CUMBERLAND COUNTY SCHOOLS

Protocol for Medication Administration

Revised 01/26/2024

CUMBERLAND COUNTY SCHOOLS
Protocol for Medication Administration

General Information

Cumberland County Schools (CCS) acknowledges the diverse health needs of our student body and has developed this protocol to inform parents, guardians, and staff about best practices for medication administration. The school district reserves the right to decline a request for medication administration, and medications will not be given outside of regular school hours. The school system and its personnel will only assume responsibility and liability in adhering to instructions provided by the parent/guardian and physician. Collaborating with the Cumberland County Department of Public Health (CCDPH), the Office of Health Services offers various support services, workshops, and connections to community resources.

Handling, Storage, and Disposal of Medications

- Student medications will be securely stored in a medication cart to maintain their safety. Medications requiring refrigeration will be placed in a designated refrigerator located in a locked room. For medications requiring refrigeration, a dedicated refrigerator solely for student medications will be utilized to prevent any chance of cross-contamination.
- The school district is committed to providing secure, locked storage for all medications, aiming to prevent misuse or unintended ingestion by any individual.
- When schools take possession of medications, they bear the responsibility of ensuring that the prescribed medication is available to the designated student while safeguarding against access by other students.
- Proper storage and security measures dictate that all medications be kept within the provided medication cart by Health Services.
- For medications requiring refrigeration, a dedicated refrigerator solely for student medications will be utilized to prevent any chance of cross-contamination.
- Access to stored medications and keys is restricted to the building principal and individuals authorized to administer medications.
- The health office should remain locked when the school nurse, health services personnel, or trained staff members assisting students are not present. Additionally, medication carts must be kept locked at all times.
- Any unused, discontinued, or expired medication will be collected by the parent/guardian. Medication remaining beyond the approved period or the conclusion of the school year will be disposed of within two weeks.

School Nurses and Medication Clerks

Every school is equipped with three medication clerks, one of whom works on a 12-month basis, ensuring continuous monitoring of medications. These clerks will collaborate on schedules to guarantee that there is always someone available to administer and oversee medication. Additionally, a public health school nurse is on-site one day per week and is available for phone consultations.

Parent/Guardian Responsibilities

The parent or guardian is responsible for:

- Completing the CCS Confidential School Health Form.
- Providing written consent (since schools operate in loco parentis, 18-year-old students living with their parent or guardian should have parental consent).
- Supplying medications, orders, consents, and necessary supplies.
- Furnishing a written provider order on an approved CCS medication form and the required supplies to meet the order's specifications.
- Providing a signed release of liability.
- Administering the first dose of a new medication at home, including any dosage changes.
- Delivering medication to school staff in an original container, clearly labeled with the student's name, physician's name and contact information, medication name, and strength, amount given per dose, route and time of administration, and the dispensing pharmacy.
- Ensuring that medications packaged in an original pharmacy-labeled container match the physician's order.
- Requesting the pharmacist to divide the required medication into two doses, with one designated for at-home use and the other for school use.
- Supplying any necessary equipment or supplies for administration (e.g., syringes and needles, spacers, special snacks for diabetics, etc.).
- Counting or measuring medications with the medication clerk during the check-in and check-out of prescribed medications. Parents or guardians also have the liberty to sign out their student's medication from the school at any time.
- Replacing used and expired medication promptly.
- Providing the school with appropriate documentation and medication to meet their child's medical needs within 30 calendar days.
- Present emergency medications as soon as possible, but no later than 30 calendar days, along with a matching physician's order and pharmacy label, to the school medication clerk.
- Communicating any changes in a student's health status and/or medication regime to the medication clerk and school nurse.

Field Trips

The parent or guardian is required to obtain physician authorization for the administration of medication beyond the regular school day or that needs to be administered during weekends. In cases where a student requires medication during field trips, weekends, or overnight school-related activities, the principal will appoint an individual to administer the medication during the field trip.

This designated person must familiarize themselves with the CCS Medication Protocol and transport the medication dosage in an individual container (such as a Ziploc bag or envelope) prepared by the primary medication clerk or the principal's designee. The container should include the following identifiers:

- Student's name
- Name, dosage, and route of medication
- Time for administration
- Additionally, a copy of the CCS Physician's School Medication form(s) or an approved emergency action plan will accompany the student on the field trip.

Guidelines for Proper Completion of Medication Paperwork

- The physician is required to provide a comprehensive order, including the medication's name, dosage, time, route, and frequency.
- Orders should be documented on the current CCS School Medication Form.
- Specific doses must be indicated; otherwise, the order will not be accepted. An unacceptable order example is "2-4 puffs" or "1-2 pills."
- Orders must specify a particular time for administration; vague references like "Lunchtime" or "Breakfast" will not be accepted.
- For as-needed medication, orders must outline a specific interval between doses. An unacceptable example is "Give prn 'three times a day,'" while "Give prn 'every eight hours'" is acceptable.
- Orders must be legible and accompanied by a matching pharmacy label. Failure to communicate medication instructions and pertinent information will result in rejection.

Emergency Transportation for Students with Special Needs

In specific situations, a student unable to self-administer emergency medication may require an adult to transport the prescribed medicines to and from school for medical reasons.

Medication Clerks will confer with their school nurse to request special approval for bus driver transport to the parent or guardian. The Director of Health Services and School Nurse Supervisor will review such cases before granting permission.

Upon approval, an emergency transport log will be issued to ensure the student's safety and proper medication handling.

When transporting medication on the bus, it must be securely stored in a designated container. Staff members should hand over the emergency medication and emergency transport log to the bus driver or transportation aide, who can then pass it to the parent or guardian when the student returns home. The entire chain of custody will be meticulously documented on the CCS Emergency Medication Transport Log provided by the Health Services Director and Public Health Nursing Supervisor.

Short-term Prescription Medications

The parent or guardian is responsible for delivering the prescribed medication to the school in its original pharmacy-labeled container. Additionally, the parent or guardian must complete a CCS Short-term Medication Form, providing the following information:

- Student's name
- Name, dosage, and route of medication
- Time for administration
- A signed Release of Liability

Short-term prescription medications are restricted to a maximum of 14 calendar days. The parent or guardian must retrieve any unused short-term medications. Any medication remaining after the 14 days will be appropriately discarded within two weeks.

CUMBERLAND COUNTY SCHOOLS
SHORT-TERM MEDICATION FORM
May Not Exceed 14 Calendar Days

Rev. 05/2018

Student's Name: _____ Date of Birth: _____

Name of School: _____ Grade: _____

Parent/Guardian: _____ Phone: _____

Prescribing Physician: _____ Physician's Phone: _____

Reason for medication: _____

Date and time this medication was first administered to the student by the parent/guardian. _____

List allergies: _____

Name of prescription medication: _____ Dose: _____ Route: _____

Medication exact time to be given _____ a.m. _____ p.m. **Dose must be exact; ranges will not be accepted.**

Directions for administering medication: _____

Short-term medication may not exceed 14 calendar days. Start date for medication: _____

I understand that:

- the school nurse is available one day a week.
- non-medical personnel administer medications daily.
- prior to school administration, the parent/guardian is required sign the check-in/check-out log for medication.
- students are not permitted to transport medication to or from school.
- I may contact the Primary Medication Clerk or school nurse if assistance is needed to ensure medication meets CCS Protocol for Medication Administration.
- medication not picked up within fourteen (14) calendar days of the expiration of this form will be discarded.

RELEASE OF LIABILITY FORM

I, _____ the parent/legal guardian of _____ enrolled at _____ school realizing the importance of administering medication to my child as prescribed by the child's physician, do hereby agree to relieve designated school personnel, the Cumberland County Schools, and the Cumberland County Board of Education of and from any liability from any potential ill effects as a result of their injecting or giving my child medication prescribed by the child's physician. I have discussed this with my physician and/or legal counsel (lawyer) and realize its ramifications and thoroughly understand the meanings of these statements. I consent for the medical provider to disclose health or medical information regarding medication prescribed. I understand that I may revoke this consent at any time, except to the extent action has been taken in reliance on it. This consent is valid until I revoke it in writing or for the term fourteen (14) calendar days.

Parent/Legal Guardian's Signature: _____ Date: _____

Principal's Signature: _____ Date: _____

FOR OFFICE USE ONLY: This form will expire 14 days from the date the parent signed. This form will expire on _____
DISPOSITION OF MEDICATION: Date medication was picked up _____ or date medication was discarded _____
by Staff Name: _____ Staff Signature: _____ Witness: _____

Long-term and Over-the-Counter Medications

Long-term medications are prescribed for fifteen (15) days or more. Before the acceptance of these medications, the parent or guardian is required to submit a CCS School Medication Form.

The instructions on the CCS Physician's School Medication Form should align with the details on the pharmacy-labeled container.

For Over-the-Counter (OTC) medications (non-prescription medications), they must be accompanied by a completed CCS Physician's School Medication Form, which should have a corresponding pharmacy label.

Example of Over-the-Counter Medication

All Over-the-Counter Medication must have a Physician's Order with a matching pharmacy label.

Example of Prescription Medication

CUMBERLAND COUNTY SCHOOLS
PHYSICIAN'S SCHOOL MEDICATION FORM

Rev. 05/2018

TO BE COMPLETED BY MEDICAL PROVIDER

Student's Name: _____ Date of Birth: _____

Name of School: _____ Grade: _____

The above named person is a patient currently under my medical care. Due to a medical condition the medication listed below must be (given/taken/injected) during regular school hours according to the following protocol:

Medication: _____ Dose: _____ Route: _____

Dose must be exact; ranges will not be accepted.

☐ Routine/Daily Medications: exact time to be given _____ a.m. _____ p.m.

☐ As needed (p.r.n.) medication for: _____ give every _____ hour(s).

Directions for administering medication: _____

_____

Please indicate any special storage requirements such as room temperature, refrigeration, etc. _____

_____

MD Stamp Below

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____

Office Phone: _____ FAX: _____

Office Address: _____

City, State, ZIP: _____

This order will expire one year from the date the physician signed.

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

I understand that:

- prescription medications may be administered at school and must be in a pharmacy-labeled prescription bottle that matches the CCS Physician's School Medication Form. Medication dosage, time and intervals, must be exact.
- the school nurse is available one day a week.
- non-medical personnel administer medications daily.
- prior to school administration, the parent/guardian is required to sign the check-in/check-out log for medication.
- students are not permitted to transport medication to or from school.
- medication may only be administered as ordered on the approved CCS medication forms.
- if medication is not available at the school, 911 will be called for emergencies.
- the parent/guardian is responsible for notifying coaches or supervising staff of before and/or after-school activities of the child's health status and/or the need for medication.
- I may contact the Primary Medication Clerk or school nurse if assistance is needed to ensure medication meets CCS Protocol for Medication Administration.
- **medication not picked up within two weeks of the last day of school will be discarded.**

RELEASE OF LIABILITY FORM

I, _____ the parent/legal guardian of _____ enrolled at _____ school realizing the importance of administering medication to my child as prescribed by the child's physician, do hereby agree to relieve designated school personnel, the Cumberland County Schools, and the Cumberland County Board of Education of and from any liability from any potential ill effects as a result of their injecting or giving my child medication prescribed by the child's physician. I have discussed this with my physician and/or legal counsel (lawyer) and realize its ramifications and thoroughly understand the meanings of these statements. I consent for the medical provider to disclose health or medical information regarding medication prescribed. I understand that I may revoke this consent at any time, except to the extent action has been taken in reliance on it. This consent is valid until I revoke it in writing or for the term of one year.

Parent/Legal Guardian's Signature: _____ Date: _____

Principal's Signature: _____ Date: _____

FOR OFFICE USE ONLY: This order will expire one year from the date the physician signed. This form will expire on _____

DISPOSITION OF MEDICATION: Date medication was picked up _____ or date medication was discarded _____

by Staff Name: Staff Signature: Witness:

Controlled Substances

Narcotics refer to controlled substances utilized for short-term pain relief, such as Tylenol w/codeine, Percocet, etc. In contrast, non-narcotic controlled substances like Adderall, Ritalin, and Focalin may be prescribed for more extended periods.

For controlled substances, CCS mandates the following:

The CCS Controlled Substance Accountability Form will detail the type of controlled substance, dosage, and the number of doses provided. It will include information such as the date and time of administration, student's name, prescribing physician's name, quantity administered, balance on hand after each administration, and the signature of the administering CCS employee.

Any discrepancies will be promptly reported to the parent or guardian, safety and security personnel, administrators, and the Office of Health Services.

Reports of missing medications will be reviewed by the school administration, school nurse, CCS Director of Safety and Security, CCS Director of Health Services, and Public Health School Nurse Supervisor. Necessary adjustments to protocols will be made to prevent future occurrences.

Intravenous Medication

As the enrollment of students with chronic health conditions rises, schools are encountering a growing need to administer medications intravenously. These medications are often crucial for the well-being and safety of the students. Consequently, schools will exclusively administer intravenous (IV) drugs when they cannot be given at any other time of the day. While technological advancements allow for the safe administration of these medications within school premises, the involvement of a Registered Nurse is essential. Requests for intravenous medication will be examined on an individual basis by the Office of Health Services.

Missed Doses

Staff is authorized to administer only the doses specified in the medication order. Medication can be administered within a 30-minute window before or after the scheduled dose.

Requests from a parent or guardian to administer medication not listed on the CCS Physician’s School Medication Form will not be accommodated, including phone requests.

In the event of a missed dose, school staff will promptly fill out a CCS Medication Administration Incident Report and notify the necessary personnel. Immediate notification to the parent or guardian, school nurse, and, if necessary, the physician, must be provided for any missed doses.

Student Non-compliance

In instances where a student refuses to cooperate with a staff member administering medication, the following procedure will be implemented:

First Incident: The primary medication clerk or principal designee will contact the parent or guardian by telephone to explain the concern. Staff will document concerns on the CCS Student Medication Administration Non-compliance Individual Medication Documentation Form.

Second Incident: A parent or guardian conference will be convened at the school, involving the principal, medication clerk, school nurse, and parent or guardian. Staff will record concerns on the CCS Student Medication Administration Non-Compliance Individual Medication Documentation Form.

Third Incident: The principal will notify the parent or guardian that the student has persistently demonstrated non-compliance with medication administration regulations, and as a result, school staff will no longer administer the prescribed medication. Staff will document concerns on the CCS Student Medication Administration Non-compliance Individual Medication Documentation Form.

Confidential School Health Forms and Care Plans

The nurse will review the confidential school health form and document any areas of concern, communicate with parents as necessary, and collaborate with the physician to create emergency action plans as required. After finalizing the care plan, the school nurse will coordinate training for school staff, including bus drivers and monitors. Medication Clerks will make certain that substitutes and new hires who will be directly involved with the student are oriented to the student's care plan. Parents are requested to complete and return the confidential school health form the following day after receiving it. We also request that parents update their contact information as it changes.

Allergies and Anaphylaxis

The paramount measure to avert life-threatening allergic reactions is preventing student exposure to allergenic foods or substances. In the absence of a physician's written dietary order, the parent or guardian, with the assistance of the school nurse or medication clerk, must complete a Temporary Special Nutritional Needs form and submit it to the cafeteria manager.

For students with life-threatening allergies, a CCS Severe Allergy Medication Plan and/or CCS Emergency Self-medication Authorization Form is essential. Approval for the Emergency Self-medication Authorization Form may be granted for students in grade 4 or higher. Prescription labels must align with the provided order. Students with provider orders and written parent or guardian consent to carry and administer medication should be allowed to carry and use their medication on the bus.

Parents or guardians of students with food allergies are required to submit the CCS Medical Statement for Students with Unique Mealtime Needs for School Meals to cafeteria staff, the principal, and the school nurse as soon as possible or within 30 calendar days.

To support students with food or substance allergies, parents or guardians are encouraged to provide the classroom teacher with suitable snacks.

Adherence to effective handwashing techniques before and immediately after food consumption is mandatory for both students and staff.

The school nurse will conduct staff training on the administration of emergency medication, and an emergency action plan will be completed by the school nurse or healthcare provider.

In the absence of emergency medication, school staff will promptly call 911 if a severe allergic reaction occurs.

Guidance for Completing the Medical Statement for Students with Unique Mealtime Needs for School Meals

PART A - PARENT/GUARDIAN

The *Medical Statement for Students with Unique Mealtime Needs for School Meals* helps schools provide meal modifications for students who require them. **Schools cannot change food textures, make food substitutions, or alter a student's diet at school without proper documentation from the healthcare providers.** Completion of all items will allow your child's school to create a plan with you for providing safe, appropriate meals and snacks to your child while at school.

Your participation in this process is very important. The sooner you provide this signed and completed form to your child's school, the sooner the School Nutrition Program and their staff can prepare the food your child needs. Your signature is required for your school to take action on the Medical Statement.

Follow these steps to get started:

1) Complete all sections of PART A of the Medical Statement.
2) Take the Medical Statement to your child's pediatrician or family doctor/nurse practitioner/physician's assistant and have him/her complete and sign PART B.
3) RETURN THE FULLY COMPLETED MEDICAL STATEMENT WITH SIGNATURES FROM BOTH PARENT/GUARDIAN AND MEDICAL AUTHORITY, TO YOUR CHILD'S TEACHER, PRINCIPAL, NURSE, SPECIAL EDUCATION CASE MANAGER, OR SECTION 504 CASE MANAGER, SCHOOL NUTRITION ADMINISTRATOR, OR THE SCHOOL STAFF PERSON WHO GAVE YOU THE BLANK FORM.
4) Ask the school when a team, including you, the school system's School Nutrition Administrator and others, will meet to consider the information provided on the form. You may also invite people from the community who are knowledgeable about your child's feeding and nutrition issues to the meeting. These would be people who could help school staff design a school mealtime plan for your child, like your child's pediatrician, nurse, speech-language pathologist, occupational therapist, registered dietitian or personal care aide.

PART B – RECOGNIZED MEDICAL AUTHORITIES *(Licensed physician, physician assistant, and nurse practitioner)*

A Recognized Medical Authority's signature is *required* for students with a disability. Schools cannot change food textures, make food substitutions, or alter a student's diet at school without proper documentation from the healthcare providers. Meal modifications are implemented based on medical assessment and treatment planning and *must be ordered by a recognized medical authority.*

Please consider the following as you complete **PART B** of the Medical Statement:

1) Complete all sections of **PART B**. Completion of all items will streamline efficient care of the student at school.
2) Be as specific as possible about the nature of the student's physical or mental impairment, its impact on the student's diet and major life activities that are affected. In the case of food allergy, please indicate if the student's condition is a food intolerance, an allergy that would affect performance and participation at school (e.g., severe rash, swelling, and discomfort), or a life-threatening allergy (e.g., anaphylactic shock).
3) If your assessment of the child does not yield sufficient data to make a determination about food substitutions, consistency modifications, or other dietary restrictions, please refer the child/family to the appropriate health care professional for completion of the assessment. Schools do not routinely have instrumentation and/or staff trained for a comprehensive nutrition and feeding assessment and must partner with community providers to meet a student's unique feeding and nutrition needs.
4) Attach any previous and/or existing feeding/nutrition evaluations, care plans, or other pertinent documentation housed in the student's medical records to the Medical Statement for parent/guardian delivery to the school.
5) Consider being available to consult with the student's mealtime planning team as it implements the feeding/nutrition care plan.

PART C – SCHOOL NUTRITION ADMINISTRATOR and IEP/504 REPRESENTATIVE

Please consider the following as you complete **PART C** of the Medical Statement:

Signature of the School Nutrition Administrator and 504 Coordinator or IEP Case Manager/EC Program representative indicates the medical statement has been received, reviewed, and a plan to address the student's unique mealtime needs is being developed/implemented.

Medical Statement for Students with Unique Mealtime Needs for School Meals

When completed fully, this form gives schools the information required by the U.S. Department of Agriculture (USDA), U.S. Office for Civil Rights (OCR), and U.S. Office of Special Education and Rehabilitative Services (OSERS) for meal modifications at school. See *"Guidance for Completing Medical Statement for Students with Unique Mealtime Needs for School Meals"* (previous page) for help in completing this form.

PART A *(To be completed by **PARENT/GUARDIAN**)*

STUDENT INFORMATION	**Last Name:**	**First Name:**	**Middle Name:**	**Date of Birth**
	School:		**Grade**	**Student ID#**
SELECT the school-provided meals and/or snacks in which this student will participate:	☐ School Breakfast Program ☐ National School Lunch Program ☐ Afterschool Snack Program ☐ Afterschool Supper Program ☐ Fresh Fruit & Vegetable Program			
PARENT/GUARDIAN CONTACT INFORMATION	**Printed Name of PARENT/GUARDIAN:**			
	Mailing Address:	**City:**	**State:**	**Zip Code:**
	Work Phone:	**Home Phone:**	**Mobile Phone:**	**Email:**
Please describe the concerns you have about your student's nutritional needs at school:				
Please describe the concerns you have about your student's ability to safely participate in mealtime at school?				

Does the student already have an Individualized Education Program (IEP)?
☐ YES ☐ NO

Does the student already have a 504 Plan?
☐ YES ☐ NO

NOTE: *Unique mealtime needs for students without an IEP, 504 or disability, but with general health concerns, are addressed within the meal pattern at the discretion of the School Nutrition Administrator and policies of the school district.*

PARENT/GUARDIAN Consent

I agree to allow my child's health care provider and school personnel to communicate as needed regarding the information on this form.

Parent/Guardian Signature **Date**

Please return this fully completed Medical Statement with signatures from both parent/guardian and medical authority, to your child's teacher, principal, nurse, Special Education case manager, or Section 504 case manager, School Nutrition Administrator, or the school staff person who gave you the blank form.

STUDENT NAME: _____ **STUDENT ID#:** _____

PART B *(To be completed by a **RECOGNIZED MEDICAL AUTHORITY**, i.e., Licensed physicians, physician assistants, and nurse practitioners)*

Describe the student's physical or mental impairment:

Explain how the impairment restricts the student's diet:

Major life activities affected: *Select all that apply.*

☐ Walking ☐ Seeing ☐ Hearing ☐ Speaking ☐ Performing manual tasks
☐ Learning ☐ Breathing ☐ Self-Care ☐ Eating/Digestion
☐ Other *(please specify):*

Is this a Food Allergy? ☐ YES ☐ NO

Is this a Food Intolerance? ☐ YES ☐ NO

If student has life threatening allergies* check appropriate box(es):

**Students with life threatening food allergies must have an emergency action plan in place at school.*

☐ Ingestion ☐ Contact ☐ Inhalation

Specify any dietary restrictions or special diet instructions for accommodating this student in school meals:

For *any* special diet, list specific foods to be omitted and the recommended substitutions. *(You may attach a separate care plan)*

Check all food items to be Omitted		***Recommended Substitutions:***
DAIRY: ___ Fluid Milk ___ Recipes with fluid milk as an ingredient ___ Yogurt ___ Cheese ___ Ice Cream ___ Recipes/food products with any dairy listed. **EGG:** ___ Whole egg such as scrambled or boiled ___ Food with any egg listed as an ingredient. **SOY:** ___ Soybean ___ Food with any soy listed as an ingredient.	**WHEAT:** ___ Food with any wheat listed as an ingredient (this includes white bread). **Other foods to be Omitted:** _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____

Designate safest consistency requirement for FOOD:

☐ Pureed ☐ Mechanical Soft ☐ Other *(please specify):*
☐ Ground ☐ Chopped

Designate safest consistency requirement for LIQUIDS:

☐ Clear Liquid ☐ Nectar-thick ☐ Other *(please specify):*
☐ Full Liquid ☐ Honey-thick
☐ Pudding-thick

Other comments about the child's eating or feeding patterns, including tube feeding if applicable:

NOTE* If your assessment of the child does not yield sufficient data to fully complete the above sections applicable to the student's mealtime needs, please refer the child/family to the appropriate health care professional for completion of the assessment.

Signature of Recognized Medical Authority*	Printed Name	Phone Number	Date
		( )	

**** A recognized medical authority in N.C. includes licensed physicians, physician assistants and nurse practitioners.***

PART C *(To be completed by **SCHOOL DISTRICT ADMINISTRATORS**)*

School Nutrition Administrator's Signature: **Date:**

IEP/504 Coordinator Signature: **Date:**

NOTES: *(School Nutrition or other School Program staff)*

Epinephrine

In the event of a severe, life-threatening allergic reaction (anaphylaxis), a student may necessitate an injection of epinephrine, commonly administered through an EpiPen. Severe allergic reactions can manifest within minutes of exposure to the allergen, making immediate action imperative if the student displays severe allergic symptoms such as swelling of the eyes, lips, face, or throat, raised rash (hives), difficulty breathing, loss of consciousness, etc.

Every school is equipped with emergency epinephrine to facilitate urgent care for persons experiencing an anaphylactic event. Stock EpiPens should be securely stored in the AED closest to the front office.

CUMBERLAND COUNTY SCHOOLS
SEVERE ALLERGY MEDICATION PLAN

Rev. 06/2018

To be completed by Medical Provider

MEDICATION ORDERS AND INSTRUCTIONS *(to be completed by the Student's Medical Provider)*

[PLEASE CHECK ☑ APPROPRIATE BOXES AND FILL IN THE BLANKS.]

Student's Name: _____ Wt: ____ *lbs.* DOB: _____ Age: _____

The above named person is a patient currently under my medical care. Due to a medical diagnosis of severe allergies, the medication listed below may need to be given during school hours according to the following protocol and the CCS Severe Allergy Emergency Plan of Action on page two:

List **SEVERE** allergies: _____

Type of exposure: ☐ Contact (skin) ☐ Ingestion ☐ Inhalation (airborne) ☐ Injection (insect bites/stings, allergy shots, etc.)

Past allergic reactions: ☐ Positive allergy test ☐ Anaphylaxis ☐ Other: _____

EPINEPHRINE AUTO-INJECTOR

➢ **DOSAGE**

☐ 0.15mg/3ml (Inject into middle of outer thigh muscle)

☐ 0.3mg/3ml (Inject into middle of outer thigh muscle)

➢ **TIME TO BE GIVEN**

☐ Give immediately if known exposure/ingestion.

☐ Give immediately if has symptoms of severe allergic reaction

**(flushed face; dizziness; seizures; confusion; weakness; paleness; hives all over body; blueness around mouth, eyes; difficulty breathing; drooling or difficulty swallowing; loss of consciousness.)* Other: _____

_____

☐ If second dose is available and symptoms continue or worsen, may give second dose at least five minutes after first dose.

*NC School Health Program Manual-2014 pg.E3-27

ORAL ANTIHISTAMINE ☐ NOT ordered for school

➢ **DRUG NAME** _____

➢ **DOSAGE** (Must be exact; Dose ranges not acceptable): _____

➢ **INTERVAL** every _____ hours as needed

➢ **TIME TO BE GIVEN**:

☐ Give immediately if known exposure/ingestion.

☐ Give immediately if has symptoms of mild allergic reaction

**(red, watery eyes; itchy, sneezing, runny nose; hives or rash in one area.)*

Other _____

*NC School Health Program Manual-2014 pg.E3-27

➢ Is diet modification required: ☐ Yes or ☐ No
If yes, **attach** completed CCS Medical Statement for Students with Special Nutritional Needs for School Meals Form.

➢ Is emergency self-medication to be considered: ☐ Yes or ☐ No
If yes, **attach** completed CCS Emergency Self Medication Authorization Form. Only students mature enough to self-carry will be given permission.

Physician's signature: _____

Print physician's name: _____ Date: _____ Phone: _____

Clinic address: _____ City: _____ State: ____ Zip: _____

To be completed by Parent or Legal Guardian

STUDENT INFORMATION *(to be completed by the Parent or Legal Guardian)*

Does your child have a 504 Plan? ☐ Yes or ☐ No Does your child have an IEP? ☐ Yes or ☐ No

Home address: _____

City: _____ State: _____ Zip: _____

Parent/Guardian Name: _____

Phone Number: _____ Alternate No. _____ Alternate No. _____

List other milder allergies and reactions: _____

Other health problems: _____

Current medications: _____

Transportation to and from school:

☐ Walker: a.m. ___ p.m. ___ ☐ Car rider: a.m. ___ p.m. ___

☐ Bus rider: a.m. Bus No. _____ p.m. Bus No. _____

☐ Prime Time: a.m. ___ p.m. ___

EMERGENCY CONTACTS: EMS will usually transport to nearest emergency department. Preferred medical facility: _____

_____ Relation: _____ Phone No. _____ Alternate No. _____

_____ Relation: _____ Phone No. _____ Alternate No. _____

RELEASE OF LIABILITY FORM: I, _____ the parent/legal guardian of _____ enrolled at _____ school realizing the importance of administering medication to my child as prescribed by the child's physician, do hereby agree to relieve designated school personnel, the Cumberland County Schools, and the Cumberland County Board of Education of and from any liability from any potential ill effects as a result of their injecting or giving my child medication prescribed by the child's physician. I have discussed this with my physician and/or legal counsel (lawyer) and realize its ramifications and thoroughly understand the meanings of these statements. I consent for the medical provider to disclose health or medical information regarding medication prescribed. I understand that I may revoke this consent at any time, except to the extent action has been taken in reliance on it. This consent is valid until I revoke it in writing or for the term of one year.

Parent or Guardian Signature: _____ Date: _____

Principal Signature: _____ Date: _____

FOR OFFICE USE ONLY: This order will expire 1 year from the date the physician signed. This form will expire on: _____

DISPOSITION OF MEDICATION: Date medication was picked-up _____ or date medication was discarded _____

by Staff Name: _____ Staff Signature: _____ Witness: _____

CUMBERLAND COUNTY SCHOOLS
SEVERE ALLERGY EMERGENCY PLAN OF ACTION

Rev. 06/2018

Student's Name:_____DOB:_____Teacher:_____Grade:_____

INSTRUCTIONS FOR PERSON WITH STUDENT

1. Notify office to call 911 and request student's Emergency Allergy Medication Kit.
2. If insect sting occurred—remove stinger as quickly as possible and apply ice.
3. Reassure and calm student. Position student comfortably, sitting upright may be necessary for breathing ease.
4. When emergency allergy kit arrives, trained staff will administer epinephrine/antihistamine per physician's order.
5. Note exact time(s) medication was administered and inform EMS.
   - Epinephrine 1st dose was given at time: _____
   - If required, Epinephrine 2nd dose was given at time: _____
   - Antihistamine dose was given at time: _____
6. If student's condition is worsening and EMS has not arrived, have office call 911 and report the change.
7. EMS to transport to nearest emergency department or, if able, to parent's preferred medical facility.
8. If student has an allergic reaction on the bus then bus driver should stop route, call 911, and follow above instructions when possible.

INSTRUCTIONS FOR PERSON IN OFFICE

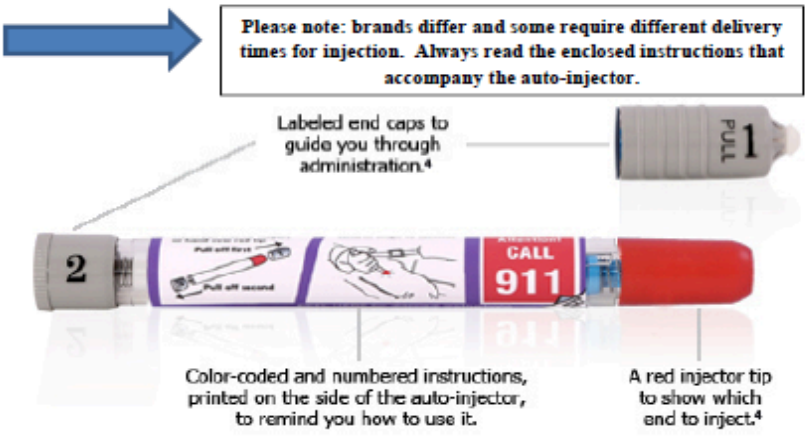
1. Kit should be taken to the student by an adult and 911 simultaneously called. The caller should state, "There has been a severe allergic reaction and I am a third party caller. Medical history includes: (see information listed on page one)."
2. Notify parent/ guardian as soon as possible.

INSTRUCTIONS FOR PERSON INJECTING EPINEPHRINE

1. Put on gloves.
2. Make sure student is sitting or lying down.
3. Follow physician's orders.
4. Follow directions that are printed on the auto-injector.
5. Keep student warm and quiet. Massage injection site for ten seconds and apply Band-Aid, if needed.
6. If condition worsens or breathing stops, begin CPR and call 911 to report condition has worsened.
7. Send used kit with EMS for disposal in a sharps biohazard container.

FOLLOW-UP AFTER USE OF AUTO-INJECTOR

1. Contact parent regarding incident outcome and need for replacement.
2. Document incident on health card to include cause of allergic reaction, date and time of incident, symptoms displayed, and if any follow-up recommendations from physician.
3. School staff, administration, and school nurse will meet to discuss and evaluate incident.



EMERGENCY MEDICATION INFORMATION *(to be completed by the school nurse)* **Nurse:** _____ **Date:** _____

LOCATION OF EMERGENCY MEDICATIONS: [Please check ☑ all that apply.]➔ ☐ School medication cart OR ☐ Prime Time OR ☐ Bus during route

1. School med cart Medication=Antihistamine-Exp. Date:_____ Epinephrine Auto-Injectors-#of doses ____ Exp. Date _____Lot# _____
2. Prime Time Medication=Antihistamine-Exp. Date _____ Epinephrine Auto-Injectors-#of doses _____ Exp. Date _____Lot# _____
3. Bus Medication=Antihistamine-Exp. Date_____ Epinephrine Auto-Injectors-#of doses _____ Exp. Date _____ Lot#._____

CUMBERLAND
COUNTY SCHOOLS

Asthma and/or Anaphylaxis Emergency Backup Medication North Carolina House Bill 496 (rev 1/24)

Date: _____

Dear Parent/Guardian

In 2005, North Carolina passed House Bill 496 to ensure the safety of all North Carolina students. This bill requires that the student's parent or guardian shall provide the school backup emergency medication that shall be kept at the student's school in a location to which the student has immediate access in the event of an asthma or anaphylaxis emergency.

Your child _____has emergency medication, which the following items marked are missing or are not in compliance with local and state guidelines:

☐ An Emergency Self-authorization Form must be completed by the student's healthcare provider, parent and submitted to the medication clerk prior to medication being accepted.

☐ Properly labeled emergency backup medication that must be brought by the parent to the school. All medications must be signed in with the medication clerk.

☐ Backup emergency medication will/has expired on: _____.

☐ Emergency medication is missing pharmacy label with the:

- ☐ Student's name
- ☐ Medication
- ☐ Dose
- ☐ Time to be administered
- ☐ Route

Items indicated must be submitted within 14 calendar days of this notification to the school staff of _____.

Thank you,

Principal

Emergency Medication Self-Administration

The following criteria must be met for a student to self-carry and administer medication at school and during after-school activities:

- Self-administration of medication is only permitted for emergency medications such as inhalers, glucagon, and epinephrine.
- To be considered for approval for self-administration of emergency medication, the student must be in grade four or higher.
- The student must demonstrate the necessary skill level to use emergency medication to the school nurse.
- Students approved for self-administration must have backup medication signed into the front office in case of forgetfulness, misplacement, or inability to communicate the whereabouts of their emergency medication.
- Medicines carried by students must be labeled with the student's name and remain in the original container with the original pharmacy label.
- Students must always carry a copy of the CCS Emergency Self-Medication Authorization Form with them.
- Medications should be carried safely, preferably in a purse or fanny pack.
- The student is responsible for keeping the emergency medication in their possession and should not leave it in a place accessible to other students.
- If students are diagnosed with a chronic disease requiring self-carrying emergency medicines, the parent must promptly inform the school office to notify the medication clerk or school nurse. In case of a health crisis, students are encouraged to notify a supervising adult who will assist them in contacting appropriate staff. Staff will assess the student's health, document the medication use, and arrange for further medical attention if needed. If an EpiPen® (epinephrine injection) is administered, an immediate call to 911 will be made.
- Students are responsible for carrying their medication to all off-campus school-related functions independently of the front office.
- The parent or guardian must confirm that the student has sufficient maturity to use the medication correctly and release the school and its personnel from any responsibility regarding the emergency medication.
- The final decision to allow a student to self-administer medication must always include the overall supervision of the school nurse, with appropriate nursing evaluations of the student's technique and self-assessment skills.
- The parent or guardian of students who self-medicate during the school day is held liable if another student takes the medication. The school system assumes no liability for students who self-medicate.
- According to House Bill 496, parents/guardians requiring backup emergency medication must provide backup medicine for all students who self-administer.
- The parent or guardian must deliver backup medicine before a student in grade four or higher is permitted to self-carry emergency medications.

Rev. 08/12

CUMBERLAND COUNTY SCHOOLS

EMERGENCY SELF-MEDICATION AUTHORIZATION FORM

TEACHER _____ SCHOOL _____

STUDENT _____ GRADE _____ DOB _____ AGE _____

MEDICATION _____ DOSE _____ ROUTE _____

TIME INTERVAL _____

Under which conditions should medications be administered? _____

I verify that the student has asthma or an allergy that could result in an anaphylactic reaction, or both, and that I, the health care practitioner, prescribed medication for use on school property during the school day, at school-sponsored activities, or while in transit to or from school or school-sponsored events.

I prescribed the asthma and/or allergy medication and I confirm that the student has been instructed in self-administration of the prescribed medication. The student has demonstrated the skill level necessary to use the asthma and/or allergy medication and any device that is necessary to treat his/her symptoms.

Physician's Signature	Phone Number	Date

I have read the **guidelines for students with emergency self-medication in their possession at school** and I judge that my child named above has sufficient maturity and knowledge to safely and correctly self-medicate.

I understand that my child must comply with the following:

- ☐ The student must keep the medication in his/her possession at all times and shall not leave it in a place accessible to other students
- ☐ The student shall not offer, nor allow any use of his/her medication by another student
- ☐ The student shall act in a responsible and discreet manner concerning his/her emergency medication

I understand that if my child has significant difficulty with his/her medication (i.e. asthma) requiring repeated use of inhaled medication; he/she shall not continue to use the medication in the place of getting appropriate medical care. I also understand that backup medication must be provided to the school within 14 calendar days of this authorization.

I further understand that the only liability that the school can assume is to comply with the terms of this protocol. I understand that the school can assume no liability for monitoring self-administration, including the frequency and dose or failure to self-medicate when necessary.

I consent for the health care practitioner to disclose health or medical information regarding medication prescribed. I understand that I may revoke this consent at any time, except to the extent action has been taken in reliance on it. This consent is valid until I revoke it in writing or for the term of one year.

I have read and agree with this authorization and have provided the school backup emergency medication for my child.

Parent/Guardian Signature _____ Date _____

FOR SCHOOL NURSE USE ONLY

This student has demonstrated the skill level necessary to use emergency medication or device.

Public Health School Nurse Signature	Date

School Administrator's Signature _____ Date _____

FOR SCHOOL USE ONLY

Date Emergency Self-Medication Form Expires ☐ / /

Please be reminded form will expire one (1) year from date of Physician's signature.

Epilepsy

A CCS Seizure Care Plan provides crucial information for school staff to assist a student experiencing seizures. It includes details on first aid, parent/guardian, health care provider contacts, and medications tailored specifically for that child. CCS Seizure Care Plans are indispensable tools fostering collaboration between parents, guardians, and school staff to ensure children's safety and well-being throughout the school day.

Diastat or diazepam is a prescription medication utilized in treating seizures. Administered rectally, it is generally given to halt a seizure once it has commenced. The provider order on the CCS Seizure Care Plan will specify when the medication should be administered. A student is unable to self-administer such medications during a seizure. In the event of a seizure, staff should promptly contact the school nurse or medication clerk for assistance and emergency medication.

Diastat / Prescribed Emergency Medication

Diastat, following the instructions on the drug package insert, is administered under specific circumstances.

Diastat or prescribed medication will be dispensed by the school nurse or trained staff who:

- ★ Can identify the distinct (*prolonged or) cluster of seizures.
- ★ Have received proper training and have been deemed competent to administer the treatment rectally.
- ★ Clearly understand which seizure manifestations may or may not be addressed with Diastat or prescribed emergency medication.

Additionally:

- ★ The school nurse will develop emergency care plans for students with health and safety conditions (e.g., seizure disorders) that may require potential health care interventions in the school setting.
- ★ The school nurse will provide specific guidelines and training for caring for students experiencing prolonged seizures.
- ★ It is advised that the initial dose of rectal Diastat or prescribed emergency medication not be administered in the school setting. The physician, family, and school nurse should be informed of the medication's effects on students before administration in school.
- ★ A CCS Seizure Care plan, signed by the doctor and the parent/guardian, must be in place to guide the care of students with a history of prolonged seizures.
- ★ School staff will contact 911 and the parent/guardian when prolonged or clustered seizures occur during the school day.

Student Transportation:
(Please check)
_____ Bus Rider
Bus No. _____
_____ Parent pickup

CUMBERLAND COUNTY SCHOOLS
SEIZURE CARE PLAN

DATE: _____

School Name: _____

Student's Name: _____ Date of Birth: ___/___/___ Age when diagnosed: _____

Parent/Guardian's Name: _____ Phone No: _____

Parent/Guardian's Name: _____ Phone No: _____

Physician's Name: _____ Phone No: _____

What type of seizure does child have? _____

How long has it been since his/her last seizure? _____ How often do the seizures occur? _____

Does child experience an aura or have a trigger before a seizure: ☐Yes ☐No If yes, please describe: _____

LIST MEDICATION	DOSE/AMOUNT TAKEN	TIME	WILL MEDICATION BE NEEDED AT SCHOOL?
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No

Does the student have a Vagus Nerve Stimulator (VNS)? ☐Yes ☐No If, yes where is magnet worn? _____

Describe the use of the magnet:

Does your child have a Section 504 Plan? ☐Yes ☐No Does your child have an Individual Education Plan (IEP)? ☐Yes ☐No

Children with Disabilities: It is and shall remain the policy of Cumberland County Board of Education not to discriminate on the basis of gender or disability in its educational programs, activities, or employment policies as required by Title IX of the 1972 Educational Amendments, the 1990 Americans with Disabilities Act, and Section 504 of the Rehabilitation Act of 1973. It is the policy of the Cumberland County Board of Education to provide equal employment opportunities on a nondiscriminatory basis, regardless of sex, race, age, national origin, disability or religion. Cumberland County Board of Education Policy 1730/4022/7231. The individual designated to ensure district compliance with Section 504 is the Executive Director of Student Services, phone (910) 678-2433, and the mailing address is Cumberland County Schools, PO Box 2357, Fayetteville NC 28302.

Release of Liability: Realizing the importance of administering medication to my child as prescribed by the child's physician, do hereby agree to relieve designated school personnel, the Cumberland County Schools, and the Cumberland County Board of Education of and from any liability from any potential ill effects as a result of their injecting or giving my child medication prescribed by the child's physician. I have discussed this with my physician and/or legal counsel (lawyer) and realize its ramifications and thoroughly understand the meanings of these statements. I consent for the medical provider to disclose health or medical information regarding medication prescribed. I understand that I may revoke this consent at any time, except to the extent action has been taken in reliance on it. This consent is valid until I revoke it in writing or for the term of one year. **Parent/Guardian Signature**: **Date:**

SIGNS OF SEIZURES: Please check ALL behaviors that apply.

SIMPLE SEIZURES	GENERALIZED SEIZURES		DANGER SIGNS: CALL 911	BEHAVIORS EXPECTED AFTER SEIZURE
☐ Lip smacking	☐ Sudden cry or squeal	☐ Stops breathing	▶ Seizure lasts more than 5 minutes	☐ Tiredness
☐ Behavioral outburst	☐ Falling down	☐ Blue color to lips	▶ Another seizure starts right after the 1st seizure	☐ Weakness
☐ Staring	☐ Rigidity/stiffness	☐ Froth from mouth	▶ Loss of consciousness	☐ Sleeping, difficult to arouse
☐ Twitching	☐ Thrashing/jerking	☐ Shallow breathing	▶ Stops breathing	☐ Somewhat confused
☐ Other: _____	☐ Loss of consciousness		▶ If the student has diabetes	☐ Regular breathing
	☐ Loss of bowel or bladder control		▶ If the seizure is the result of an injury or child is injured during the seizure	☐ Other: _____
	☐ Gurgling or grunting noises		▶ If the student is pregnant	
	☐ Other: _____		▶ If the student has never had a seizure before	**All of the above can last a few minutes to a few hours.**
			▶ Other:	

IF YOU SEE THIS		MD Stamp Below
	Stay calm. Move surrounding objects to avoid injury. Do not hold the student down or put anything in the mouth. Loosen clothing as able. After seizure stops, roll student on his/her side. If applicable, administer medications as ordered. Notify the parent/guardian and document seizure activity on the back of this form.	
Stops breathing	Begin CPR/rescue breathing. Call 911	
Loss of bowel or bladder control	Cover with blanket or jacket and if necessary, assist with changing of clothes after seizure.	**Physician's Signature and Date**
Falls down or loss of consciousness	Help the student to the floor for observation and safety.	
Vomiting	Turn on to their side.	

SIGNATURES	DATE	PARENT/GUARDIAN SIGNATURE	NURSE SIGNATURE	TEACHERS' SIGNATURE OF ACKNOWLEDGMENT	
Plan Initiated					
1st Review					
2nd Review					

Copy: Director of Health Services
504 Coordinator
EC Case Manager
Public Health School Nurse
Cum. Folder
If applicable copy:
Special Needs Nurse
School Bus Driver

CUMBERLAND COUNTY SCHOOLS
SEIZURE OBSERVATION RECORD

Student Name:							
Date & Time							
Seizure Length							
Pre-Seizure Observation: (Briefly list behaviors, triggering events, activities)							
Conscious (yes/no/altered)							
Injuries (briefly describe)							
Muscle Tone/Body Movements	Rigid/clenching						
	Limp						
	Fell down						
	Rocking						
	Wandering around						
	Whole body jerking						
Extremity Movements	(R) arm jerking						
	(L) arm jerking						
	(R) leg jerking						
	(L) leg jerking						
	Random Movement						
Color	Bluish						
	Pale						
	Flushed						
Eyes	Pupils dilated						
	Turned (R or L)						
	Rolled up						
	Staring/blinking						
	Closed						
Mouth	Salivating						
	Chewing						
	Lip smacking						
Verbal Sounds (gagging, slurred speech, throat clearing, etc.)							
Breathing (normal, labored, irregular, noisy, etc.)							
Incontinent (urine or feces)							
Post-Seizure Observation	Confused						
	Sleepy/tired						
	Headache						
	Speech slurring						
	Other						
Length of time until awake and alert?							
Parents notified? (time of call)							
EMS called? (time of call & arrival time)							
Signature of Trained Personnel		1.		3.		5.	
		2.		4.		6.	

VNS Therapy

Vagus nerve stimulation (VNS) is sanctioned for the treatment of focal or partial seizures that remain unresponsive to conventional seizure medications. VNS works by potentially preventing or reducing seizures through the delivery of regular, gentle pulses of electrical energy to the brain via the vagus nerve. When a parent/guardian informs the school of a student with a VNS device, the school nurse will conduct training for staff on optimal procedures and ensure a thorough review of the care plan.

Individual Health Care Plans

The creation of an individual health care plan involves collaboration among the parent/guardian, health care providers, and school personnel. Each plan is tailored to address the unique requirements of an individual student. Within 30 calendar days of being notified, the parent/guardian is responsible for furnishing school staff with a doctor-approved care plan.

Asthma

The Asthma Medication Plan is mandatory for students diagnosed with asthma, particularly those who may require a rescue inhaler or nebulizer during the day or before engaging in physical activity.

The Asthma Medication Plan must encompass details such as the frequency of nebulizer treatment/medication, the dosage, and the procedures to be followed if the student's condition does not improve.

The parent/guardian is required to provide a nebulizer machine and the prescribed medication for nebulizer administration.

Responsibility for replacement tubing and mouthpieces for nebulizer treatment lies with the parent/guardian. After administration, school staff will clean the mouthpiece with hot water and allow it to air dry.

The parent/guardian is also responsible for providing training on the administration of nebulizer treatment to the designated school staff and nurse.

Diabetes

Students diagnosed with diabetes must have an authorized Diabetes Care Plan on record at school. Each care plan will undergo an annual update, and certain plans may be revised after each physician visit. Parents/guardians are obligated to furnish the school with all necessary medication and equipment for the student's diabetes management, along with any updated physician's orders.

CUMBERLAND COUNTY SCHOOLS

Asthma Medication Plan

Rev. 07/2023

MEDICATION ORDERS AND INSTRUCTIONS
TO BE COMPLETED BY THE STUDENT'S MEDICAL PROVIDER
Please check appropriate boxes ☑ and fill in the blanks. Doses must be exact; ranges will not be accepted.

Student Name: _____ Date of Birth: _____

School Name: _____ Grade: _____

Asthma Triggers: ☐ Colds ☐ Grass ☐ Pollen ☐ Weather Changes
☐ Other: _____

This patient is currently under my medical care and due to a diagnosis of asthma, the rescue medication below will need to be given during the regular school day according to the following protocol.

- **Rescue Medication:** ☐ Albuterol (pharmacy will determine generic brand) or ☐ Xopenex/Levalbuterol ☐ Spacer ☐ Spacer with mask

Pretreatment before exercise: students in grades K-8 may have physical education (PE) class and recess on the same day. Students in grades 6-12 may have PE class and sports are offered after school as well.

- Specify when pretreatment dose is needed: **(check all that apply)**
  ☐ PE class ☐ Recess ☐ Sports ☐ N/A
- Dose: give rescue medication MDI_____ # Puff(s) 15 minutes before exercise.
- Minimum interval between pretreatment doses: pretreatment rescue medication may be administered every_____ hours before exercise at school

Self-carry: for this student to be allowed to self-carry and self-administer rescue medication during the school day, the medical provider must complete a CCS Emergency Self-Medication Authorization Form and allow for the parent/guardian to provide a back-up inhaler to be kept at school. The student must be in grade four or higher and will have to demonstrate to the school nurse that they have the skill level necessary to use their emergency medication.

TREATMENT OF SYMPTOMS

YELLOW ZONE: CAUTION

Coughing, Wheezing, Chest is Tight, Short of Breath, & Difficulty Breathing - Peak Flow Range: _____ to _____

Step 1: Give rescue medication and monitor 15 minutes. Dose: MDI____ #Puffs or (1) Neb____ mg/3ml

Step 2: Give every____ hours as needed for asthma symptoms.

Step 3: If the student continues to have symptoms, or condition worsens, call the parent/guardian to notify the use of medication and report symptoms and then begin **RED ZONE** directions now.

RED ZONE: EMERGENCY

Breathing is Hard & Fast, Rib & Neck Muscles Show with Breathing, Trouble Talking, or Walking

Step 1: Give rescue medication and monitor 15 minutes. Dose: MDI____ #Puffs or (1) Neb____ mg/3ml

Step 2: Give every 20 minutes for up to one hour or until help arrives.

Step 3: Call 911, if no improvement after the first **RED ZONE** dose.
Call the parent/guardian or emergency contact.

THIS IS AN EMERGENCY!

Students needing emergency care cannot remain on campus. Seek medical attention now!

Physician's Signature: _____ Date: _____ MD Stamp Below

Physician's Printed Name: _____

Office Phone: _____ FAX: _____

Office Address: _____

City, State, ZIP: _____

This order will expire one year from the date the physician signed.

CUMBERLAND COUNTY SCHOOLS
Asthma Medication Plan

Rev. 07/2023

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

Student Name: _____ Date of Birth: _____ Grade: _____

Parent/Guardian Name: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____

I understand that:

Prescription medications may be administered at school and must be in a pharmacy-labeled container that matches the Cumberland County Schools (CCS) Asthma Medication Plan. Medication dosage, time, and intervals must be exact.

CCS only permits students to self-carry and self-administer emergency medication during the school day if:

1. they are in fourth grade or higher,
2. they have submitted a completed CCS Emergency Self-Medication Authorization Form, and
3. they have demonstrated to the school nurse that they have the skill level necessary to use their emergency medication. (A **back-up inhaler** must also be signed into school before self administered will be authorized.

- The school nurse is available one day a week. Non-medical personnel administer medications daily.
- Prior to medication administration, the parent/guardian is required to sign the check-in/check-out log for medication. Asthma medication brought to school must be accompanied by a complete Asthma Medication Plan signed by the physician, and the parent/guardian.
- Students are not permitted to transport medication to or from school unless they are authorized to self carry.
- If medication is not available at the school, 911 will be called for emergencies.
- Medication may only be administered as ordered on the approved CCS medication form(s).
- The parent/guardian is responsible for notifying coaches or supervising staff of before and/or after-school activities of the child's health status and/or the need for medication.
- I may contact the primary medication clerk or school nurse if assistance is needed to ensure medication meets CCS protocol for Medication Administration during the day.
- Medications not picked up within two weeks of the last day of school will be discarded.

RELEASE OF LIABILITY FORM

I, _____ the parent/legal guardian of _____

enrolled at _____ school realizing the importance of administering medication to my child as prescribed by the child's physician, do hereby agree to relieve designated school personnel, the Cumberland County Schools, and the Cumberland County Board of Education of and from any liability from any potential ill effects as a result of their injecting or giving my child medication prescribed by the child's physician. I have discussed this with my physician and/or legal counsel (lawyer) and realize its ramifications and thoroughly understand the meanings of these statements. I consent for the medical provider to disclose health or medical information regarding medication prescribed. I understand that I may revoke this consent at any time, except to the extent action has been taken in reliance on it. This consent is valid until I revoke it in writing or for the term of one year.

Parent/Legal Guardian's Signature: _____ Date: _____

Principal's Signature: _____ Date: _____

FOR OFFICE USE ONLY: This will expire one year from the date the physician signed: This form will expire: _____

DISPOSITION OF MEDICATION: Date medication was picked up _____ or date medication was discarded _____

By Staff Name: _____ Staff Signature: _____ Witness: _____

CUMBERLAND COUNTY SCHOOLS
DIABETES CARE PLAN
Physician's Orders for Student with Diabetes

Rev. 06/2022

Student _____ DOB _____ School _____ Grade _____
Parent/Guardian _____ Phone _____ Phone _____
Home Address _____ City _____ State _____ Zip _____
Emergency Contact _____ Phone _____ Phone _____
Physician _____ Office _____ FAX _____

Child has ☐ **Type I or** ☐ **Type II Child's Blood Sugar Target Range: >** _____ **mg/dl to <** _____

When to Monitor Blood Sugar:

☐ before breakfast	☐ before lunch	☐ before snack	☐ before PE/exercise
☐ after breakfast	☐ after lunch	☐ after snack	☐ after PE/exercise
☐ before going home	☐ as needed for signs/symptoms of low or high blood sugar		

If child has a CGM and is symptomatic, confirm with finger stick.

What diabetes medications to be given at school:

☐ Apidra	☐ Humalog	☐ Novolog	☐ Metformin
☐ Glucose tabs	☐ Glucagon	☐ Other: _____	

Method of insulin delivery during school hours:

☐ Insulin Pump: ☐ Animas ☐ Medtronic ☐ OmniPod ☐ t:slim

Insulin to carbohydrate ratio:	Insulin sensitivity factor:	Basal Settings Time	Basal Settings Units/Hours
Breakfast 1 unit per _____ grams/carbs	Breakfast 1 unit per _____ points > _____		
Lunch 1 unit per _____ grams/carbs	Lunch 1 unit per _____ points > _____		
Snack 1 unit per grams/carbs	Snack 1 unit per points >		

☐ Vial/Syringe ☐ Insulin Pen

Carbohydrate Counting (use rapid acting insulin)	Insulin Sensitivity Factor	Sliding Scale (use rapid acting insulin)
1 unit per _____ grams/carbs ☐ meals/snacks	Target blood sugar: _____	Target Range: _____
☐ Fix dose { Breakfast _____ units; Lunch _____ units; Dinner _____ units; Snacks _____ units	Insulin sensitivity factor: _____	100-149 Give _____ units
	1 unit per _____ points > _____	150-199 Give _____ units
		200-249 Give _____ units
		250-299 Give _____ units
		300-349 Give _____ units
	Current BS - Target BS / Insulin sensitivity factor = Number of Units	350-399 Give _____ units
Insulin must be given anytime the child eats carbs, except in the case when treating a low blood sugar.		400-449 Give _____ units
	Sensitivity factor may not be given more frequently than every 2 hours due to the risk of low blood sugar.	450-499 Give _____ units
		> 500 Give _____ units
Inject insulin { ☐ before eating ☐ after eating		Other Give _____ units

CUMBERLAND COUNTY SCHOOLS
DIABETES CARE PLAN
Physician's Orders for Student with Diabetes

Rev. 6/2022

Blood sugar (BS) at which parent/guardian should be notified: LOW < _____ mg/dl or HIGH > _____ mg/dl.	
HYPOGLYCEMIA	**HYPERGLYCEMIA**
Do not send student unaccompanied to the office if symptomatic or blood sugar (BS) < 70mg/dl.	If blood sugar (BS) >300mg/dl with ketones or 2 consecutive unexplained BS >250 mg/dl (with or without ketones), i.e. malfunctioning pump the student may require insulin via injection and/or new infusion site/set.
➢ Test blood sugar and treat symptoms. If blood glucose meter is not available treat symptoms per care plan guidelines.	➢ First contact parent/guardian, if not available call school nurse who will call health care provider for further instructions.
➢ Blood sugar < 70mg/dl and/or symptomatic: treat with 10 to 15 grams carbohydrate snack (juice, sugar tabs, etc.) and recheck BS in 15 minutes.	➢ An order for insulin specific to the incident may be faxed from the health care provider.
➢ Mild symptoms: treat with snack, juice, sugar tabs, etc., recheck and repeat every 15 minutes until BS> 70mg/dl, then give snack with protein or lunch.	➢ Check urine ketones if BS > _____ mg/dl. and recheck in 1 hour.
➢ Moderate symptoms: if able to swallow, administer glucose gel, frosting, etc. Repeat until BS is above 70mg/dl, then give snack with protein or lunch.	➢ If trace/moderate ketones are present call parent/ guardian, provide water and student should remain under medication clerk observation until ketones clear.
➢ Call 911: if severe symptoms (which may include seizures, unconscious) or unable/unwilling to take gel or juice: administer Glucagon _____ mg(s) by intramuscular or intranasally injection and contact parent/guardian.	➢ Student will be sent home from school when ketones are large or shows symptoms of nausea, vomiting, tired, thirsty, dry mouth, difficulty breathing, fruity breath, or confused. Call 911 if severe symptoms persist.

Student's Self Care: The ability level is determined by health care provider with input from school nurse & parent/guardian.

Totally independent management	☐Yes	☐No	☐N/A	Self-injects with trained staff supervision	☐Yes	☐No	☐N/A
Tests independently	☐Yes	☐No	☐N/A	Injections to be done by trained staff	☐Yes	☐No	☐N/A
Needs verification of BS by staff	☐Yes	☐No	☐N/A	Self-treats mild hypoglycemia	☐Yes	☐No	☐N/A
Assist/testing to be done by trained staff	☐Yes	☐No	☐N/A	Monitors own snacks and meals	☐Yes	☐No	☐N/A
Administers insulin independently	☐Yes	☐No	☐N/A	Independently counts carbohydrates	☐Yes	☐No	☐N/A
Self-injects with verification of dose	☐Yes	☐No	☐N/A	Tests and interprets urine/blood ketones	☐Yes	☐No	☐N/A

Children with Disabilities: It is and shall remain the policy of Cumberland County Board of Education not to discriminate on the basis of gender or disability in its educational programs, activities, or employment policies as required by Title IX of the 1972 Educational Amendments, the 1990 Americans with Disabilities Act, and Section 504 of the Rehabilitation Act of 1973. It is the policy of the Cumberland County Board of Education to provide equal employment opportunities on a nondiscriminatory basis, regardless of sex, race, age, national origin, disability or religion. Cumberland County Board of Education Policy 1730/4022/7231. The individual designated to ensure district compliance with Section 504 is the Executive Director of Student Services, phone (910) 678-2433, and the mailing address is Cumberland County Schools, PO Box 2357, Fayetteville NC 28302.

Does your child have a Section 504 Plan? ☐Yes ☐No | Does your child have an Individual Education Plan (IEP)? ☐Yes ☐No

Release of Liability: Realizing the importance of administering medication to my child as prescribed by the child's physician, do hereby agree to relieve designated school personnel, the Cumberland County Schools, and the Cumberland County Board of Education of and from any liability from any potential ill effects as a result of their injecting or giving my child medication prescribed by the child's physician. I have discussed this with my physician and/or legal counsel (lawyer) and realize its ramifications and thoroughly understand the meanings of these statements. I consent for the medical provider to disclose health or medical information regarding medication prescribed. I understand that I may revoke this consent at any time, except to the extent action has been taken in reliance on it. This consent is valid until I revoke it in writing or for the term of one year. **Parent/Guardian Signature:** _____ **Date:** _____

MD Stamp Below		
	Physician Signature:	**Date:**
	Principal Signature:	**Date:**
	School Nurse Signature:	**Date:**

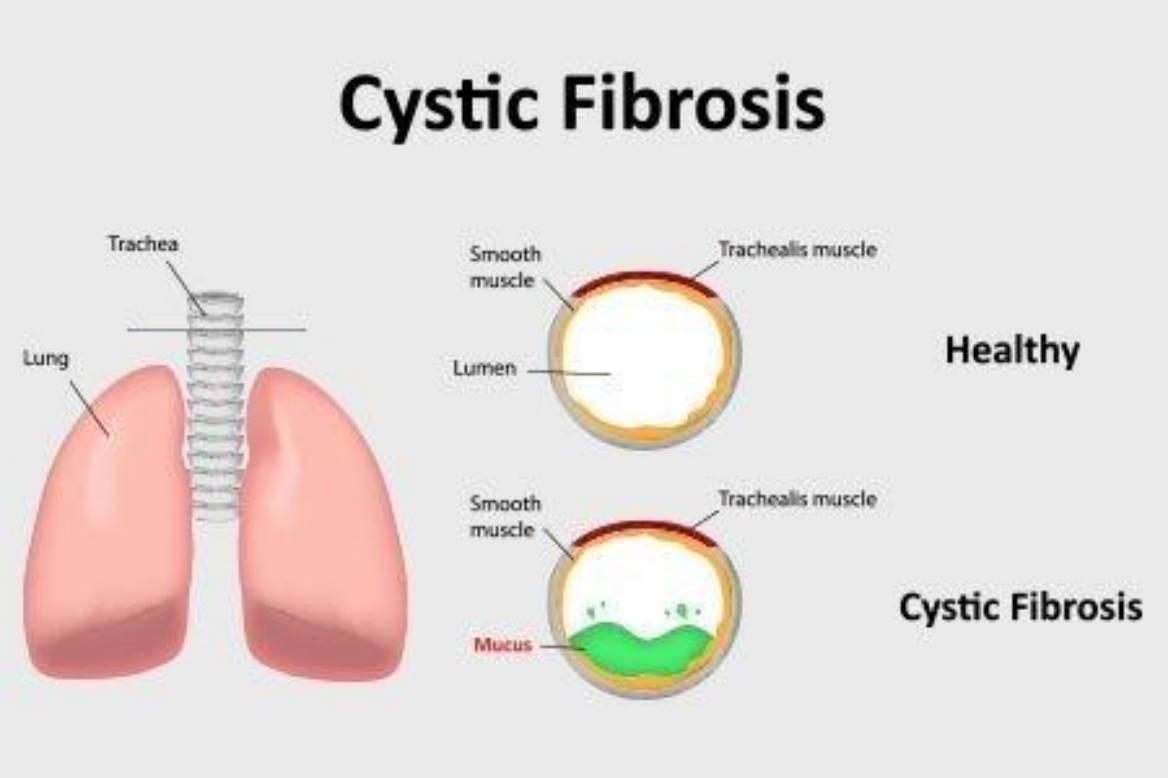
Copy: Director of Health Services, 504 Coordinator, EC Case Manager | Public Health School Nurse, Cum. Folder | If applicable cc: Special Needs Nurse, School Bus Driver

Cystic Fibrosis

Each child with cystic fibrosis is unique, and it's important to recognize that the impact of the condition varies in terms of severity and fluctuations in health. The use of pancreatin, a substance that can replace most missing enzymes, is a common approach. Various capsule preparations are available, typically taken with snacks and meals to ensure optimal absorption and nutritional benefits. The CCS staff will adhere to the directives provided by the physician.

It's crucial to understand that enzymes, in this context, serve as supplements rather than medications. Children with cystic fibrosis are advised to take these enzymes immediately before meals and snacks, sometimes during eating. Despite the potentially large quantity, it's important to note that this is a safe practice.

For students in fourth grade and above with cystic fibrosis, the option to carry these enzymes in a suitable container is available, accompanied by the completion of a Cystic Fibrosis Self-Carry Authorization Form by the parent or guardian and physician. No special storage conditions are necessary. However, younger children require supervision to ensure timely enzyme intake. When submitting enzymes to the medication clerk, a physician's school medication form must be provided.



Effective 4/2022

CUMBERLAND COUNTY SCHOOLS

CYSTIC FIBROSIS SELF-CARRY AUTHORIZATION FORM

TEACHER _____ SCHOOL _____

STUDENT _____ GRADE _____ DOB _____ AGE _____

Cystic fibrosis (CF) is an inherited disease that mainly affects the lungs and the digestive system. As a result, this student will need to take the following pancreatic enzyme medication with all meals and snacks. Drinks that are mainly water, sugar or fruit may be an exception.

ENZYME BRAND NAME _____

NUMBER OF CAPSULES TO BE TAKEN WITH MEALS _____ AND WITH SNACKS _____

SPECIAL INSTRUCTIONS _____

TO BE COMPLETED BY PHYSICIAN

I verify that the student has cystic fibrosis. The enzymes are not addictive, and will not change the behavior of the student. Most children with CF have been taking these enzymes since infancy, and take them on their own. If children with CF are allowed to take their enzymes on their own they are usually more compliant with this vital part of their care.

I, the health care practitioner, prescribed medication for use on school property during the school day, at school-sponsored activities, or while in transit to or from school or school-sponsored events.

I prescribed the medication and I confirm that the student has been instructed in self-administration of the prescribed medication. The student has demonstrated the skill level necessary to use the medication to treat his/her symptoms. Physician's signature: _____ Date: _____

Print Physician's Name: _____ Phone: _____

Print Clinic/Office Name: _____ FAX: _____

Clinic Address: _____ City: _____ State: _____ Zip: _____

IMPORTANT INFORMATION FOR SCHOOL STAFF

- Coughing is a common part of CF, and the child should have water and tissues readily available. Coughing is encouraged and necessary to clear the mucus out of the lungs. If the coughing is disruptive to the classroom, the child should be excused for a drink of water.
- Restroom privileges should be flexible and provided as needed.
- Due to a productive cough and urgent bathroom needs, the child should feel free to leave the classroom when necessary, to avoid unnecessary embarrassment over disease symptoms.
- Pancreatic enzymes, which aid in digestion, are needed before every meal and snack. Just to be clear, these enzymes are not dangerous and are not addictive.
- Exercise can provide great benefit to the child with CF by helping to clear mucus and increasing the strength of the respiratory muscles. The child with CF should be encouraged to participate in all physical activities at school. At times, a child might encounter limitations in strength or endurance. Nevertheless, the child needs to be encouraged to participate as much as possible but should be allowed to set individual limits on total physical exertion. When questions arise, please contact the child's parents or healthcare provider.
- Extra fluid consumption should be encouraged before, during and after physical activity. During aerobic activity, a child with CF should drink between six and twelve ounces of fluid every 20 to 30 minutes. Because of the added carbohydrates and salt, sports drinks provide an excellent choice for kids with cystic fibrosis.

CONTINUED ON REVERSE SIDE

Effective 4/2022

CUMBERLAND COUNTY SCHOOLS

CYSTIC FIBROSIS SELF-CARRY AUTHORIZATION FORM

TEACHER _____ SCHOOL _____

STUDENT _____ GRADE _____ DOB _____ AGE _____

To be completed by Parent/Guardian:

I have read the **guidelines for students with self-medication in their possession at school** and I judge that my child named above has sufficient maturity and knowledge to safely and correctly self-medicate.

I understand that my child must comply with the following:

- ☐ The student must keep the medication in his/her possession at all times and shall not leave it in a place accessible to other students.
- ☐ The student must keep this Cystic Fibrosis Self-carry Authorization Form in his/her possession at all times and shall present form to school staff and/or administration when requested.
- ☐ The student shall not offer, nor allow any use of his/her medication by another student.
- ☐ The student shall act in a responsible and discreet manner concerning his/her digestive enzymes.

I further understand that the only liability that the school can assume is to comply with the terms of this protocol. I understand that the school can assume no liability for monitoring self-administration, including the frequency and dose or failure to self-medicate when necessary.

I consent for the health care practitioner to disclose health or medical information regarding medication prescribed. I understand that I may revoke this consent at any time, except to the extent action has been taken in reliance on it. This consent is valid until I revoke it in writing or for the term of one year.

I have read and agree with this authorization.

Parent/Guardian Name _____ Phone No. _____

Parent/Guardian Signature _____ Date _____

FOR SCHOOL NURSE USE ONLY

This student has verbalized understanding of the above guidelines.

_____ _____

Public Health School Nurse Signature Date

School Administrator's Signature _____ Date _____

FOR SCHOOL USE ONLY

Date Cystic Fibrosis Self-medication Form Expires ☐ / / ☐

Please be reminded form will expire one (1) year from date of physician's signature.

MD Stamp Below

FOR PHYSICIAN USE ONLY

Physician's Signature _____ Date _____

In the Event of Suspected Poisoning:

School personnel will contact poison control for assistance. The parent/guardian will be promptly informed about the emergency at the provided contact number: 1-800-222-1222 (American Association of Poison Control Centers).

Following guidance from poison control, school staff will promptly dial 911 if instructed.

Children with Disabilities

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Additional Information

The individual designated to ensure district compliance with Section 504 may be contacted at (910) 678-2496.