________

School Year: ___________ ___________ ___________  __________________________

ASSESSMENT

A. Date Health Assessment Update Requested: __________________________

1) From:  2) By:  3) Release form Sent:

_____ Parent  _____ Letter  _____ Yes

_____ Physician  _____ Telephone  _____ No

_____ Student  _____ Visit/Meeting*

B. Date Health Update/Orders Received: __________________________

1) Emergency Medicine Required?  Yes ____  No ____

Present at School?  Yes ____  No ____

_____ Emergency Seizure Medication  Expires _______

_____ Epinephrine  Expires _______

_____ Benadryl  Expires _______

_____ Glucagon  Expires _______

_____ Inhaler  Expires _______

_____ Other __________________________  Expires _______

____ Health Intervention Guide

____ Informational Memorandum

____ Dietary Sheet

Distributed to:  Date: ________

_____ Principal

_____ Counselor

_____ School Cooks

_____ Food Service Director

_____ Parent

_____ Bus Driver # ______

_____ Special Education

_____ Secretary

Date: _______

Teachers and/or School Staff:

__________________________

__________________________

__________________________

__________________________

__________________________

Date Completed: ____________  Signature: ______________________________________
RALEIGH COUNTY SCHOOL HEALTH SERVICES
EMERGENCY ACTION PLAN/INTERVENTION GUIDE

ANXIETY/PANIC ATTACKS

Student Name: ___________________ DOB: _______ Grade:_____
Teacher: _________________________ School:_________________

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IF YOU SEE THIS:

Physical Symptoms:
Dizziness, light-headedness, fainting, sweaty or clammy feeling skin, flushing, breathing fast, palpitations, pacing, pupil dilation, trembling, and restlessness.

Behavioral Symptoms:
Crying, Difficulty Concentrating, Memory Problems, Hopelessness, Poor Appetite, Poor sleeping.

*If fainting episode occurs and no injury sustained call parent/guardian immediately to pick up student. If injury is sustained, call for Blue Team and follow Blue Team protocol.*

DO THIS:

*Please notify School Nurse if in the building*

*Assist student to reduce present level of anxiety by:
*Remove from classroom to safe location (i.e.-counselor or nurse's office)
*Never send student anywhere alone*
*Provide reassurance and comfort
*Speak in short, simple sentences
*Stay with person
*Don't make demands/request any decisions
*Speak slowly and calmly

*Encourage student to relax by taking slow, deep breaths.*

*Use relaxation techniques: identify, and help to relax, the parts of the student's body that get the tensest during a panic attack. First tense and then relax the muscles of the jaw, neck, shoulders, back and legs.

*If hyperventilating student may complain of dizziness or numbness/tingling in extremities. Assist student in slowing his/her breathing down by encouraging to breath in through their nose and blow out through their mouth or may use brown paper bag to breathe in and out of.

*Notify parent/guardian if symptoms do not resolve within ________ minutes.

*Student has available __________ (Medication) at school and should report to __________ (Location).

This Emergency Action Plan will be shared with appropriate school staff.

School Nurse: ____________________________

School Nurse Signature ____________________ Date ____________

To Be Completed By School Nurse

Location of medicine _________________________

Revised 10/2018
RALEIGH COUNTY SCHOOL HEALTH SERVICES
EMERGENCY ACTION PLAN/INTERVENTION GUIDE

**ASTHMA**

Student Name: ___________________ DOB: _______ Grade/Teacher: __________________

### EMERGENCY CONTACT INFORMATION

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*If the School Nurse is in the building please notify nurse immediately!* *

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<th><strong>DO THIS:</strong></th>
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</thead>
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<tr>
<td><strong>Onset of Symptoms:</strong></td>
<td><em>Encourage student to stay calm- breathe in through nose and blow out through mouth.</em></td>
</tr>
<tr>
<td>Coughing, Wheezing, Shortness of Breath, Chest Tightness, Rapid Breathing, Working Hard to Breath, Anxiety</td>
<td><strong>Student has available: ___________________________</strong> Inhaler at school and should report to ___________________________ (Location).</td>
</tr>
<tr>
<td></td>
<td><em>If student has had an asthma attack at school, restrict physical activity and allow the student to rest.</em></td>
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<tr>
<td></td>
<td><em>If no relief within 10 minutes, call school nurse and/or parent.</em></td>
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<tr>
<td></td>
<td><em>Inhaler to be used _____ minutes prior to gym/recess. □ Yes □ No</em></td>
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<tr>
<th><strong>For Worsening Symptoms:</strong></th>
<th><strong>DO THIS:</strong></th>
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</thead>
<tbody>
<tr>
<td><em>Failure of medications to reduce worsening symptoms</em></td>
<td><em>Call for Blue Team</em></td>
</tr>
<tr>
<td><em>Difficulty breathing, walking, &amp; talking</em></td>
<td><em>Stay with student and monitor breathing pattern</em></td>
</tr>
<tr>
<td><em>Blue/gray discoloration of lips/fingernails and skin</em></td>
<td><em>Call parent/guardian</em></td>
</tr>
<tr>
<td></td>
<td><em>Call 911 if symptoms continue to worsen (blue lips/fingernails/skin).</em></td>
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<tr>
<td></td>
<td><em>Be prepared to start CPR if breathing stops</em></td>
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</table>

This Emergency Action Plan will be shared with appropriate school staff.

School Nurse Received and Reviewed: ___________________________ ___________________________  
School Nurse Signature: ___________________________ Date: ___________________________

**To Be Completed by School Nurse**

*Location of medicine*  
__________________________________________________________________________
RALEIGH COUNTY SCHOOL HEALTH SERVICES
School Year ____________
SCHOOL EMERGENCY ASTHMA CARE PLAN

School __________________________________________ DOB: ______________________

Student: __________________________________________ Phone: (H) ______________________ (W) ______________________ (Cell): ______________

Parent: __________________________________________ Phone: ______________________

Second Contact Person: ______________________________ Phone: ______________________

Common Asthma triggers: _______________________________________

Common asthma attack signs and symptoms include:
- Persistent coughing • Shortness of breath • Wheezing while breathing in or out • Chest Tightness

Steps to take during an asthma episode:

1. Give medications as listed: ______________________

2. Contact parent if no improvement seen.

Emergency Asthma Medications: Refer to attached medication forms.

Location of inhaler/nebulizer: ______________________

CALL 911 NOW FOR:
- □ Rapid, labored breathing
- □ Pulling of skin of neck and chest with breathing and nasal flaring
- □ Can talk only in short, clipped sentences
- □ Blueness around mouth and nailbeds (paleness in children of color)
- □ Change in mental status (becoming agitated, anxious, declining consciousness)
- □ Sweaty, clammy skin

NEVER SEND A CHILD WITH A SUSPECTED ASTHMA ATTACK ANYWHERE ALONE

*Remember to take inhaler on field trips!*  Date: __________________________

This student has a prescribed inhaler for asthma and:
- □ Demonstrates correct use of the inhaler
- □ Acknowledges proper timing for inhaler use
- □ Has demonstrated independent use of the inhaler, but
  needs assistance to know when medicine is needed.
- □ Knows when inhaler is to be used
- □ Needs assistance with physical use of the inhaler
- □ Has parent and physician permission to independently carry and use asthma inhaler

Distribution List
- □ Teaching staff
- □ PE teacher/Music teacher
- □ Secretary
- □ Principal
- □ Guidance
- □ Bus driver

Student’s Signature ____________________________ Date __________

Nurse’s Signature ____________________________ Date __________

Adopted 10/04
Revised 7/12
# Raleigh County School Health Services

## Health Intervention Guide & Emergency Plan for Bleeding Disorders

**Student:**

**Intervention Guide Focus:** *Bleeding Disorders*

**Nursing Diagnosis:** Potential for alteration in cardiac functioning related to inability to maintain adequate volume of circulating blood

**Student Goal:** Student will appropriately respond to treatment of bleeding episode

**Physician Order/Parent Request:**

## Explanation of Bleeding Disorders

Hemophilia, von Willebrand disease and platelet disorders are three bleeding episodes that result in prolonged bleeding in various parts of the body. These bleeding episodes can occur spontaneously or after some type of trauma. Although hemophilia occurs mostly in males, von Willebrand disease and platelet disorders can occur in both males and females. In school, a student with one of these bleeding disorders will require extra assistance during a bleeding episode. Treatment of bleeding episodes depends on the severity of the episode.

**Symptoms of Bleeding Indicating the Need to Administer First Aid & Call Parent:**

Student should be closely observed for any signs of bleeding such as:

### Obvious Bleeding:
- *nosebleed
- *cut or lacerations
- *bleeding from gums

### Bleeding Related to Blunt Injury:
- *student complains of tingling or ache in area
- *swelling of body area
- *pain in body area

### Trauma to Joint:
- *swelling of joint
- *inability to move joint

### Other Signs of Trauma:
- *blurred vision
- *slurred speech
- *loss of consciousness
- *change in color of urine or stool
- *complains of headache
- *change in behavior

**Comments on Student's Health Condition:**

## Staff Responsibilities & Action Steps

Call parent immediately when bleeding is noted! If condition seems to be worsening and parent has not arrived or unable to contact parent, call 911 for ambulance transport to hospital. Also provide the following first aid:

**If a student has external bleeding from a cut, scrape or laceration:**
- *put on gloves—use Standard Precautions
- *clean the cut, scrape or laceration with soap & water
- *apply firm pressure and elevate body part until bleeding stops
- *apply sterile dressing/bandage
- *limit movement of affected area
- *apply ice to area over dressing/bandage

**If a student has a nosebleed:**
- *put on gloves—use Standard Precautions
- *position student in upright position
- *pinch the bridge of the nose using firm continuous pressure for 20 minutes
- *apply a cold pack to the back of the neck

**If a student has a blunt injury to body or joint:**
- *immobilize the joint or body area
- *if joint, apply ice and elevate body part
- *monitor area for increase in size
- *do not allow student to move

**If student experiences trauma to head:**
- *remain with student; do not allow student to get up or move around
- *observe for complaints of headache, blurred vision, slurred speech, change of behavior, and change in level of consciousness
- *call parent and/or ambulance immediately

*Adopted 7/06*
RALEIGH COUNTY SCHOOL HEALTH SERVICES
EMERGENCY ACTION PLAN/INTERVENTION GUIDE

CARDIAC

Student Name: ___________________________ DOB: ________ Grade: ________
Teacher: ________________________________ School: ______________________

The student has the following restrictions/limitations: ____________________________________________
The following safety measures need to be taken during the school day: ________________________________

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*If School Nurse is in building please notify nurse immediately!*

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<th>IF YOU SEE THIS:</th>
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<td>Shortness of Breath</td>
<td>*Encourage to lean slightly forward and breathe through pursed lips.</td>
</tr>
<tr>
<td></td>
<td>*Contact parent with any episode.</td>
</tr>
<tr>
<td></td>
<td>*Adult stays with student and watches for any worsening of symptoms.</td>
</tr>
<tr>
<td>Chest Pain</td>
<td>*Allow to rest in whichever position is most comfortable</td>
</tr>
<tr>
<td></td>
<td>*Contact parent with any episode.</td>
</tr>
<tr>
<td></td>
<td>*Adult stays with student and watches for any worsening of symptoms.</td>
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</table>

LIFE-THREATENING SYMPTOMS:
- Sudden Severe Chest Pain
- Sudden Severe Shortness of Breath
- Loss of Consciousness

**Activate Blue Team and Call 911**
**NOTIFY SCHOOL NURSE**

BREATHING STOPS

**Activate Code Blue and Call 911**
**Begin CPR/RESCUE BREATHING**

School Nurse: ___________________________ School Nurse Signature __________ Date __________

Revised 10/2018
RALEIGH COUNTY SCHOOL HEALTH SERVICES
EMERGENCY ACTION PLAN/INTERVENTION GUIDE

[Box: CEREBRAL PALSY]

Student Name: ______________________ DOB: _______ Grade: _______
Teacher: ___________________________ School: ______________________

The student has the following restrictions/limitations: ______________________
The following safety measures need to be taken during the school day: ________________

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| Shortness of Breath, Fatigue | *Allow to rest in whichever position is most comfortable.  
*Contact parent with severe or frequent episodes.  
*Adult stays with student and watches for any worsening of symptoms. |
| Severe Muscle Spasms | *Clear area around student so that so that student doesn’t injure self.  
*If vomiting or choking, position student on side.  
*If loss of bowel/bladder control, please cover with blanket to provide privacy.  
*Notify parent AND school nurse of episode. |
| Complaints of Pain | *Administer pain medication if prescribed.  |
| Choking            | *Initiate Heimlich Maneuver, and call Blue Team  
*Call 911. |

This Emergency Action Plan will be shared with appropriate school staff.

School Nurse: ___________________________ School Nurse Signature: ______________________

Date: ______________________  Revised: 10/2018
RALEIGH COUNTY SCHOOLS

School: ________________

CODE BLUE SCHOOL PLAN YEAR: ________________

CODE BLUE

♦ A medical emergency where one or more people are seriously ill or injured and cannot be safely escorted to nurse (or secretary if no nurse in the building). The immediate concern is to aid the injured or sick student. Medical emergencies and/or accidents can occur at any time and may involve a student or employee. Some emergencies may only require first aid care, while others may require Emergency Medical Services (EMS). When in doubt, it is better to err on the side of caution and call 911. All emergencies involving EMS must be reported to the office of the Superintendent and Safety Officer by the principal or designee within the same day. Do not call CODE BLUE TEAM if there is not a medical emergency as defined above.

Code Blue Team Members: (Please list below, it is highly recommended that all Code Blue Team Members have First Aid/CPR certification)

1. ____________________________ 5. ____________________________
2. ____________________________ 6. ____________________________
3. ____________________________ 7. ____________________________
4. ____________________________ 8. ____________________________

Responsibilities During a Code Blue Team Emergency

Administrator

♦ Coordinates members of the code blue team and assures code blue scene safety.

Nurse

♦ Assess the scene, address any life-threatening injuries and determine if EMS needs activated. The person with the highest medical degree will lead the code blue team. Example: RN would lead if in building. If SBHC provider is on site, he/she would lead the code.

Secretary

♦ Communicates with EMS and parent/guardians.

Counselor or Resource Officer

♦ Sets up/monitors traffic pattern and helps maintain safety of the scene.

Teachers/Staff not on Code Blue Team

♦ Stay with students and continue instruction. No students should be traveling hallways during active code.

July 2018
In the Event of a Code Blue:

1. Call office (ext. ___) and state emergency and report location. If secretary does not answer dial ________ or _____________________________.

2. Secretary announces “Code Blue Team report to ____________”. Repeat announcement two times. Announce Code Blue Team on two-way radio (if available in your school). Secretary is to remain in the office to handle calls and two-way radio communications.

3. All teachers will stay with their students and instruction continues uninterrupted. If the code location is near your classroom, please close classroom door. Bells are disregarded during code blue team response. However, do not disregard if the fire alarm is sounded.

*When code blue team announcement is heard over the intercom, the following people will relieve Code Blue Team Members of current duties. Coverage will be as follows:

_________________________ to relieve ___________________________

_________________________ to relieve ___________________________

4. ______________________ will be responsible for obtaining emergency bag, two-way radio, and will report to code blue team scene. May need to retrieve medication from nurse’s office/classroom/secretary’s office, if necessary. The alternate for obtaining emergency bag will be _______________________.

5. ______________________ will be responsible for obtaining AED and reporting to code blue scene. If your building has more than one AED, get the one closest to you or the scene.

6. The remaining code blue team members will report immediately to the emergency location and, upon arrival, the following needs to be implemented:
   - Assess scene for safety.
   - Address life threatening injury and determine responsiveness of student/injured person(s). Remember to check ABC (Airway, Breathing and Circulation) and start CPR if necessary. Apply direct pressure to severe hemorrhage or to nearest blood vessel. **DO NOT MOVE HEAD/SPINE** of injured, only if in imminent danger (i.e. fire). Assess and determine if EMS needs activated.
   - Report information from team to the secretary and activate EMS if directed by principal or lead on the team. After activating EMS, secretary will notify parent/guardian.
   - Take notes of events for later documentation.
   - Maintain crowd control and privacy of injured person.
   - Custodian or designee to meet EMS if called and bring responders to code blue scene.
   - Two Code Blue Team Members must stay with the student/injured person until EMS staff arrive and assume responsibility for care. (The first member to arrive should remain with injured person).
   - The principal or designee will coordinate all calls and notifications.

July 2018
7. If EMS is called, principal or designee will notify the Superintendent/Assistant Superintendent.

8. ______________ and/or ______________ will be responsible for completing the Code Blue Team Documentation Form and call school nurse following incident. If injured person is student, an accident report must be completed by eye witness or first staff on the scene. If injured person is a staff member, an incident/accident report must be completed.

9. Normal school operations will resume when the principal or designee makes the announcement.
Raleigh County Schools CODE BLUE TEAM Documentation Form

Name: ________________________________ DOB: ____________________

Date and time of incident/illness: ___________________________ EMS Notified: Yes/No Time: ______

Parent/Guardian notified: Yes No Name: ____________________________ Phone # ________________

Allergies: __________________________________________________________ Last oral intake: ____________

Pertinent past medical history: ______________________________________________________________________________________

Medications: None Unknown List _____________________________________________________________________________________

Baseline mental status: A-is alert V-responds to voice P-responds to pain U-unresponsive

Reason for calling Code Blue Team:
- Allergic reaction
- Breathing difficulty
- Uncontrolled Bleeding from injury
- Seizure
- Other: ____________________________________________________________

Initial physical findings: ____________________________________________________________________________________________

Treatment/medication given:
- Epinephrine auto injector/Benadryl: Dose __________ Time: __________
- Inhaler/Nebulizer medication: ____________________________ Time: __________
- Emergency Seizure Medication: Name: ______________ Dose ______ Time ______
- Bleeding controlled by direct pressure: Yes No
- Splinting: ____________________________________________________________

Response to interventions: Improved Condition worsened No Change

Describe next action(s) taken: ______________________________________________________________________________________

Vital signs: (if someone available to do them)

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<thead>
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</table>

Transported to Emergency Department: YES NO If yes, time___________ by whom: ____________________________

Signature of Code Blue Team Representative/First on Scene: ____________________________ Date: _____________

School Nurse Follow-up: ______________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Nurse Signature: ____________________________ Date: ____________
RALEIGH COUNTY SCHOOL HEALTH SERVICES

Continuous Glucose Monitor (CGM)

A Continuous Glucose Monitor (CGM) reads glucose levels from a sensor in the interstitial fluid (under the skin). It usually reads within 20% of a finger stick blood sugar value. It can be programmed to alert (vibrate or alarm) for high and low glucose levels. CGM is meant to provide additional glucose information. It is not approved for use in making treatment decisions.

Student: ___________________________ DOB: ____________ Date of Plan: ____________

Physician: ___________________________ Phone: ___________________________ Date of Orders: ____________

School Nurse: ___________________________ Phone: ___________________________

CGM: Brand/Model:

CGMs contain three parts: 1) Glucose sensor: Placed just under skin by the user with an inserter. The sensor contains an electrode that creates a small current to detect changes in glucose levels, 2) Transmitter: Connects to the sensor to send results to the receiver, 3) Receiver: Shows the glucose results and allows you to operate the CGM. (May be within pump) Software for data analysis: All CGMs integrate with proprietary software, which allows the user to track trends and communicate data to health care providers.

Alert Settings: CGM alerts for low or high glucose levels

Warning: Since the FDA has not approved CGM’s for treatment in Pediatrics, glucose levels must be confirmed with a fingerstick/meter before making a change in treatment. If student has symptoms/signs of hypoglycemia, check finger stick blood glucose level regardless of CGM.

Arrows: Arrows on the screen indicate the speed at which the glucose levels are changing. Arrows on the face of the monitor may point straight down, indicating a rapidly falling glucose level. The arrows may also point straight up, which means a rapid increase in glucose level. A horizontal or 45-degree arrow (or one arrow in contrast to two arrows) may mean that the glucose level is not changing as rapidly.

CGM will alert audibly if interstitial glucose sugar is less than _______ or above _______.

Pending Lows or Hypoglycemia:

• CGM screen shows < _____ mg/dl with or without arrow(s)
• Test finger blood sugar and follow Emergency Action Plan: Glucose Monitoring & Treatment
• Repeat finger blood sugar every fifteen minutes until level is within target range

Pending High or Hyperglycemia

• CGM screen shows > _____ mg/dl with or without arrow(s)
• Test finger blood sugar and follow Emergency Action Plan: Glucose Monitoring & Treatment
• Repeat finger blood sugar every 1.5-2.5 hrs. until level is within target range

Notify Parent/Guardian:

• Glucose Sensor becomes dislodged
• Soreness, redness or bleeding at infusion site
• Dislodged Infusion Set
• Leakage of insulin at connection to CGM or infusion site
• CGM Malfunction
• Repeated Alarms

Additional Information:

• Parents will calibrate CGM daily per manufacturing recommendations
• Sensors remain in place for 3 days up to a week, the parent is responsible for changing the sensor and site.
• Parents will set the alarms and notify school nurse of the parameters. Alarms should be used conservatively so as not to unnecessarily disrupt the student’s school activities.

• Parent: ___________________________ Date/Updated ___________________________

• School Nurse: ___________________________ Date ___________________________

Feb.2019
RALEIGH COUNTY SCHOOL HEALTH SERVICES
HEALTH INTERVENTION GUIDE & EMERGENCY PLAN
FOR DUCHENNE MUSCULAR DYSTROPHY

STUDENT: ___________________________ SCHOOL: ___________________________

INTERVENTION GUIDE FOCUS: *Duchenne Muscular Dystrophy*

NURSING DIAGNOSIS: Potential risk for injury related to decreasing ability to independently ambulate

STUDENT GOAL: Student will remain free of bodily injury or harm from accident

PHYSICIAN ORDER/PARENT REQUEST:

<table>
<thead>
<tr>
<th>EXPLANATION OF DUCHENNE MUSCULAR DYSTROPHY</th>
<th>STAFF RESPONSIBILITIES &amp; ACTION STEPS</th>
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</thead>
<tbody>
<tr>
<td>Duchenne Muscular Dystrophy is a genetic disease passed from one generation to the next in an X-linked recessive trait. This means females carry the defective gene that causes the disorder, but males are predominantly affected by the disease. The symptoms result from the weakness of the muscle. Progression of the disease is as follows: Children begin with difficulty in running and will have a characteristic “waddling” run. They will also have problems with going up and down steps. They typically then develop a “tiptoe walking” and forward curve of the spine. They will also have increased episodes of falling. The weakness progresses until the student can no longer walk and requires the use of a wheelchair. Weakness in their arms is typically present but does not create problems until after the student begins using a wheelchair. While the student is ambulatory, the focus should be on preventing any falls and also on maintaining the abilities the student has. Health issues of particular concern with these students are:</td>
<td>In advance, the teacher should assess the room for environmental adaptations that need to be made to prevent any falls and to allow the student to remain independent. Adaptations may include raised toilet seats, special desk tops, ramps and handrails. The following concerns are essential to providing care for the student:</td>
</tr>
<tr>
<td>1) respiratory infections</td>
<td>1) Identify the need to assist the student with ambulation through observing gait and classroom assessment of potential safety concerns.</td>
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<tr>
<td>2) contractures of the joints</td>
<td>2) Consult with physical therapist as needed to maximize the student’s safety and assure optimal independence.</td>
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<tr>
<td>3) heart complications</td>
<td>3) Anticipate environmental hazards as the student ambulates throughout the school.</td>
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<tr>
<td>Activities for the student are NEVER restricted. The student should be allowed to participate in all activities without restriction. Allow the student to self pace and to rest as needed.</td>
<td>4) Report any falls experienced by the student to the parent and complete a Report of Liability Accident.</td>
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<td>5) Notify the parent of any excessive fatigue noted with student.</td>
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<td>6) Advise parent of any outbreaks of contagious illnesses within the classroom</td>
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<td></td>
<td>7) Maintain confidentiality about the student’s health condition</td>
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</table>

Specific Concerns Related to the Student:

Adopted 7/06
EMERGENCY REPLACEMENT OF TRACHEOSTOMY TUBE

I. Guidelines: Tracheostomy tubes should not be changed in the school setting except in an emergency. An example of such an emergency would be if the tube became completely dislodged, or partially dislodged creating an obstruction at which point it may need to be removed. If the entire tube comes out it must be replaced immediately. Before a student with a tracheostomy is permitted to attend school, the certified school nurse must assess the level of care needed for that individual student.

Based on this assessment, a plan of care stating how this procedure can be safely performed in the school setting must be developed.

A. Equipment: (Parent responsibility unless otherwise noted).
   1. Sterile tracheostomy tube (with obturator). A tube the same size the child is using, and one smaller size should be available.
   2. Scissors.
   3. Twill tape/Velcro ties or commercially available tracheostomy securing device.
   4. Suction machine, including collecting bottle and connecting tube.
   7. Non-waxed disposable cups.
   8. Supply of sterile normal saline.
   10. Disposable medical gloves (county).
   12. Stethoscope (county).
   13. Face shield or goggles (county).

B. Personnel: Certified school nurse or other qualified licensed health care professional such as an RN or LPN with current training in replacing a tracheostomy tube under the direct or indirect supervision of the certified school nurse.

ESSENTIAL STEPS:

1. Position student with head tilted back as far as possible.
2. Open tracheostomy tube, moisten tube and obturator with sterile normal saline.
3. Insert tracheostomy tube with obturator into trach opening in neck where previous trach has just been removed.
4. Hold tracheostomy tube, pull out the obturator and insert cannula. Hold on to the newly placed tube carefully at its insertion sight. Minimize movement as much as possible. Assess breathing status. Suction or use manual resuscitator as indicated. Replace trach ties, if needed, or secure tube with Velcro or another trach device.
### EXPLANATION OF EPIDERMOLYSIS BULLOSA

Epidermolysis Bullosa is a generic condition of the skin. There are a variety of forms of this condition which can range from a mild disorder to a severely mutilating disorder. In this disorder, the skin is fragile with reoccurring blisters that can become open/oozing sores which are difficult to heal. Scarring can result. The outer layer of the skin is called the “epidermis” while the inner layer is called the “dermis”. The term “bullous” means blister while “lysis” means breakdown. In this skin condition, the skin is fragile skin that is particularly vulnerable to damage from friction. This friction causes blisters that may occur anywhere like the palms of hands, soles of feet, etc. The treatment is directed toward prevention of blisters. This condition is aggravated by prolonged exposure to heat such as in a hot classroom or during very warm or hot weather.

**Specific Concerns Related to This Student:**

### STAFF RESPONSIBILITIES & ACTION STEPS

The following guidelines are essential to providing care for this child:

1. Identify repetitive actions which can cause blisters or aggravate existing blisters
2. Recognize student may need to wear special shoes, etc to keep from aggravating blisters
3. Student may need alteration in Physical Education class activities as defined by **written physician order**
4. Student may require classroom modifications
5. Maintain confidentiality about student’s health condition
6. Question parent to determine substances that may be used in classroom activities that may cause child to experience more skin problems; plan appropriate substitution for these substances so child may continue to participate in activities
7. If blisters open during school day (begin to ooze fluid):
   * use **Standard Precautions & gloving**
   * rinse blisters with tap water
   * pat skin dry with gauze pads
   * apply dry dressing
   * notify parent
RALEIGH COUNTY SCHOOL HEALTH SERVICES
INTERVENTION GUIDE/EMERGENCY ACTION PLAN
EPINEPHRINE (Epi-Pen, AUVI-Q)

Student: ___________________________ DOB: ___________________________
Grade: ___________________________ Teacher: ___________________________
School: ___________________________

Parent/Guardian: ___________________________ Phone #1: ___________________________
Alternate Contact: ___________________________ Phone #2: ___________________________

<table>
<thead>
<tr>
<th>IF YOU SEE THIS:</th>
<th>DO THIS:</th>
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<tr>
<td>Anaphylactic Shock occurs within seconds of exposure to the substance to which a person is allergic. Anaphylactic Shock is LIFE THREATENING and can cause death if not properly treated. The emergency medication ordered for the treatment of anaphylactic shock is an Epinephrine. It will stop the reaction that is occurring, but the medication stays in the body a very brief time (only about 15-30 minutes) so an AMBULANCE MUST BE CALLED IMMEDIATELY to transport the individual to the hospital. SYMPTOMS OF ANAPHYLACTIC SHOCK: Rapid heart rate, Hives, Excessive swelling of body part, Swelling of neck, Coughing, Wheezing, Difficulty breathing, Discoloration of skin or nail beds, Itching, Headache (rapid onset), Low blood pressure</td>
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<tr>
<td>If student demonstrates signs of Anaphylactic Shock: 1. Activate Blue Team, stay with the student, send someone to get the Epinephrine and to call AMBULANCE!!! Note time student began to have reaction. 2. If student can self-administer injection, allow him/her to do so. If student is unable to administer, then administer Epinephrine. Restrain the student if situation indicates. See reverse side for instructions on how to administer.</td>
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This Emergency Action Plan will be shared with appropriate school staff.

__________________________
School Nurse Signature

__________________________
Date

To Be Completed By School Nurse

Location of medicine/Special Equipment:

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________
Administer medication as indicated by physician’s order.

Epi-Pen:

Remove the EpiPen® Auto-Injector from the carrier tube steps: Remove the EpiPen® Auto-Injector from the carrier tube and follow these 2 simple steps: Grasp with orange tip pointing downward. Remove blue safety cap by pulling straight up. Place the orange tip against the middle of the outer thigh, push the auto-injector firmly into the thigh until it “clicks”, Hold firmly in place for 3 seconds – count slowly, “1, 2, 3”. After injection, the orange cover automatically extends to ensure the needle is never exposed.

Call 911 after using EpiPen®.

1. Pull AUVI-Q up from the outer case.
2. Pull Red safety guard down and off of AUVI-Q.
3. Place black end of AUVI-Q against the middle of the outer thigh (through clothing, if needed), then push firmly until you hear a click and hiss sound, and hold in place for 2 seconds.

Only inject into the middle of the outer thigh. Do not inject into any other part of the body.

If you are administering AUVI-Q to a young child or infant, hold the leg firmly in place while administering an injection.

4. Get emergency medical help right away.

After the use of AUVI-Q:
- The black base will lock into place.
- The voice instruction system will say “seek emergency medical attention”, say “this AUVI-Q has been used...”, and the lights will blink red.
- The red safety guard cannot be replaced.
- The viewing window will no longer be clear.
- It is nonnal for some medicine to remain in your AUVI-Q after you have received your dose of medicine.
- Talk to your healthcare provider about the right way to throw away your AUVI-Q.

AUVI-Q is a single-use auto-injector and cannot be reused.
RALEIGH COUNTY SCHOOL HEALTH SERVICES
HEALTH INTERVENTION GUIDE & EMERGENCY PLAN
FOR GASTROSTOMY TUBE

<table>
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<tr>
<th>STUDENT:_________________________</th>
<th>SCHOOL:_________________________</th>
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<tbody>
<tr>
<td>INTERVENTION GUIDE FOCUS: <strong>Gastrostomy Feeding</strong></td>
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<tr>
<td>NURSING DIAGNOSIS: Alteration in nutrition less than body requirements related to inability to adequately ingest and swallow foods,</td>
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<tr>
<td>STUDENT GOAL: Student will tolerate modifications in diet as demonstrated by adequate physical growth.</td>
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<td>PHYSICIAN ORDER/PARENT REQUEST:</td>
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<tr>
<th>EXPLANATION OF GASTROSTOMY TUBE</th>
<th>STAFF RESPONSIBILITIES &amp; ACTION STEPS</th>
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<tbody>
<tr>
<td><strong>The purpose of a gastrostomy tube is to provide or supplement daily feeding. The tube is inserted through the abdominal wall into the stomach about midway along the greater curvature and secured by a purse-string suture. The tube used can be a foley, wing tip or mushroom catheter. For children on long term gastrostomy feeding, a skin level device (MIC-KEY) is often used. The skin level device requires a well-established gastrostomy site.</strong></td>
<td><strong>Prepare for Feeding Child by:</strong></td>
</tr>
</tbody>
</table>

*review physician order for specific amount & time of feeding as indicated by physician order*

*make sure tube feeding is at appropriate temperature prior to actual feeding experience*

*prepare child for feeding by placing child in high Fowler’s or sitting position; if child unable to sit, place child on right side*

*assure privacy for the child*

*gather equipment and wash hands*

*put on disposable gloves*

**Performing the Feeding:**

1. **Check placement of feeding tube prior to actual feeding by:**
   a. **aspirating stomach contents with syringe**
   b. **injecting 5-10cc air & listening for air sounds**

2. **Check for residual feeding prior to initiating feeding:**
   a. **Withhold feeding if aspirate equal to or more than amount specified by physician**
   b. **replace aspirate**

3. **Administering the feeding:**
   * **clamp tube & open safety plug or remove adapter**
   * **attach feeding syringe; pour feeding into syringe; unclamp tube; allow feeding to infuse; keep solution in syringe at all times until feeding is complete**
   * **allow feeding to flow in by gravity; maintain slow constant rate**
   * **flush tube with water after feeding; remove syringe, replace adaptor or safety plug.**

4. **Cleanse equipment; document feeding; report problems to parent & the certified school nurse.**

REVISED 7/06
RALEIGH COUNTY SCHOOL HEALTH SERVICES
INTERVENTION GUIDE/EMERGENCY ACTION GUIDE
GLUCAGON INJECTION

Student ___________________________ DOB ________________________
Grade ___________________ Teacher ___________________ School ______________

Parent/Guardian: __________________ Phone #1: __________________ Phone #2: __________________ Phone #3: __________________
Alternate Contact: __________________ Phone #1: __________________ Phone #2: __________________ Phone #3: __________________

IF YOU SEE THIS:
Physicians may order Glucagon for the treatment of hypoglycemia. Glucagon is administered only when there is a physician order to give the medication and the parent has brought the emergency injection kit to the school. Only trained staff may administer this medication. Individuals who are trained in this student’s school are:
1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________

When Glucagon is administered, an ambulance must be called to transport the student to the hospital. Side effects of Glucagon include nausea and vomiting. After administration of this medication, the student should be placed in a side lying position until the ambulance arrives!

This student’s Glucagon is located: ________________________________

DO THIS:
Steps for performing the Glucagon injection include:
1) Determine need for Glucagon injection to be administered.
2) Notify trained staff of need to administer Glucagon injection; notify administration to call an ambulance, parent and school nurse.
3) For the person performing the Glucagon injection, use the following guidelines test:
   - cleanse vial top with alcohol
   - using syringe with sterile water inject water into vial with glucagon tablet, remove syringe from vial
   - gently rotate vial between palms of hands until solution has dissolved
   - use syringe to withdraw desired dosage from vial
   - check syringe for large air bubbles & remove
   - perform injection into arm or thigh by:
     - cleanse arm or thigh with alcohol
     - insert needle at 90 degrees angle or as indicated by physician
     - stabilize needle with hand & inject medication
     - withdraw needle & apply pressure
   *Give used Glucagon kit to Emergency responder

This Emergency Action Plan will be shared with appropriate school staff.

__________________________  ________________________
School Nurse Signature Date

To Be Completed By School Nurse

Location of medicine/Special Equipment:

_________________________________________________________________________________________________________________________________________________
RALEIGH COUNTY SCHOOL HEALTH SERVICES
INTERVENTION GUIDE/EMERGENCY ACTION PLAN
GLUCOSE MONITORING

Student: ________________________ DOB: ________________________

Grade: _______  Teacher: _______  School: ________________________

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<th>Parent/Guardian</th>
<th>Phone #1</th>
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<th>Phone #3</th>
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<tr>
<th>Alternate Contact</th>
<th>Phone #1</th>
<th>Phone #2</th>
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**IF YOU SEE THIS:**

*The goal of effective diabetes management is to control blood glucose levels by keeping them in a target range that is determined for the student.*

*Students with diabetes must check (or test) their blood glucose levels throughout the day by using a blood glucose meter. The role of the individual assisting the student with glucose testing is to observe and assist the student in self-monitoring, and should note the following:*  
- student's skill in performing the procedure  
- student's knowledge of the meaning of results of blood sugar testing

*Students BG range is ____________________*

**DO THIS:**

*When glucose monitoring is performed, use the following guidelines:*

1) Assure privacy for the student
2) Perform testing according to Physician orders
3) Use Standard Precautions when testing.
4) Student should wash hands prior to testing
   - Assemble equipment:
     - Insert Lancet into the lancet device
     - Insert strip into the monitor
5) If assisting the student, disposable gloves should be worn
6) Perform fingerstick & place blood drop on strip or proper port of machine.
7) Dispose of lancets in a Sharps container!
8) Record blood glucose reading on the log
9) Follow physician written orders for treatment of glucose level.

Notify the school nurse if BG level is outside of normal range for this student.

This Emergency Action Plan will be shared with appropriate school staff.

__________________________  ______________
School Nurse Signature            Date

*To Be Completed by School Nurse*

*Location of medicine/Special Equipment: ____________________________*

Revised 10/2018
| DATE | TIME | BLOOD GLUCOSE | CORRECTION COVERAGE | TOTAL CHO COVERAGE | TOTAL INSULIN | TIME ADMINISTERED | INTERVENTION | SIGNATURE |
|------|------|---------------|---------------------|--------------------|---------------|------------------|--------------|
|      |      |               |                     |                    |               |                  |             |           |
|      |      |               |                     |                    |               |                  |             |           |
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|      |      |               |                     |                    |               |                  |             |           |

Reviewed by School Nurse: ___________________________ Date: ___________________________
RALEIGH COUNTY SCHOOL HEALTH SERVICES
EMERGENCY ACTION PLAN/INTERVENTION GUIDE

**Hyperglycemia (High Blood Sugar)**

Student Name: ____________________  DOB: _________  Grade: ___
Teacher: __________________________  School: __________________________

**EMERGENCY CONTACT INFORMATION**

<table>
<thead>
<tr>
<th>Parents/Guardian:</th>
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<td>Alternate Contact:</td>
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**If the School Nurse is in the building please notify nurse immediately!**

<table>
<thead>
<tr>
<th>IF YOU SEE THIS:</th>
<th>DO THIS:</th>
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</thead>
<tbody>
<tr>
<td><strong>Mild Symptoms:</strong> (thirst, fatigue/sleepiness, blurred vision, stomach pain, lack of concentration, frequent urination, increased hunger, flushing of skin)</td>
<td>*Notify school nurse immediately if in the building</td>
</tr>
<tr>
<td></td>
<td>*Assist student in checking blood glucose.</td>
</tr>
<tr>
<td></td>
<td>*Check urine for ketones if blood glucose if &gt;250 and strips are available. (Typically Negative to Trace/Small)</td>
</tr>
<tr>
<td></td>
<td>*Encourage student to drink 8 oz. of water.</td>
</tr>
<tr>
<td></td>
<td>*Have student (per physician order) or nurse administer insulin per physician orders.</td>
</tr>
<tr>
<td></td>
<td>*Recheck blood glucose and ketones again in 2 hours.</td>
</tr>
<tr>
<td></td>
<td>*Notify parent and/or school nurse as needed.</td>
</tr>
</tbody>
</table>

| **Moderate Symptoms:** (Sweet, fruity breath, dry mouth, stomach cramps, nausea, vomiting) | *Notify school nurse immediately                                           |
|                                                                                         | *Notify parent/guardian immediately                                        |
|                                                                                         | *Assist student in checking blood glucose.                                 |
|                                                                                         | *Check urine for ketones if blood glucose if >250 and strips are available. (Typically Small to Moderate) |
|                                                                                         | *Encourage student to drink 8 to 16 oz. of water.                           |
|                                                                                         | *Restrict physical activity/recess                                          |
|                                                                                         | *Have student or nurse administer insulin per physician orders.            |
|                                                                                         | *Recheck blood glucose and ketones again in 2 hours.                       |

| **Severe Symptoms:** Mild and moderate symptoms plus                             | *Activate Blue Team and call parent immediately                           |
| Labored breathing, confused, very weak or unconscious                           | *Notify school nurse immediately                                           |
|                                                                                         | *Assist student in checking blood glucose (if conscious)                   |
|                                                                                         | *Administer emergency medication as ordered, call 911                    |

This Emergency Action Plan will be shared with appropriate school staff.

______________________________  ____________________
School Nurse Signature        Date

Revised 10/2018
RALEIGH COUNTY SCHOOL HEALTH SERVICES
EMERGENCY ACTION PLAN/INTERVENTION GUIDE

HYPERTENSION/HYPERTENSIVE CRISIS

Student Name: ___________________________ DOB: ___________ Grade: ______
Teacher: ___________________________ School: ___________________________

EMERGENCY CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Parents/Guardians:</th>
<th>Phone #1:</th>
<th>Phone #2:</th>
<th>Phone #3:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternate Contact:</td>
<td>Phone #1:</td>
<td>Phone #2:</td>
<td>Phone #3:</td>
</tr>
</tbody>
</table>

IF YOU SEE THIS:

**Onset of Symptoms:**
- Headache
- Flushed face
- Dizziness

**Hypertensive Crisis:**
- Severe headache with confusion and/or blurred vision
- Severe Chest Pain
- Severe anxiety
- Shortness of breath
- Seizures
- Unresponsiveness

**DO THIS:**
- Move student to quiet, calm space
- Encourage relaxation techniques
- Remain with student until trained staff arrives. Trained staff may take student's blood pressure and report to school nurse and/or parent.
- Administer Medication if indicated by MD order:
- Notify School Nurse immediately
- Activate Blue Team and 911
- Remain with student until trained staff arrive
- Trained staff may obtain blood pressure and document
- Administer Medication if indicated by MD order:
- Notify parent

This Emergency Action Plan will be shared with appropriate school staff.

School Nurse: ___________________________
School Nurse Signature: ___________________________
Date: ___________________________

Location of medicine: ___________________________

Revised 10/2018
## RALEIGH COUNTY SCHOOL HEALTH SERVICES

### EMERGENCY ACTION PLAN

### Hypoglycemia (Low Blood Sugar)

Never send a student with suspected low blood sugar anywhere alone!

Student Name: ____________________ DOB: ____ Grade/Teacher: ______________

### EMERGENCY CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Parents/Guardians:</th>
<th>Phone #1:</th>
<th>Phone #2:</th>
<th>Phone #3:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Alternate Contact:</th>
<th>Phone #1:</th>
<th>Phone #2:</th>
<th>Phone #3:</th>
</tr>
</thead>
</table>

*If the School Nurse is in the building please notify nurse immediately!*

### IF YOU SEE THIS:

<table>
<thead>
<tr>
<th>Mild/Moderate Symptoms: (hunger, shakiness, weakness, paleness, anxiety, dizziness, irritability, sweating, drowsiness, poor concentration, headache, confusion, blurred vision, slurred speech, poor coordination)</th>
<th>DO THIS:</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Notify school nurse immediately if in the building</em></td>
<td><em>If nurse is not in the building (if ordered) have student check blood glucose</em></td>
</tr>
<tr>
<td><em>Provide quick acting sugar source of 15 grams carbohydrate: 3-4 glucose tabs or 4 ounces of juice</em></td>
<td><em>Wait 15 minutes &amp; recheck blood glucose (if ordered)</em></td>
</tr>
<tr>
<td><em>Staff to remain with student if no nurse available</em></td>
<td><em>Repeat quick acting sugar source if symptoms persist or blood glucose is less than ____.</em></td>
</tr>
<tr>
<td><em>If next meal or snack is longer than 30 minutes away, follow with a snack of carbohydrate and protein (e.g., cheese and crackers or peanut butter and crackers)</em></td>
<td><em>Communicate with parents</em></td>
</tr>
</tbody>
</table>

### Severe Symptoms: (Loss of consciousness, seizure, or inability to swallow)

<table>
<thead>
<tr>
<th>DO THIS:</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Activate Blue Team and Call 911</em></td>
</tr>
<tr>
<td><em>Contact parents/guardians immediately</em></td>
</tr>
<tr>
<td><em>Do not attempt to give anything by mouth</em></td>
</tr>
<tr>
<td><em>Position on side, if possible</em></td>
</tr>
<tr>
<td><em>Administer glucagon per physicians order (if ordered).</em></td>
</tr>
<tr>
<td><em>Do NOT leave student unattended</em></td>
</tr>
</tbody>
</table>

This Emergency Action Plan will be shared with appropriate school staff.

School Nurse: ____________________ School Nurse Signature Date ____________________

To Be Completed by School Nurse

**Location of medicine** ____________________
### IF YOU SEE THIS:

<table>
<thead>
<tr>
<th>Symptoms of Increased Intracranial Pressure</th>
<th>DO THIS:</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>change in level of consciousness</em></td>
<td>Have someone to remain with the student</td>
</tr>
<tr>
<td><em>complaints of headache</em></td>
<td><em>place the student in a calm environment with lights dim</em></td>
</tr>
<tr>
<td><em>projectile vomiting</em></td>
<td><em>Have the student to lie down.</em></td>
</tr>
<tr>
<td><em>seizure activity</em></td>
<td><em>If student has a seizure:</em></td>
</tr>
<tr>
<td><em>excessive crying not consolable</em></td>
<td>- do not attempt to restrain student;</td>
</tr>
<tr>
<td>*drowsiness <em>weakness</em></td>
<td>- loosen tight clothing</td>
</tr>
<tr>
<td><em>decrease in activity level</em></td>
<td>- do not restrain, place on side if possible</td>
</tr>
</tbody>
</table>

*Notify parent and the certified school nurse.*

This Emergency Action Plan will be shared with appropriate school staff.

---

**School Nurse Signature**

**Date**

**To Be Completed by School Nurse**

**Location of medicine/Special Equipment:**

---

Revised 1/2019
RALEIGH COUNTY SCHOOL HEALTH SERVICES

Student: ________________________ School/Grade: ____________________________

AGREEMENT FOR STUDENTS INDEPENDENTLY MANAGING THEIR DIABETES

STUDENT

☐ I agree to dispose of any sharps either by keeping them in my kit and disposing at home or placing them in the Sharps container provided at school.

☐ I will notify the school nurse if my blood sugar is below ___ mg/dl or above ___ mg/dl.

☐ I will not allow any other person to use my diabetes supplies.

☐ I plan to keep my diabetes supplies with me in a secure accessible location __________ __________, or in the school nurse’s office.

☐ I understand that the freedom to manage my diabetes independently is a privilege and I agree to abide by this contract.

Student’s Signature: ____________________________ Date: ______________

PARENT/GUARDIAN

☐ I agree that my child can self-manage his/her diabetes and can recognize when he/she needs to seek the help of a staff member or the school nurse.

☐ It has been recommended to me that back up supplies be provided to the nurse’s office for emergencies.

☐ I understand that this contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contingencies.

Parent’s Signature: ____________________________ Date: ______________

SCHOOL NURSE

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

School Nurse’s Signature: ____________________________ Date: ______________

Feb. 2019
RALEIGH COUNTY SCHOOL HEALTH SERVICES
HEALTH INTERVENTION GUIDE & EMERGENCY PLAN
FOR INTERMITTENT CATHETERIZATION

STUDENT: ___________________ SCHOOL: ________________

INTERVENTION GUIDE FOCUS: Catheter Insertion

NURSING DIAGNOSIS: Altered pattern of urinary elimination related to inability to control bladder functioning

STUDENT GOAL: Student will successfully evacuate urinary bladder every four hours

PHYSICIAN ORDER/PARENT REQUEST:

EXPLANATION OF INTERMITTENT CATHETERIZATION

The purpose of intermittent catheterization is to promote independence for the student by eliminating the use of the retention catheter. Intermittent catheterization consists of inserting a straight urethral catheter into the bladder or specified body orifice at predetermined intervals during the day. The catheter is inserted, urine is drained and the catheter is removed. A written physician order for catheterization is necessary for the procedure to be performed. The physician will indicate whether the procedure is to be clean or sterile.

Daily Concerns As Related to Student:
Check daily for:
* available supplies (catheter, gloves, cleansing agent, lubricant, urinal, diaper, etc)
* changes in the student's classroom schedule that may affect performance of procedure

Observations Related to Catheterization:
Identify the student is experiencing difficulty with urinary tract as evidenced by:
* foul smelling urine
* thick, cloudy, urine
* blood in urine
* elevated body temperature or complaints of not feeling well
* sediment in the urine
* rash in genital area

Observations & Documentation of Catheterization:
Following catheterization, document procedure and student's reaction. Notify parent and Certified School Nurse if student exhibits any of the symptoms listed above or demonstrates problems with procedure performance.

Specific Concerns As related to the Student:

<table>
<thead>
<tr>
<th>EXPLANATION OF INTERMITTENT CATHETERIZATION</th>
<th>STAFF RESPONSIBILITIES &amp; ACTION STEPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepare for catheterization by:</td>
<td></td>
</tr>
<tr>
<td>* review physician order for specific time &amp; frequency of catheterization</td>
<td></td>
</tr>
<tr>
<td>* assemble all equipment, wash hands &amp; glove (recognize vinyl gloves may be necessary)</td>
<td></td>
</tr>
<tr>
<td>* assure privacy for the student</td>
<td></td>
</tr>
<tr>
<td>* student may or may not require assistance with the catheterization; refer to self help guidelines if student has an IEP, encourage student to participate in self care</td>
<td></td>
</tr>
<tr>
<td>* observe standard precautions for body fluids</td>
<td></td>
</tr>
</tbody>
</table>

Performing Catheterization
1. Position student; open all supplies; place lubricating jelly on catheter package
2. Place designated gloves on
3. If female, separate labia and cleanse urethral opening; if male, grasp penis with nondominant hand and firmly hold; cleanse penis with cleansing agent
4. Lubricate catheter and insert into urethral opening or specified orifice (urinary diversion stoma). During insertion of catheter into male penis, hold penis at right angle to the body.
5. Insert catheter in female urinary meatus, after urine begins to flow, insert an additional inch; in male, insert catheter into end of penis until urine begins to flow, then insert an additional 2 inches further
6. Allow urine to drain into designated container until no longer flowing
7. Remove catheter and appropriately discard
8. If urine is being measured, record volume obtained; discard disposable equipment; empty urine into toilet; use standard and splash precautions
9. Wash hands; document procedure; notify parent and Certified School Nurse of any problems

Adopted 7/06
RALEIGH COUNTY SCHOOL HEALTH SERVICES

Individual Health Care Plan

School Year ________________

Student: ____________________________

DOB: ______________

MEDICATIONS ORDERED: ____________________________

________________________________________

KNOWN ALLERGIES: ____________________________

HEALTH CONCERNS: ____________________________

________________________________________

________________________________________

________________________________________

________________________________________

SOURCE OF HEALTH CARE INFORMATION:

________________________________________

__________________________  ____________
Nurse’s Signature            Date

Revised 09/2016
<table>
<thead>
<tr>
<th>Nursing Diagnosis</th>
<th>Goals</th>
<th>Nursing Intervention</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential for Injury Related to Health Condition or Concern</td>
<td>Student: Student will not experience injury as a result of diagnosed health condition. Staff: Staff will perform health care procedures as instructed and listed on health intervention guide.</td>
<td>1. Complete assessment of student's health care condition by contact with parent/guardian/licensed prescriber/other healthcare professionals as to specifics related to condition. Consider student readiness to participate in procedure.</td>
<td>1. Refer to narrative assessment nursing notes.</td>
</tr>
<tr>
<td>Potential for Knowledge Deficit Related to Health Condition or Concern</td>
<td>Student: According to student's cognitive ability, student will verbalize recognition of health concerns and respond accordingly. Staff: Designated staff will verbalize recognition of health care concerns and respond as instructed.</td>
<td>2. Determine the school staff to be included in inservice: transportation, meals, additional settings. 3. Obtain consent from licensed prescriber/parent for specialized health care procedures. 4. Design health intervention guides for health care concerns. 5. Instruct and inservice designated staff (student, if appropriate) in a—emergency response and/or transportation by ambulance b—precautions c—procedures d—documentation e—general knowledge of health condition f—notification of parent/school health services. 6. Instruct regarding universal precautions—if applicable. 7. Emphasize confidentiality with health care information. 8. Assist designated staff in planning strategies to facilitate student participation in school day activities and on field trips. 9. Continue to monitor health condition and/or parent/teacher concerns.</td>
<td>2. *as above 3. Refer to licensed prescriber order sheet 4. Refer to attached health intervention guide(s) 5. Refer to nursing notes 6. Refer to health intervention guide(s) 7. *as above 8. *as above 9. Refer to nursing notes.</td>
</tr>
<tr>
<td>Altered in Health Maintenance as Related to Health Condition or Concern</td>
<td>Student: Student will maintain ability to continue with school activities. Staff: Staff will maintain school activities while recognizing health condition.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Intrathecal Baclofen Therapy

**Student** __________________________ ___________  **DOB** __________________________

**Grade** ______  **Teacher** ______  **School** __________

<table>
<thead>
<tr>
<th>Parent/Guardians:</th>
<th>Phone #1:</th>
<th>Phone #2:</th>
<th>Phone #3:</th>
</tr>
</thead>
<tbody>
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<th>Phone #3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**IF YOU SEE THIS:**

- **Facts about this type of therapy:**
  1) The functioning of this device is not affected by cellular phones or microwave ovens.
  2) The pump and catheter are inserted during a surgical procedure.
  3) When the pump is inserted, the student is given a card with emergency medical information; this card needs to be with the student at all times.
  4) The pump has different alarms that may sound that indicate potential problems with the pump.
  5) Students will need to be closely observed for signs of overdose and underdose.

**Signs of Overdose:**
- Drowsiness, diziness, lightheadedness, slow shallow breathing, seizures, loss of consciousness, blurred or double vision, muscle weakness.

**Signs of Underdose:**
- Itching, blood pressure changes, spastic or rigid muscles, high fever, altered mental status, seizures, hallucinations, nausea or vomiting, headaches.

- Signs of problems at the site of the pump include: "redness, pain or swelling of skin at incision site"

**DO THIS:**

- If student is experiencing signs/symptoms of overdose or underdose, immediately call the parent and call an ambulance to transport the student to the hospital.

- If the pump begins to alarm, this indicates an actual or potential problem with the pump. The audible alarms are:
  - Low Reservoir Alarm: typically occurs when reservoir has less and 3 ml remaining; is a single beep occurring every 5-15 seconds
  - Low Battery Alarm: occurs when battery is low; is a single beep; tends to be a low sounding single beep
  - Pump Memory Error Alarm: occurs as two beeps close together and indicates the pump has detected a memory error.

**WHEN AN ALARM IS HEARD**

- Immediately contact the parent.

- If the student has signs of problems at the insertion site of the pump, immediately contact the family.

- If student experiences any trauma to pump site, immediately notify parent and/or emergency medical personnel.

**NOTIFY YOUR SCHOOL NURSE!**

This Emergency Action Plan will be shared with appropriate school staff.

<table>
<thead>
<tr>
<th>School Nurse Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To Be Completed By School Nurse

**Location of medicine/Special Equipment:**

<table>
<thead>
<tr>
<th>Location</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
RALEIGH COUNTY SCHOOL HEALTH SERVICES
INTERVENTION GUIDE/EMERGENCY ACTION PLAN
FOR NEBULIZATION TREATMENT

Student: ___________________________ DOB: ___________________________
Grade ______ Teacher ___________________________ School: ___________________________

Parents/Guardians: ____________________ Phone #1: ____________________ Phone #2: ____________________ Phone #3: ____________________

Alternate Contact: ____________________ Phone #1: ____________________ Phone #2: ____________________ Phone #3: ____________________

IF YOU SEE THIS:

Onset of Symptoms:
*excessive wet, gurgling noise with breathing *blueness around lips or nail beds *difficulty in breathing; increased rate of breathing *student choking, gagging or coughing excessively

DO THIS:
*review physician order for specific time & frequency of treatment
*assemble all equipment & wash hands
*prepare student for treatment by placing student in sitting position
*assure privacy for the child
*allow student to perform procedure if possible
*some students may only require adult supervision as opposed to direct assistance with the treatment

Observations & Documentation:
Following nebulization treatment, document procedure and student’s reaction. If nebulization treatment does not cause a decrease in symptoms, call parent immediately. If during the nebulization treatment, the student’s symptoms become worse, stop the treatment.
If parent unavailable and student in respiratory distress, call an ambulance!
Notify the School Nurse!

Performing Nebulization Treatment:
1. Place medication in nebulization chamber
2. Turn on nebulization machine
3. Have student to place lips over nebulizer mouth piece
4. Encourage student to take slow deep breaths during the treatment
5. Tap side of nebulizer chamber to cause droplets of medication to fall back into chamber
6. Nebulization treatment is completed when all medication is gone from the nebulizer chamber
7. Cleanse equipment; wash hands; document treatment; notify parent and/or the certified school nurse as needed

This Emergency Action Plan will be shared with appropriate school staff.

School Nurse Signature: ___________________________ Date: ___________________________

To Be Completed by School Nurse

Location of medicine/Special Equipment: ___________________________ ___________________________

___________________________ ___________________________

___________________________ ___________________________

___________________________ ___________________________
RALEIGH COUNTY SCHOOL HEALTH SERVICES
INTERVENTION GUIDE/EMERGENCY ACTION PLAN
ORAL FEEDING

Student: ___________________________  DOB: ___________________________

Grade: __________________  Teacher: __________________  School: ___________________________

Parents/Guardians: ___________________________  Phone #1: ___________________________
Phone #2: ___________________________  Phone #3: ___________________________

Alternate Contact: ___________________________  Phone #1: ___________________________
Phone #2: ___________________________  Phone #3: ___________________________

**MANAGEMENT:**

**Daily Concerns During Feeding:**

* Proper identification of specific amount, type, and consistency of feeding
* Make sure feeding is at appropriate temperature & texture
* Have suction machine available
* Assure privacy, constantly observing for airway obstruction
* Position student in upright position with appropriate clothing protection
* Feed small bites slowly, make sure food is being swallowed
* Provide oral care after feeding; check for remaining foods not swallowed
* Use standard precautions including gloving
* Document feeding as indicated

**Signs of Airway Obstruction:**

Coughing, excessive gagging, change in face color, difficulty in breathing, stridor, high pitched noise

**ACTION:**

* Obstructed Airway, Call 911

**Performing Heimlich Maneuver:**

Consider student's age, size and environment in determining how to perform the Heimlich Maneuver, (discuss with school nurse prior to having to perform this procedure).

If airway is completely obstructed and you can see the object, perform a sweeping motion to remove the object. If the student is coughing and airway seems to be partially blocked, observe to see if they can cough up the object.

If the airway obstruction is complete and student is < 3 years old or very small in size, hold student in your arms, turn onto their stomach give 5 quick blows between shoulder blades, turn student on his/her back & give 5 chest thrusts (place heel of one hand on lower portion of sternum & apply pressure, check student’s mouth). If obstruction complete & student can stand: stand behind student & place your fist in student’s abdomen (above the navel) & perform 5 quick thrusts. If airway is completely obstructed & student becomes unconscious or unable to stand: place student on floor, check student’s mouth for object and remove if seen; attempt rescue breathing, straddle student & place your hands on student’s abdomen & do 5 abdominal thrusts; check for object and remove if seen.

This Emergency Action Plan will be shared with appropriate school staff.

______________________________  ___________________________
School Nurse Signature  Date  

*To Be Completed By School Nurse*

**Location of medicine/Special Equipment:**

______________________________  ___________________________
______________________________  ___________________________
______________________________  ___________________________
______________________________  ___________________________
RALEIGH COUNTY SCHOOL HEALTH SERVICES
HEALTH INTERVENTION GUIDE AND EMERGENCY PLAN
FOR POTENTIAL FOR INFECTION RELATED TO EPIDERMOLYSIS BULLOSA

STUDENT: ________________________________ SCHOOL: _______________________

INTERVENTION GUIDE FOCUS: Potential for infection Related to Epidermolysis Bullosa _______

NURSING DIAGNOSIS: Potential Risk for Infection _______________________________________

STUDENT GOAL: Student will not acquire infection from school setting.

PHYSICIAN ORDER/ PARENT REQUEST RELATED TO HEALTH CONCERN:

<table>
<thead>
<tr>
<th>EXPLANATION OF EPIDERMOLYSIS BULLOSA</th>
<th>STAFF RESPONSIBILITIES &amp; ACTION STEPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epidermolysis Bullosa is a generic condition of the skin. There are a variety of forms of this condition which can range from a mild disorder to a severely mutilating disorder. In this disorder, the skin is fragile with reoccurring blisters that can become open/oozing sores which are difficult to heal. Scarring can result. The outer layer of the skin is called the “epidermis” while the inner layer is called the “dermis”. The term “bullosa” means blister while “lysis” means breakdown. In this skin condition, the skin is fragile skin that is particularly vulnerable to damage from friction. This friction causes blisters that may occur anywhere like the palms of hands, soles of feet, etc. The treatment is directed toward prevention of blisters. This condition is aggravated by prolonged exposure to heat such as in a hot classroom or during very warm or hot weather.</td>
<td>The following guidelines are essential to providing care for this child:</td>
</tr>
<tr>
<td>Specific Concerns Related to This Student:</td>
<td>1. Identify repetitive actions which can cause blisters or aggravate existing blisters</td>
</tr>
<tr>
<td></td>
<td>2. Recognize student may need to wear special shoes, etc to keep from aggravating blisters</td>
</tr>
<tr>
<td></td>
<td>3. Student may need alteration in Physical Education class activities as defined by written physician order</td>
</tr>
<tr>
<td></td>
<td>4. Student may require classroom modifications</td>
</tr>
<tr>
<td></td>
<td>5. Maintain confidentiality about student’s health condition</td>
</tr>
<tr>
<td></td>
<td>6. Question parent to determine substances that may be used in classroom activities that may cause child to experience more skin problems; plan appropriate substitution for these substances so child may continue to participate in activities</td>
</tr>
<tr>
<td></td>
<td>7. If blisters open during school day (begin to ooze fluid):</td>
</tr>
<tr>
<td></td>
<td>* use Standard Precautions &amp; gloving</td>
</tr>
<tr>
<td></td>
<td>* rinse blisters with tap water</td>
</tr>
<tr>
<td></td>
<td>* pat skin dry with gauze pads</td>
</tr>
<tr>
<td></td>
<td>* apply dry dressing</td>
</tr>
<tr>
<td></td>
<td>* notify parent</td>
</tr>
</tbody>
</table>

Adopted 8/07
Raleigh County Schools Health Services Department

Emergency Seizure Medication Safe Scale

School ____________________________________________

Student _____________________________ Dr. _____________________________


Parent Transports ______ Can be Delegated ______ Give Within _______ Minutes

AM Bus# _______________ Driver Name _______________ Aide _______________

PM Bus# _______________ Driver Name _______________ Aide _______________

Minutes on Bus to School _________________ to Home _______________________

Other Transport Concerns ________________________________________________

Decision: ________________________________________________________________

___________________________________________
Nurse’s Signature

_________________________
Date

12/2018
SEIZURE:
What is the most frequent type of seizure the child has?

_____ Absence (1)
_____ Simple Partial (2)
_____ Complex Partial (3)
_____ Tonic Ciotic (4)

Even though the student is on seizure medication, does the student still have breakthrough seizures?

_____ Yes (3)
_____ No (0)

ADMINISTRATION OF MEDICATION OR USE OF VAGUS NERVE SIMULATOR (VNS):
How many seizure medications does the child take (other than EMERGENCY MEDICATION)?

_____ One(1)
_____ Two (2)
_____ More than 2 (3)

Has Emergency Seizure Medication ever been administered?

_____ Yes (5)
_____ No (0)

Has Emergency Seizure Medication ever been administered at school?

_____ Yes (5)
_____ No (0)

Has respiratory depression ever occurred after the administration of Emergency Seizure Medication?

_____ Yes (5)
_____ No (0)

Does student have VNS?

_____ Yes (5)
_____ No (0)

FREQUENCY:
How often does the student have seizures at school?

_____ Daily (5)
_____ Weekly (4)
_____ 1-2 Times Monthly (3)
_____ Monthly (2)
_____ 1-2 Times Yearly (1)
_____ Never (0)
How often does the student have seizures at home?

- ___ Daily (5)
- ___ Weekly (4)
- ___ 1-2 Times Monthly (3)
- ___ Monthly (2)
- ___ 1-2 Times Yearly (1)
- ___ Never (0)

ENVIRONMENT:
How often has Emergency Seizure Medication been administered at home?

- ___ Never (0)
- ___ Once (1)
- ___ Two or More Times (2)
- ___ Monthly (3)
- ___ Weekly (4)
- ___ Other ____________________________

How often has Emergency Seizure Medication been administered at school?

- ___ Never (0)
- ___ Once (1)
- ___ Two or More Times (2)
- ___ Monthly (3)
- ___ Weekly (4)
- ___ Other ____________________________

How far is the school from the nearest hospital?

- ___ 1-10 miles (1)
- ___ 11-20 miles (3)
- ___ More than 21 miles (5)

TOTAL SCORE: __________________(56 possible)

Comments:
RALEIGH COUNTY SCHOOL HEALTH SERVICES  
EMERGENCY ACTION PLAN  

SEIZURE

<table>
<thead>
<tr>
<th>Student Name:</th>
<th>DOB:</th>
<th>Grade/Teacher:</th>
<th>School:</th>
</tr>
</thead>
</table>

Does your student ride a bus? Morning bus# Afternoon bus #

EMERGENCY CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Parent/Guardian:</th>
<th>Phone #1:</th>
<th>Phone #2:</th>
<th>Phone #3:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternate Contact:</td>
<td>Phone #1:</td>
<td>Phone #2:</td>
<td>Phone #3:</td>
</tr>
</tbody>
</table>

Seizure Type: Normal Length/Frequency: 
Seizure Triggers or Warning Signs: 
Daily medication for seizures:

Does student have a Vagal Nerve Stimulator (VNS)? □ YES □ NO
Does student have an Emergency/Rescue Medication? □ YES □ NO Name? 
  ◆ Emergency medication to be given for seizures lasting longer than _________ Minutes
  ◆ Emergency medication is stored?

IF YOU SEE THIS:

ABSENCE:
Momentary loss of awareness sometimes accompanied by movements of the face, blinking or arm movement. Returns to full awareness. No first aid required.

SIMPLE PARTIAL
Consciousness not lost, unable to control body movements. Senses distorted, sees, hears, smells things that are not real. Reassure student, notify parent.

COMPLEX PARTIAL
Automatic behavior. Student may get up and walk around. Unresponsive to spoken directions, may appear to be sleepwalking. Do not grab or speak loudly, use calm gentle voice to avoid student resistance. Notify parent.

TONIC CLONIC (Grand Mal)
Convulsions, body stiffens and jerks, child loses consciousness, may lose bowel/bladder control. Typically lasts 1-2 minutes. Breathing may be shallow or stop briefly and student may be confused or belligerent. Remain calm. Note beginning and ending time of seizure. Notify parent immediately.

TONIC-CLONIC SEIZURE
Discuss an emergency plan in advance with staff.
Call for Blue Team
Never restrain the student
Clear area around student to avoid injury
DO NOT put anything in the mouth
Loosen clothing, remove eyeglasses or any sharp objects or furniture
If vomiting or choking turn student onto their side
Do not give anything by mouth until seizure is over
Always provide privacy
Have student rest
Notify parents of seizure
Record observations of seizure activity

EMERGENCY MEDICATION? YES / NO
To be administered for seizure lasting longer than _________ minutes.

Please Sign on Back
<table>
<thead>
<tr>
<th>IF YOU SEE THIS:</th>
<th>DO THIS:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Danger Signs:</strong></td>
<td>Call 911</td>
</tr>
<tr>
<td>• Seizure lasts longer than 5 Minutes</td>
<td>Begin CPR and Rescue Breathing if breathing stops</td>
</tr>
<tr>
<td>• No history of previous seizure.</td>
<td>Call Parents</td>
</tr>
<tr>
<td>• Another seizure starts immediately after the first seizure.</td>
<td></td>
</tr>
<tr>
<td>• Consciousness does not return at the end of a seizure.</td>
<td></td>
</tr>
<tr>
<td>• Bluish color to lips AFTER seizure ends.</td>
<td></td>
</tr>
<tr>
<td>• Stops breathing</td>
<td></td>
</tr>
<tr>
<td>• If student is a diabetic, pregnant, or has a head injury or high fever.</td>
<td></td>
</tr>
</tbody>
</table>

Symptoms to Expect After a Seizure (can last a few minutes or hours)

(Tiredness, weakness, sleepy, difficult to arouse, somewhat confused, regular breathing)

• These are all NORMAL post seizure*

This Emergency Action Plan will be shared with appropriate school staff.

School Nurse: ____________________________                     School Nurse Signature  __________________

Date: ____________________________

*To Be Completed by School Nurse

**Location of Medication**

**Authorized person/s to give medicine**
RALEIGH COUNTY SCHOOL HEALTH SERVICES
HEALTH INTERVENTION GUIDE & EMERGENCY PLAN
FOR SUCTIONING

STUDENT: ___________________________ SCHOOL: ____________

INTERVENTION GUIDE FOCUS: *Suctioning*

NURSING DIAGNOSIS: Ineffective airway clearance related to inability to manage oral secretions.

STUDENT GOAL: Student will exhibit improved ventilation capacity.

PHYSICIAN ORDER/PARENT REQUEST:

---

**EXPLANATION OF SUCTIONING**

The purpose of suctioning is to facilitate airway patency. Secretions can be removed by suctioning the mouth, nose, or through a tracheostomy tube. Standard precautions are essential when performing suctioning and must be followed at all times. In the school environment, the student's parents must provide this equipment for suctioning. The student's physician must provide a written order for suctioning to be performed.

**Daily Care of Suction Machine:**
Check the suction machine daily for:
- *available supplies (catheter, gloves, water)*
- *appropriate cleanliness of the machine*
- *patency and proper functioning of machine*
- *record equipment checks on documentation log*

**Assure maintenance of the Suction Machine:**
On a daily basis check the machine for the following:
- *adequacy of the machine vacuum*
  - Remember vacuum pressure should range from:
  - 80-100 mm Hg for children birth to 10 years
  - 80-120 mm Hg for children above 10 years
- *if portable suction machine, recharge machine as indicated in machine instructions*

**Observations Indicating Need to Suction:**
Identify the student is experiencing difficulty in breathing as may be evidenced by:
- *excessive wet, gurgling noise with breathing*
- *blueness around lips or nail beds*
- *difficulty in breathing; increased rate of breathing*
- *student choking, gagging or coughing excessively*
- *tactile assessment of auscultation of chest reveals audible excessive rhonchi present in lung fields*

**Observations & Documentation Suctioning:**
Following suctioning, document procedure and student's reaction. Notify parent and the certified school nurse if student is suctioned more than once during school day.

---

**STAFF RESPONSIBILITIES & ACTION STEPS**

**Prepare for Suctioning Student by:**
*review physician order for specific time and frequency of suctioning*
*assemble all equipment, wash hands & glove*
*prepare student for suctioning by placing student in high Fowler's or sitting position*
*assure privacy for the child*
*recheck vacuum of suction machine*
*if student has Tracheostomy tube which is coughed or pulled out, follow physician’s orders regarding care; if no orders call ambulance for immediate transport to hospital!*

**Performing Suctioning:**
1. Lubricate catheter in water, suctioning a small amount of water
2. Insert catheter into proper orifice (mouth, nose or tracheal inner cannula)
3. Apply intermittent suction for no longer than 10 seconds at a time. Rotate catheter while applying suction.
4. Remove catheter from orifice; suction water into catheter to cleanse catheter of secretions
5. Repeat steps 2-4 as necessary; allow 1 minute between suctioning
6. Observe student for excessive coughing, gagging, cyanosis or shortness of breath; allow rest periods as needed
7. Discard disposable equipment; empty contents of suction container into toilet; use standard and splash precautions
8. Cleanse equipment; wash hands; document suctioning; notify parent and/or the certified school nurse as needed.

**Special Concerns As Related to Student:**
RALEIGH COUNTY SCHOOL HEALTH SERVICES
INTERVENTION GUIDE/EMERGENCY ACTION PLAN
TRACHEOSTOMY

Student: _____________________ D0B: ____________________

Grade: ____ Teacher: ____________________ School: ____________

Parents/Guardians: Phone #1: __________ Phone #2: __________ Phone #3: __________

Alternate Contact: Phone #1: __________ Phone #2: __________ Phone #3: __________

IF YOU SEE THIS: DO THIS:

- Only designed qualified licensed health care providers such as a RN, LPN or respiratory therapist under the direct or indirect supervision of a certified school nurse may provide care for this student.

**Daily Concerns of Tracheostomy Stoma:**

- Observe for signs of any drainage, excessive secretions
- Inspect gauze for placement & need for changing
- Check tracheostomy ties to determine if secure
- Check to make sure supplies are present and additional tracheostomy tube is available.
- Check adequacy of suction machine
- Check for presence of manual resuscitator

**Observations Indicating potential problems:**

- Difficulty breathing during suctioning or not relieved by suctioning
- Trach tube or inner cannula becomes dislodged
- Bleeding occurs during suctioning
- Bronchospasm occurs during suctioning

**DAILY:** *inspect tracheostomy supplies and equipment; replace missing supplies immediately.*

*Check suctioning equipment for adequacy of machine vacuum, (refer to guidelines for suctioning)*

1. Follow physician orders for routine and emergency suctioning of tracheostomy tube.

2. Follow physician orders for re-insertion of tracheostomy tube if it accidentally comes out of the stoma.


4. Observe student for problems with the tube or air exchange.

   (See back for reinsertion procedure)

This Emergency Action Plan will be shared with appropriate school staff.

School Nurse Signature ____________________ Date ______________

To Be Completed By School Nurse

Location of medicine/Special Equipment ____________________________
RALEIGH COUNTY SCHOOL HEALTH SERVICES
INTERVENTION GUIDE/EMERGENCY ACTION PLAN
USE OF MANUAL RESUSCITATOR

Student: ____________________ DOB: ____________________
Grade ______ Teacher ______________ School ______________

Parents/Guardians:                                               Phone #1:                  Phone #2:                  Phone #3:                  
Alternate Contact:                                               Phone #1:                  Phone #2:                  Phone #3:                  

IF YOU SEE THIS:                                                DO THIS:

Determining Need to Use Manual Resuscitator                    If the student is experiencing respiratory distress and is unable to breathe on their own:
A Manual Resuscitator will need to be used when any of the following situations occur:
*student develops difficulty breathing during suctioning or is not relieved by suctioning
*if a large amount of blood is suctioned from the tracheostomy & student appears to be in respiratory distress
*the child develops respiratory distress while being suctioned
*student has a respiratory arrest

*Call Blue Team tell someone to call 911. Do not leave the student!
*Position the child so that you can inflate the resuscitator; neck should be extended & trach opening exposed.
*Attach Manual Resuscitator to tracheostomy tube; hole one hand on Trach tube @ all times to prevent accidental dislodgement while attaching it to adaptor.
*If the student can breathe independently, coordinate the manual breaths with their breaths. Give a breath by squeezing the bag as the student begins to inhale. If you feel resistance and/or the student looks distressed, make sure the tube is patent.
*If the student is unable to breathe on his/her own, squeeze the bag at a regular rate to deliver the prescribed breaths per minute: 20-24 infants, 16-20 children, 12-16 adolescents. Check for effectiveness of ventilation: look, listen & feel for movement Continue manual ventilation until relieved by EMS or until student resumes adequate respirations.

This Emergency Action Plan will be shared with appropriate school staff.

__________________________________________________________
School Nurse Signature                                         Date

To Be Completed By School Nurse

Location of medicine/Special Equipment:
RALEIGH COUNTY SCHOOL HEALTH SERVICES
HEALTH INTERVENTION GUIDE
FOR USING SALINE DROPS DURING TRACHEOSTOMY CARE

STUDENT: ___________________________ SCHOOL: ___________________________

INTERVENTION GUIDE FOCUS: Using Saline Drops During Tracheostomy Care

NURSING DIAGNOSIS:

STUDENT GOAL: Student will exhibit normal respiratory functions

PHYSICIAN ORDER/PARENT REQUEST:

---

<table>
<thead>
<tr>
<th>EXPLANATION OF TRACHEOSTOMY</th>
<th>STAFF RESPONSIBILITIES &amp; ACTION STEPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>A tracheostomy is an opening through the neck into the trachea through which an indwelling tube may be inserted. Care of the student with a tracheostomy consists of maintaining a patent airway, adequate humidification, and replacement of tracheostomy tube as needed. Only designed qualified licensed health care providers such as a RN, LPN or respiratory therapist under the direct or indirect supervision of a certified school nurse may provide care for this student. The student’s physician must provide written orders for care of the tracheostomy. The physician may order saline drops be instilled into the tracheostomy to loosen secretions &amp; encourage coughing. Guidelines for Suctioning of the tracheostomy, daily Tracheostomy Care &amp; Problem Management, Tracheostomy Reinsertion and procedure for Use of Manual Resuscitator are provided on separate Intervention Guides and will need to be followed.</td>
<td></td>
</tr>
<tr>
<td>Determining Need for Instilling Saline:</td>
<td></td>
</tr>
<tr>
<td>* must have a written order from the physician to instill saline</td>
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<tr>
<td>* assess student’s respiratory status prior to instillation of saline</td>
<td></td>
</tr>
<tr>
<td>* Check tracheostomy ties to determine if secure</td>
<td></td>
</tr>
<tr>
<td>Observations Indicating Problems with Tracheostomy Tube or Air Exchange:</td>
<td></td>
</tr>
<tr>
<td>* student develops difficulty breathing during suctioning or is not relieved by suctioning</td>
<td></td>
</tr>
<tr>
<td>* Trach tube or inner cannula becomes dislodged</td>
<td></td>
</tr>
<tr>
<td>* bleeding occurs during suctioning</td>
<td></td>
</tr>
<tr>
<td>* bronchospasm occurs during suctioning</td>
<td></td>
</tr>
<tr>
<td>Follow procedure for preparing student for suctioning procedure. Assemble equipment, wash hands &amp; glove, place student in high Fowler's or sitting position, assure privacy and recheck suction machine vacuum. (Assess your need for goggles for eye protection from secretions.)</td>
<td></td>
</tr>
<tr>
<td>1. After preparing student and equipment, unplug tracheostomy tube.</td>
<td></td>
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<tr>
<td>2. Administer 1/2-1 cc saline into the opening of tracheostomy tube.</td>
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</tr>
<tr>
<td>3. Using suction catheter, apply intermittent suction for no longer than 10 seconds or encourage the student to cough.</td>
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<tr>
<td>4. Remove any excess mucus from the tracheal opening with tissue.</td>
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</tr>
<tr>
<td>5. Allow student a chance to “catch” his/her breath after each installation.</td>
<td></td>
</tr>
<tr>
<td>6. Repeat procedure as directed by physician.</td>
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</tr>
<tr>
<td>7. Observe student for problems with the tracheostomy tube or air exchange as listed under “Observation Indicating Problems”. Refer to flow chart on the back of this page for management of these problems.</td>
<td></td>
</tr>
</tbody>
</table>

Specific Concerns As Related to this Student:

* Source: Cincinnati Children’s Hospital Medical Center
Children & Youth Assisted by Medical Technology in Educational Settings

Adopted 7/06
RALEIGH COUNTY SCHOOL HEALTH SERVICES
HEALTH INTERVENTION GUIDE & EMERGENCY PLAN
FOR VAGAL NERVE STIMULATOR

<table>
<thead>
<tr>
<th>STUDENT: ___________________</th>
<th>SCHOOL: ___________________</th>
</tr>
</thead>
</table>

INTERVENTION GUIDE FOCUS: Vagal Nerve Stimulator (VNS)

NURSING DIAGNOSIS: High risk for bodily injury and trauma related to uncontrolled seizure activity.

STUDENT GOAL: Student will not sustain injury and will appropriately respond to use of VNS magnet.

PHYSICIAN ORDER/PARENT REQUEST:

**EXPLANATION OF USE OF VAGAL NERVE STIMULATOR FOR SEIZURE MANAGEMENT**

Students who have a history of frequent seizure activity that is not totally managed by medication may have a Vagal Nerve Stimulator. This is a device that consists of a pulse generator implanted surgically in the chest or near the underarm area. It is connected to a wire attached to the vagus nerve where it sends an electric impulse to the brain to control seizures. The device is programmed to emit electrical impulses at predetermined intervals. The student has a magnet that can be used to cause additional impulses to be sent to the brain when seizure activity occurs.

The following guidelines must be followed with this device:

1. VNS magnet is used only as directed by the physician via written physician orders.
2. Students who have Vagal Nerve Stimulators may also have Diastat rectal gel ordered by the physician for seizure activity not controlled by the magnet.
3. Precautions to remember regarding the magnet include:
   *DO NOT DROP THE MAGNET
   *DO NOT STORE MAGNET NEAR:
   Credit cards, computers, computer disks, magnetized lunch cards, microwave ovens or other magnets.

   Keep the magnet 10 inches away from these items!!
4. Document magnet use on the seizure log and student’s response to the magnet use. Notify parent of magnet use — by note or copy of log sent home.
5. If magnet is used more than 2 times during a school day, telephone parent to advise of use of magnet and type of seizure activity. Notify certified school nurse.

**STAFF RESPONSIBILITIES & ACTION STEPS**

In advance, discuss with staff an emergency plan with staff in the classroom. Consider preparing other students in the room for possibility of seizure. Determine which individuals are allowed to use magnet to control seizure activity. Make arrangements for substitute teacher to be aware of student’s health problems in your absence. Remember when this student goes on a field trip that the person who is trained to use the VNS magnet must accompany the student on the field trip.

If student has a seizure and VNS magnet must be used:

1. Magnet must be used according to written physician orders.
2. Once student starts to have a seizure, student must not be left unattended. Follow guidelines for Seizure care. Make sure to note time and length of seizure.
3. To use the VNS magnet:
   —Identify student is having seizure
   —Locate site of pulse generator
   —Pass magnet over pulse generator for one second, count one one thousand, moving magnet from upper to lower chest, using a semi-circle path, count two one thousand
   —Can leave magnet in pouch to use; can use over regular clothing but not a heavy coat
   —If seizure does not stop, magnet use may be repeated after one minute (60 seconds) from previous use; if seizure does not stop, magnet can be used up to 5 times (once every minute up to 5 minutes)
4. If seizure activity continues for 5 minutes without being stopped by use of magnet; call ambulance! If Diastat ordered, administer Diastat. Notify parent and the certified school nurse.

REVISED 7/06
RALEIGH COUNTY SCHOOL HEALTH SERVICES

Student: ___________________________ School/Grade: ___________________________

AGREEMENT FOR STUDENTS INDEPENDENTLY MANAGING THEIR DIABETES

STUDENT

☐ I agree to dispose of any sharps either by keeping them in my kit and disposing at home or placing them in the Sharps container provided at school.

☐ I will notify the school nurse if my blood sugar is below ___ mg/dl or above ___ mg/dl.

☐ I will not allow any other person to use my diabetes supplies.

☐ I plan to keep my diabetes supplies with me in a secure accessible location _______________ _______________, or in the school nurse’s office.

☐ I understand that the freedom to manage my diabetes independently is a privilege and I agree to abide by this contract.

Student’s Signature: ___________________________ Date: ________________

PARENT/GUARDIAN

☐ I agree that my child can self-manage his/her diabetes and can recognize when he/she needs to seek the help of a staff member or the school nurse.

☐ It has been recommended to me that back up supplies be provided to the nurse’s office for emergencies.

☐ I understand that this contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contingencies.

Parent’s Signature: ___________________________ Date: ________________

SCHOOL NURSE

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

School Nurse’s Signature: ___________________________ Date: ________________

Feb. 2019
Children with Disabilities and Special Dietary Needs

Schools/Sites participating in a federal school meal program (National School Lunch Program, School Breakfast Program, Child and Adult Care Food Program, Summer Food Service Program, Fresh Fruit and Vegetable Program, Special Milk Program, and Afterschool Snack Program) are required to make reasonable accommodations for children who are unable to eat the school/site meals because of a disability that restricts the diet.

1. Licensed Medical Authority’s Statement for Children with Disabilities

U.S. Department of Agriculture (USDA) regulations at 7 CFR Part 15b require substitutions or modifications in school/site meals for children whose disabilities restrict their diets. School Food Authorities/Sponsors must provide modifications for children on a case-by-case basis when requests are supported by a written statement from a state licensed medical authority.

The third page of this document ("Medical Plan of Care for School/Site Food Service") may be used to obtain the required information from the licensed medical authority. For this purpose, a state licensed medical authority in West Virginia includes a:

- Physician, (MD or DO)
- Physician assistant,
- Certified registered nurse practitioner, or
- Dentist.

The written medical statement must include:

- An explanation of how the child’s physical or mental impairment restricts the child’s diet;
- An explanation of what must be done to accommodate the child; and
- The food or foods to be omitted and recommended alternatives, if appropriate.

2. Other Special Dietary Needs

School/Site food service staff may make food substitutions for individual children who do not have a medical statement on file. Such determinations are made on a case-by-case basis and all accommodations must be made according to USDA’s meal pattern requirements. Schools/Sites are encouraged to have documentation on file when making menu modifications within the meal pattern.

3. Rehabilitation Act of 1973 and the Americans with Disabilities Act

Under Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA) of 1990 and the ADA Amendments Act of 2008, a person with a disability means any person who has a physical or mental impairment that substantially limits one or more major life activities or major bodily functions, has a record of such an impairment, or is regarded as having such an impairment. A physical or mental impairment does not need to be life threatening in order to constitute a disability. If it limits a major life activity, it is considered a disability.

Major life activities include, but are not limited to: caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. A major life activity also includes the operation of a major bodily function, including but not limited to: functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.
4. Individuals with Disabilities Education Act

A child with a disability under Part B of the *Individuals with Disabilities Education Act* (IDEA) is described as a child evaluated in accordance with IDEA as having one or more of the recognized thirteen disability categories and who, by reason thereof, needs special education and related services. The Individualized Education Program (IEP) is a written statement for a child with a disability that is developed, reviewed, and revised in accordance with the IDEA and its implementing regulations. When nutrition services are required under a child's IEP, school officials need to ensure that food service staff is involved early in decisions regarding special meals.

**Nutrition Program Contact**

For more information about requesting accommodations to meals and the meal service for children with disabilities at [School or Site Name], please contact:

(Name and contact information)

**USDA Nondiscrimination Statement**

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed complaint or letter to USDA by:

1. (mail: U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410;

2. fax: (202) 690-7442; or

3. email: program.intake@usda.gov.

This institution is an equal opportunity provider.
Medical Plan of Care for School/Site Food Service

Please read pages 1 and 2 before completing this form.

<table>
<thead>
<tr>
<th>Child's Name</th>
<th>Date of Birth</th>
<th>Grade Level/Classroom</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Name of School/Site</th>
<th>WVEIS Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Name of Parent/Guardian</th>
<th>Phone Number of Parent/Guardian</th>
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</table>

<table>
<thead>
<tr>
<th>Signature of Parent/Guardian</th>
<th>Date</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

1. Provide an explanation below of how the child’s physical or mental impairment restricts the child’s diet:

2. Describe the specific diet or necessary modifications prescribed by the state licensed medical authority to accommodate the child’s needs:

3. List the food or foods to be omitted (please be specific) and recommended alternatives, if appropriate.
   - Foods to be omitted:
     1-  
     2-  
   Suggested substitutions:
   1-  
   2-  
   3-  

4. Indicate texture modifications, if applicable:
   - Chopped/Cut into bite-sized pieces
   - Diced
   - Finely Ground
   - Pureed
   - Other: ____________________________

5. List any required special adaptive equipment:

<table>
<thead>
<tr>
<th>Name of Physician/Medical Authority &amp; Title (Please Print)</th>
<th>Provider Phone Number</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Signature of Physician/Medical Authority: __________________________
Date: __________________________

Signing the following section is optional, but may prevent delays by allowing the school/site to speak with the physician/medical authority.

Health Insurance Portability and Accountability Act Waiver

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act, I hereby authorize __________________________ (medical authority) to release such protected health information of my child as is necessary for the specific purpose of Special Diet Information to __________________________ (child nutrition program) and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child with the school/site program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on __________________________ (date). This information is to be released for the specific purpose of Special Diet information.

The undersigned certifies that he/she is the parent, guardian or representative of the person listed on this document and has the legal authority to sign on behalf of that person.

Parent/Guardian Signature: __________________________
Date: __________________________
Raleigh County Schools Health Services Department  

_Emergency Seizure Medication Safe Scale_

School ________________________________

Student_______________________________ Dr. ____________________________


Parent Transports _____ Can be Delegated ________ Give Within________ Minutes

AM Bus# ___________ Driver Name _______________ Aide _________________

PM Bus# ___________ Driver Name _______________ Aide _________________

Minutes on Bus to School _________________ to Home _____________________

Other Transport Concerns ________________________________

Decision: _____________________________________________________________

__________________________________________

Nurse’s Signature

__________________________

Date

12/2018
SEIZURE:
What is the most frequent type of seizure the child has?

____ Absence (1)
____ Simple Partial (2)
____ Complex Partial (3)
____ Tonic Clonic (4)

Even though the student is on seizure medication, does the student still have breakthrough seizures?

____ Yes (3)
____ No (0)

ADMINISTRATION OF MEDICATION OR USE OF VAGUS NERVE SIMULATOR (VNS):
How many seizure medications does the child take (other than EMERGENCY MEDICATION)?

____ One (1)
____ Two (2)
____ More than 2 (3)

Has Emergency Seizure Medication ever been administered?

____ Yes (5)
____ No (0)

Has Emergency Seizure Medication ever been administered at school?

____ Yes (5)
____ No (0)

Has respiratory depression ever occurred after the administration of Emergency Seizure Medication?

____ Yes (5)
____ No (0)

Does student have VNS?

____ Yes (5)
____ No (0)

FREQUENCY:
How often does the student have seizures at school?

____ Daily (5)
____ Weekly (4)
____ 1-2 Times Monthly (3)
____ Monthly (2)
____ 1-2 Times Yearly (1)
____ Never (0)
How often does the student have seizures at home?

____ Daily (5)
____ Weekly (4)
____ 1-2 Times Monthly (3)
____ Monthly (2)
____ 1-2 Times Yearly (1)
____ Never (0)

ENVIRONMENT:
How often has Emergency Seizure Medication been administered at home?

____ Never (0)
____ Once (1)
____ Two or More Times (2)
____ Monthly (3)
____ Weekly (4)
____ Other __________________________

How often has Emergency Seizure Medication been administered at school?

____ Never (0)
____ Once (1)
____ Two or More Times (2)
____ Monthly (3)
____ Weekly (4)
____ Other __________________________

How far is the school from the nearest hospital?

____ 1-10 miles (1)
____ 11-20 miles (3)
____ More than 21 miles (5)

TOTAL SCORE: ______________________(56 possible)

Comments:
RALEIGH COUNTY SCHOOLS
FERPA/HIPAA CONSENT

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN HEALTH CARE PROVIDERS AND SCHOOL DISTRICTS

Completion of this document allows the disclosure and/or use of individual identified education records and health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: ____________________________

Last Name First Name MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and/or health care providers):

(1) ____________________________________________

(2) ____________________________________________

to provide health information from the above-named child's medical record to and from:

__________________________
Raleigh County Schools
School District to Which Disclosure is Made

__________________________
105 Adair St., Beckley, WV 25801
Address/City and State/Zip

__________________________
Contact Person at School District

__________________________
Area Code and Telephone Number

The disclosure of health information is required for the following purpose:

Description of Information to be Disclosed: I authorize the release and disclosure of any and all medical records, histories, reports, notes, diagnostic films or imaging, and all other health information pertaining to ______________________, a minor, of whatever kind and character, and including but not limited to any psychiatric, psychological or mental health records, from ________ to the date this release is presented for such records, to the persons/entities identified herein.

DURATION:
This authorization shall become effective immediately and shall remain in effect for one year from the date of signature, unless sooner revoked by me in writing.

RESTRICTIONS:
Law prohibits the School District from making further or different disclosure of the health information contemplated by this Consent form unless another authorization form is obtained from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:
I understand that I have the following rights with respect to this Authorization: I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the school district/health care agencies/persons listed above. My refusal will be effective upon receipt but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization. I understand that any use or disclosure made prior to the effective revocation under this authorization will not be affected by a revocation.

RE-DISCLOSURE:
I understand that the School District will not improperly disclose this information, as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that this information becomes part of the student's educational record upon being transmitted to a public school that receives federal funding. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings, school health services, or other academic or extracurricular programs.
I have a right to receive a copy of this Authorization. Signing the Authorization may be necessary in order for this student to obtain appropriate services in the School District.

**APPROVAL:**

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<th>Printed Name</th>
<th>Signature</th>
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<th>Relationship to Patient/Student</th>
<th>Area Code and Telephone Number</th>
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(01/2019)
RALEIGH COUNTY SCHOOL HEALTH SERVICES

Individual Health Care Plan

School Year ________________

Student: ________________________________

DOB: ________________

MEDICATIONS ORDERED: ____________________________

______________________________

KNOWN ALLERGIES: ________________________________

HEALTH CONCERNS: ________________________________

______________________________

______________________________

______________________________

______________________________

SOURCE OF HEALTH CARE INFORMATION:

______________________________________________

______________________________________________

Nurse’s Signature ____________________________ Date ________________

Revised 09/2016
<table>
<thead>
<tr>
<th>NURSING DX</th>
<th>GOALS</th>
<th>NURSING INTERVENTION</th>
<th>EVALUATION</th>
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<tbody>
<tr>
<td>POTENTIAL FOR INJURY RELATED TO HEALTH CONDITION OR CONCERN</td>
<td>STUDENT: STUDENT WILL NOT EXPERIENCE INJURY AS A RESULT OF DIAGNOSED HEALTH CONDITION. STAFF: STAFF WILL PERFORM HEALTH CARE PROCEDURES AS INSTRUCTED AND LISTED ON HEALTH INTERVENTION GUIDE.</td>
<td>1. COMPLETE ASSESSMENT OF STUDENT'S HEALTH CARE CONDITION BY CONTACT WITH PARENT/GUARDIAN/LICENSED PRESCRIBER/OFFICE HEALTHCARE PROFESSIONALS AS TO SPECIFICS RELATED TO CONDITION CONSIDER STUDENT READINESS TO PARTICIPATE IN PROCEDURE 2. DETERMINE THE SCHOOL STAFF TO BE INCLUDED IN INSERVICE: TRANSPORTATION, MEALS, ADDITIONAL SETTINGS 3. OBTAIN CONSENT FROM LICENSED PRESCRIBER/PARENT FOR SPECIALIZED HEALTH CARE PROCEDURES. 4. DESIGN HEALTH INTERVENTION GUIDES FOR HEALTH CARE CONCERNS. 5. INSTRUCT AND INSERVICE DESIGNATED STAFF (STUDENT, IF APPROPRIATE) IN a—EMERGENCY RESPONSE AND/OR TRANSPORTATION BY AMBULANCE b—PRECAUTIONS c—PROCEDURES d—DOCUMENTATION e—GENERAL KNOWLEDGE OF HEALTH CONDITION f—NOTIFICATION OF PARENT/SCHOOL HEALTH SERVICES 6. INSTRUCT REGARDING UNIVERSAL PRECAUTIONS—IF APPLICABLE 7. EMPHASIZE CONFIDENTIALITY WITH HEALTH CARE INFORMATION 8. ASSIST DESIGNATED STAFF IN PLANNING STRATEGIES TO FACILITATE STUDENT PARTICIPATION IN SCHOOL DAY ACTIVITIES AND ON FIELD TRIPS 9. CONTINUE TO MONITOR HEALTH CONDITION AND/OR PARENT/TEACHER CONCERNS</td>
<td>1. REFER TO NARRATIVE ASSESSMENT NURSING NOTES 2. AS ABOVE 3. REFER TO LICENSED PRESCRIBER ORDER SHEET 4. REFER TO ATTACHED HEALTH INTERVENTION GUIDE(S) 5. REFER TO NURSING NOTES 6. REFER TO HEALTH INTERVENTION GUIDE(S) 7. AS ABOVE 8. AS ABOVE 9. REFER TO NURSING NOTES</td>
</tr>
<tr>
<td>POTENTIAL FOR KNOWLEDGE DEFICIT RELATED TO HEALTH CONDITION OR CONCERN</td>
<td>STUDENT: ACCORDING TO STUDENT'S COGNITIVE ABILITY, STUDENT WILL VERBALIZE RECOGNITION OF HEALTH CONCERNS AND RESPOND ACCORDINGLY. STAFF: DESIGNATED STAFF WILL VERBALIZE RECOGNITION OF HEALTH CARE CONCERNS AND RESPOND AS INSTRUCTED.</td>
<td>1. REFER TO NARRATIVE ASSESSMENT NURSING NOTES</td>
<td>2. AS ABOVE</td>
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<td>ALTERATION IN HEALTH MAINTENANCE AS RELATED TO HEALTH CONDITION OR CONCERN</td>
<td>STUDENT: STUDENT WILL MAINTAIN ABILITY TO CONTINUE WITH SCHOOL ACTIVITIES. STAFF: STAFF WILL MAINTAIN SCHOOL ACTIVITIES WHILE RECOGNIZING HEALTH CONDITION.</td>
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RALEIGH COUNTY SCHOOL HEALTH SERVICES
INITIAL NURSING INTAKE / ASSESSMENT

STUDENT ___________________ DOB ______ AGE _____ GRADE ________
SCHOOL ____________________ SCHOOL YEAR __________________

INFORMATION PROVIDED BY: (Name) _______________________________________
Relationship to Student: ___________________________________________________
Phone: Home __________________ Work ___________________ Cell ________________
Address: ________________________________________________________________

Pediatrician / Health Provider: ____________________________________________

MEDICAL HISTORY:

1. Has the student ever been hospitalized? □ YES □ NO
   Reason for hospitalization: ______________________________________________

2. Does the student take any prescription medication? □ YES □ NO

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<th>MEDICATION</th>
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<th>ROUTE</th>
<th>TIME(S)</th>
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3. Does the student take any over-the-counter medications? □ YES □ NO
   □ Vitamins________________________ □ Herbal medicine____________________
   □ Other __________________________

4. Does the student have any allergies? □ YES □ NO
   □ Outside or Indoor Allergies________________________
   □ Food Allergies____________________________________
   □ Insect or Animal Allergies__________________________
   □ Medication or Immunization________________________
   □ Does the student have an Epi-Pen? □ YES □ NO

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<th>ALLERGY</th>
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5. History of Medical Problems or Injuries:

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<tr>
<th>Condition</th>
<th>YES</th>
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<td>Immunizations Up-to-Date</td>
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<tr>
<td>History of Surgeries (Date of any surgeries)</td>
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<tr>
<td>Head Injury or Concussion</td>
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<td>Headaches/Migraines</td>
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<td>Eyes (blurred vision, lazy eye, glasses, irritation)</td>
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<td>Glasses or contacts to help see</td>
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<td>Ears (frequent infections, tubes)</td>
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<td>Hearing (difficulty hearing, hearing aids)</td>
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<td>Nose (sinus infections, nose bleeds)</td>
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<td>Mouth/Throat (strep, difficulty swallowing, enlarged tonsils)</td>
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<td>Heart (irregular heart beat, murmur, birth defect, pain)</td>
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<td>Lungs (difficulty breathing, cough, asthma, infections)</td>
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<td>Stomach (nausea/vomiting, pain)</td>
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<td>Urinary (urgency, bed wetting, pain)</td>
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<td>Bowel (constipation/diarrhea)</td>
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<td>Back (scoliosis, pain)</td>
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<td>Muscles (weakness, pain)</td>
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<td>Bones (history of injury/break)</td>
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<td>Skin (acne, eczema, dry/flaking skin, rashes, hives)</td>
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<tr>
<td>Seizures</td>
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<td>ADD/ADHD</td>
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<td>Emotional Problems (depression, anxiety, fears)</td>
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SPECIAL CONCERNS:

________________________________________________________________________
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________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Nurse’s Signature ___________________________ Date ___________________________
RALEIGH COUNTY SCHOOL HEALTH SERVICES

LICENSED PRESCRIBER'S ORDER SHEET

Children attending Raleigh County Schools are required to have written licensed prescriber’s orders for specific procedures/activities related to their health condition. Please provide orders for the listed health condition/concern. This should include treatment information such as:

- specific time if required
- need for adult supervision
- student independence in performing procedure
- emergency measures/responses
- activity restrictions

USE ONE FORM FOR EACH HEALTH CONDITION/CONCERN

Date of Request: ___________________________ School: _______________

Student Name: ______________________________ Birthdate: ____________

Parent/Guardian: ____________________________________________

Diagnosis: _________________________________________________

Specific Licensed Prescriber’s Order for above condition/concern:

Licensed Prescriber Signature: __________________________ Date: __________ Phone: __________________________

Licensed Prescriber Name Printed: __________________________ FAX: __________________________

REVISED 1/2018
<table>
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<tr>
<th>Date</th>
<th>Time</th>
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<th>Signature</th>
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<th>Signature</th>
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</thead>
</table>

**Medication to:**

- Home ______
- Destruction ______
- Other ____________________

**Final Count ______**

1. Signature: ____________________ Date: ____________

2. Signature: ____________________ Date: ____________
Raleigh County School Health Services
Medication Instructions and Authorization

School Year: ____________________

Student Name: ____________________
Date of Birth: ____________________
Address: _________________________
Telephone: ________________________
School: ____________________________ Grade: ____________
Physician: _________________________

About this Form and Medications
- This form must be completed and signed by a licensed Prescriber and a parent/guardian.
- A separate form is required for each medication.
- All medication changes (e.g., dosage, time, etc.) require a new form.
- Some medications may be given by unlicensed personnel designated and trained by Health Services.
- The medication must be delivered to the school in the original container by the parent/guardian unless otherwise authorized by Raleigh County Schools and Health Services.

To be completed by Prescriber:

Diagnosis: ________________________________
Medication: ____________________________ Dosage: ___
Directions: ______________________________ Route: ___
Specific time(s) to be administered: _________________
Please provide indications for use: _________________________
Allergies: __________________________________
Special Instructions:
- This medication may be self-administered (If eligible according to district policy). Yes ___ No ___
- This medication may be carried by the student (If eligible according to district policy). Yes ___ No ___

Prescriber Signature ___________________ Prescriber Phone Number ___________________ Date __________

To be completed by Parent/Guardian:

I understand that, whenever possible, all medication should be given at home. I give permission for my child to take this medication at school according to county policy. I also understand and agree that the school nurse may talk with the prescriber and his/her staff, as well as school personnel, regarding my child’s condition and administration of this medication and its effects. I further understand that the school, county school board and its employees or agents are exempt from any liability, except for willful and wanton conduct, resulting in injury arising from the self-administration of asthma medication, and agree to indemnify and hold harmless the school, the county board of education and its employees or agents against any claims arising from the self-administration of asthma medications.

Parent/Guardian Signature ___________________ Parent/Guardian Phone Number ___________________ Date __________

Revised 10/2018
Name of Student: _____________________________ Date of Birth _____-____-____

School: _____________________________ Grade: __________

To the licensed prescriber: The monitoring and treatment of students with diabetes, requires medical clearance and direct written orders from their licensed prescriber. These orders will be carried out for one school year unless otherwise ordered, or there is a change in the student's health status. Please use this form to indicate treatment that pertains to your patient.

PLEASE COMPLETE THE FOLLOWING: Diagnosis: Diabetes, □ Type 1 □ Type 2

Blood Glucose Testing:
Frequency: before lunch and as needed for symptoms of high or low blood sugar.
□ before breakfast □ snack □ before boards bus □ before PE □ before drivers ed.

Consent for self-testing (provided the school nurse determines it is safe and appropriate):
□ Yes (No supervision required) □ Yes (Under direct supervision) □ No

Orders and Guidelines for Hypoglycemia (Blood sugar less than 80 mg/dl)
1. Treat with fast acting carbohydrate. Blood sugar <50 = 30g CHO and retest in 15 minutes, blood glucose 50-79 = 15g CHO
2. Re-test in 15 minutes. If blood sugar is 80 or above, student may return to class. If blood sugar is not at least 80, retreat with fast acting carbohydrate and then re-test in 15 minutes. Repeat until blood sugar is at least 80.
3. If next meal/snack > 60 minutes away, please follow with small snack containing complex carbohydrates with protein, such as cheese crackers, up to approximately □ carbohydrates.

Glucagon:
Route of Administration: SQ/IM Dosage: □ 1/2 cc (0.5 mg) □ 1 cc (1mg) □ NA

Frequency: as needed for severe low blood sugar with altered consciousness (loss of consciousness, seizure, inability to swallow).

Call EMS.
Possible side effects, contraindications, or adverse reactions: nausea/vomiting.
Position student on side after Glucagon administration until fully awake.
May not be self-administered.

Other Medications:
Other Diabetes medications being taken by student:

Insulin at home: _____________________________
Oral Diabetes medication: _____________________________

Any Additional Orders: ____________________________________________________________

Name and Title of Licensed Prescriber (PRINT): _____________________________
Phone: _____________________________ Fax: _____________________________
Signature of Licensed Prescriber: _____________________________ Date: __________

Continued On Back

Adopted 6/09
Medication Orders and Guidelines for Diabetic Treatment

Part 2

Name of Student: ___________________________ Last First M I Date of Birth __________

Insulin: Route of administration: SQ by syringe or insulin pen Pump Snacks

Time: ❑ Breakfast ❑ Lunch ❑ Snacks

Insulin Type: ❑ Humalog ❑ Novolog ❑ Regular

Correction Method for Elevated Blood Glucose

A. If blood sugar is ___________________________ or above, use the following sliding insulin scale:

<table>
<thead>
<tr>
<th>Sliding Scale</th>
<th>Give</th>
<th>Units</th>
<th>Give</th>
<th>Units</th>
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B. Algorithm for bolus/injections:

Formula for high blood glucose (BG) correction: (Current BG) - (Target BG) = Units of insulin to be given

Correction Factor:

Blood Glucose Target: ___________________________ mg/dl.

Correction Factor: ___________________________

C. Allow Pump Correction Feature ("Bolus Wizard" etc) to determine dosage with input of BG and/or carbohydrate intake. In event of insulin pump failure revert to Algorithm method above and cover by injections (SQ).

Coverage of Carbohydrate Intake:

Insulin to carbohydrate ratio: ___________________________ Units Insulin for every ___________________________ grams of carbohydrate intake

Snacks and Meals:

School Breakfast Recommended carbohydrate range: ___________________________ / Grams of carbs

❑ AM Snack time ___________________________ / Grams of carbs

Lunch Recommended carbohydrate range: ___________________________

❑ PM Snack time ___________________________ / Grams of carbs

Additional Treatment Protocol:

Ketone Management

Check ketones when BG > 250 mg/dl. Parents will supply ketone strips. Students only need to be sent home if nauseated and/or vomiting. Strenuous exercise will be permitted when BG > 250 mg/dl only if ketones negative to trace amount. If ketones are small or trace and student is not nauseated then they should drink extra water. Ketosis (lasting 4 hours or more) indicates need for q ______ hr. BG monitoring and Insulin by injection, not by pump.

Hyperglycemia management Additional To Mealtime Management

Students should receive additional care at home, at hospital, or through follow-up with physician/practitioner if:

• BG = "HI" at any time

• Persistent hyperglycemia (BG>400 mg/dl) persists after 2-3 hours of treatment and monitoring

School nurse may administer pump bolus or injection of Humalog/Novolog for BG>300 mg/dl q 2 Hr. PRN: ❑ Yes ❑ NO

Other: ___________________________

Insulin Side Effects: Hypoglycemia, Do not correct high blood glucose more frequently than every 2 hours with Humalog or Novolog or every 3 hours with regular Insulin.

Any Additional Orders:

Consent for self-administration (provided school nurse determines it is safe and appropriate.)

❑ Yes (Independent without supervision)

❑ Yes (Under direct supervision of licensed personnel)

❑ No (Must be administered by licensed personnel)

Name and Title of Licensed Prescriber (PRINT): ___________________________

Phone: ___________________________ Fax: ___________________________

Signature of Licensed Prescriber: ___________________________ Date: ___________________________
RALEIGH COUNTY SCHOOL HEALTH SERVICES LICENSED
PRESCRIBER'S ORDER SHEET FOR STUDENTS WITH SEIZURES

Dear Licensed Prescriber:
The parent of the student listed below has indicated that their child has a history of seizures. Students enrolled in Raleigh County Schools who have seizures are required to have licensed prescriber’s orders for the procedure to follow if the student should have a seizure a school. Please keep in mind that schools are not equipped with oxygen or suction machines. Please complete this form for the student.

Date of Request: ___________________________ School: ___________________________ Grade: ______

Student Name: ___________________________ Birthdate: ___________________________

Seizure History:

1) What type of seizure does this student typically have? (Indicate by checkmark)
   - ____ Absence (Petit Mai)
   - ____ Simple Partial
   - ____ Complex Partial
   Date of last seizure: __________
   - ____ Atonic Seizures (Drop Attacks)
   - ____ Myoclonic Seizures
   - ____ Tonic-Clonic
   - ____ Febrile

2) Please list the medications the student is currently taking for seizures:

____________________________________________________________________________________

____________________________________________________________________________________

Emergency Medication: ___________________________ to be administered if ____________________________________________________________________________

____________________________________________________________________________________

THIS EMERGENCY MEDICATION MAY BE DELEGATED TO TRAINED UNLICENSED PERSONNEL: Yes ______ No ______

*An ambulance should be called following a seizure if:
   - ____ The seizure lasts more than _____ minutes
   - ____ The seizure occurs while the child is swimming
   - ____ The second seizure begins shortly after the first seizure without the student regaining consciousness
   - ____ The student does not arouse within 20 minutes following a seizure
   - ____ The student vomits during the seizure

(over)
Additional Orders: 


Comments: 


Licensed Prescriber’s Signature: ___________________________ Date: __________

Phone:________________________
Fax: _________________________

Rev. 12/2018
REPORT OF ADMINISTRATION OF EMERGENCY SEIZURE MEDICATION

Date: ______________

Student’s Name: ___________________ DOB: ____________________

Student’s Normal Breathing Rate: _______ Student’s Weight _______ Pulse _______
(Breathing rate and weight should be obtained at beginning of school year & mid-year)

Time seizure begin: __________

Seizure Description: _______________________________________________________

Time Emergency Medication Given: ____________________________________________
Name/Dose of Emergency Medication: _________________________________________
Respiratory Rate: ___________________________________________________________

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<tr>
<th>Time</th>
<th>Respiratory Rate</th>
<th>Pulse</th>
<th>Comments</th>
<th>Time</th>
<th>Respiratory Rate</th>
<th>Pulse</th>
<th>Comments</th>
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Observation made: ____________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Time 911 Called: __________ Time Arrived: ________________

Time Parent Contacted: ________________

__________________________________________________________ Date

Signature of Personnel Completing Form
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</table>
# RAELIG COUNTY SCHOOL HEALTH SERVICES
## SEIZURE OBSERVATION RECORD

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
<th>Seizure Length</th>
</tr>
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<tbody>
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<table>
<thead>
<tr>
<th>Pre-Seizure Observation (Briefly list behaviors, triggering events, activities)</th>
<th>Conscious (yes/no/ altered)</th>
</tr>
</thead>
<tbody>
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</table>

<table>
<thead>
<tr>
<th>Muscle Tone/Body Movements</th>
<th>Injuries (briefly describe)</th>
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<tbody>
<tr>
<td>Rigid/clenching</td>
<td></td>
</tr>
<tr>
<td>Limp</td>
<td></td>
</tr>
<tr>
<td>Fell down</td>
<td></td>
</tr>
<tr>
<td>Rocking</td>
<td></td>
</tr>
<tr>
<td>Wandering around</td>
<td></td>
</tr>
<tr>
<td>Whole body jerking</td>
<td></td>
</tr>
<tr>
<td>(R) arm jerking</td>
<td></td>
</tr>
<tr>
<td>(L) arm jerking</td>
<td></td>
</tr>
<tr>
<td>(R) leg jerking</td>
<td></td>
</tr>
<tr>
<td>(L) leg jerking</td>
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<tr>
<td>Random Movement</td>
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</table>

<table>
<thead>
<tr>
<th>Color</th>
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<tbody>
<tr>
<td>Bluish</td>
<td></td>
</tr>
<tr>
<td>Pale</td>
<td></td>
</tr>
<tr>
<td>Flushed</td>
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</table>

<table>
<thead>
<tr>
<th>Eyes</th>
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<tbody>
<tr>
<td>Pupils dilated</td>
<td></td>
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<tr>
<td>Turned (R or L)</td>
<td></td>
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<tr>
<td>Rolled up</td>
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<tr>
<td>Staring or blinking (clarify)</td>
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<tr>
<td>Closed</td>
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<table>
<thead>
<tr>
<th>Mouth</th>
<th>|</th>
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<tbody>
<tr>
<td>Salivating</td>
<td></td>
</tr>
<tr>
<td>Chewing</td>
<td></td>
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<tr>
<td>Lip smacking</td>
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<table>
<thead>
<tr>
<th>Verbal Sounds-describe (gagging, talking, throat clearing, etc.)</th>
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<table>
<thead>
<tr>
<th>Breathing-describe (normal, labored, stopped, noisy)</th>
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<table>
<thead>
<tr>
<th>Incontinent (urine or feces)</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Post-Seizure Observation</th>
<th></th>
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<tbody>
<tr>
<td>Confused</td>
<td></td>
</tr>
<tr>
<td>Sleepy/tired</td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td></td>
</tr>
<tr>
<td>Speech slurring</td>
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<tr>
<td>Other</td>
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<table>
<thead>
<tr>
<th>Length to orientation</th>
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<thead>
<tr>
<th>Parents notified? (note time of call)</th>
<th>EMS called? (note call and arrival time)</th>
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<table>
<thead>
<tr>
<th>Observer's Name</th>
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</table>

Source: National Epilepsy Foundation

Adopted 7/06
Skills Performance Checklist

Administration of Emergency Seizure Medication

School Employee: ____________________________________________
Position: _________________________________________________
County: ___________________________________________________
Certified School Nurse Instructor: ____________________________

<table>
<thead>
<tr>
<th>Explanation/Demonstration</th>
<th>Date Completed</th>
<th>Date Completed</th>
<th>Date Completed</th>
<th>Date Completed</th>
<th>Date Completed</th>
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</thead>
<tbody>
<tr>
<td>A. Obtain instructions from school nurse.</td>
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<tr>
<td>B. Verbalize student history of seizures and their response to emergency seizure medication.</td>
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<td>C. Verbalize where procedure can be performed in school setting for student privacy.</td>
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<td>D. Verbalize emergency plan for individual student.</td>
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<td>E. Verbalized procedure for administration and monitoring student’s response.</td>
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<td>F. Obtain ordered emergency seizure medication and ensure proper storage.</td>
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<tr>
<td>G. Check student and provide safety measures for student during seizure.</td>
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<td>H. Verbalize/demonstrate administration of emergency seizure medication for established criteria.</td>
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<tr>
<td>I. Monitor student's pulse and respirations until EMS arrive.</td>
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<td>J. Document activity on student's individual treatment record.</td>
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<tr>
<td>K. Verbalize additional considerations for using emergency seizure medications.</td>
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