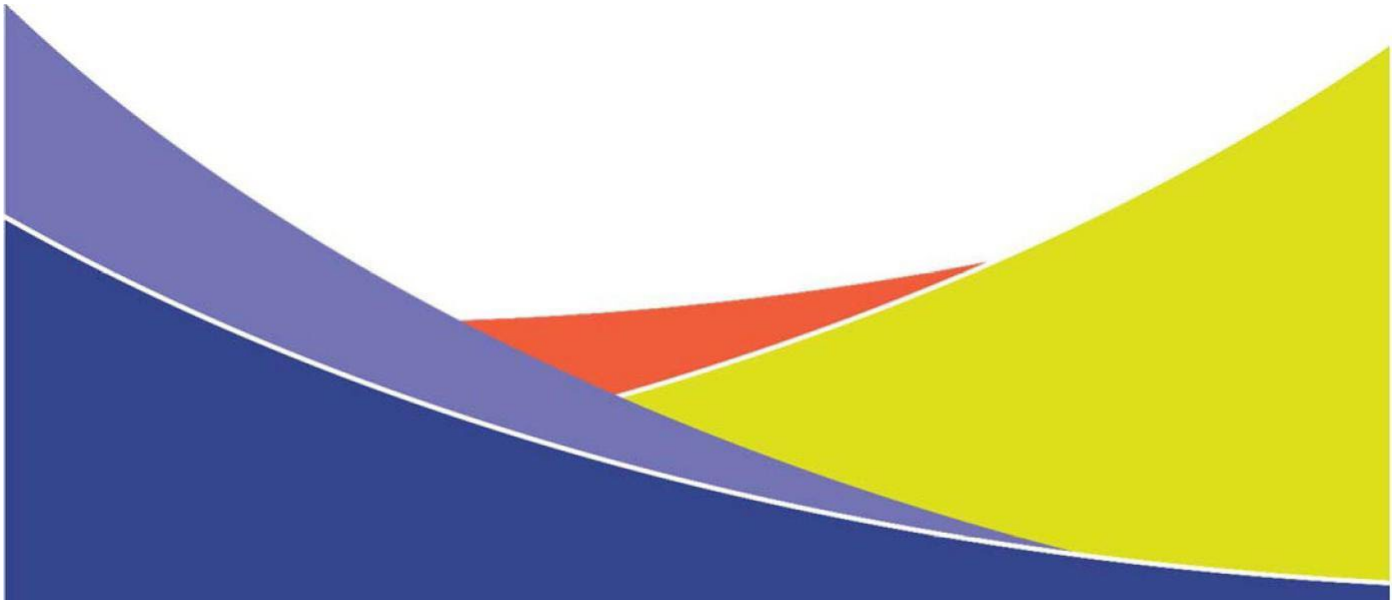
CUMBERLAND COUNTY SCHOOLS

Protocol for Medication Administration

Revised 07/27/2022



General Information

Cumberland County Schools (CCS) embraces the diverse health needs of our student population and has created this protocol to educate parents, guardians, and staff with best practices for medication administration. The school district retains the right to reject a request for the administration of medication. Medication will not be administered beyond school hours. The only responsibility of liability that can be assumed by the school system or its personnel is to comply with instructions forwarded by the parent/guardian and physician. The Office of Health Services in collaboration with the Cumberland County Department of Public Health (CCDPH) provides a variety of support services, workshops, and connections to community resources.

Handling, Storage, and Disposal of Medications

- Student medications will be locked in a medication cart to maintain security. Medications that require refrigeration will have a designated refrigerator that is kept in a locked room.
- The school district will provide secure, locked storage for all medications to prevent misuse or ingestion by another individual.
- Schools taking possession of medications are responsible for ensuring the medication is available to the student it is prescribed for while preventing access to the medicines by other students.
- All medications should be appropriately stored and secured within the medication cart provided by Health Services.
- Medications requiring refrigeration will be kept in a refrigerator used solely for student medications to avoid cross-contamination.
- Access to stored medicines and keys is limited to the building principal and persons authorized to administer medications.
- The health office should be locked when the school nurse, health services personnel, or staff members trained to assist students are not present. In addition, medication carts must be locked at all times.
- All unused, discontinued, or outdated medication will be picked up by the parent/guardian. Medication that remains after the approved time period or the school year ends will be discarded within two weeks.

School Nurses and Medication Clerks

Each school has three medication clerks, one of which is a 12-month employee, to ensure that medication is monitored at all times. Medication clerks will coordinate schedules to ensure someone is always available to administer and monitor medication. A public health school nurse is present one day each week. The school nurse is available for a phone consultation.

Parent/Guardian Responsibilities

The parent/guardian will:

- Complete the CCS Confidential School Health Form.
- Provide written parent/guardian consent (schools operate in loco parentis; therefore, 18-year-old students living with their parent/guardian should have parent/ guardian consent).
- Provide medications, orders, consents, and supplies.
- Provide a written provider order on an approved CCS medication form(s) and supplies to meet the requirements of the order.
- Provide a signed release of liability.
- Administer the first dose of a new medication at home, including a dosage change.
- Deliver medication to school staff in an original container, labeled legibly with the student's name, physician's name and contact information, medication name and strength, the amount given per dose, route and time of administration, and the dispensing pharmacy.
- Ensure medications packaged in an original pharmacy labeled container matches the physician's order.
- Ask the pharmacist to divide the required medication into two doses. One should be designated for at-home use and the other for school use.
- Provide supplies or equipment for administration (e.g., syringes and needles, spacers, special snacks for diabetics etc.).
- Count/measure medications with the medication clerk when checking in and out prescribed medications.
- Have the liberty to sign out their student's medication from the school at any time.
- Replace used and expired medication in a timely manner.
- Provide the school with appropriate documentation and medication to meet their child's medical needs within 30 calendar days.
- Present emergency medications within 30 calendar days with a matching physician's order and pharmacy label to the school medication clerk.
- Communicate any changes in a student's health status and/or medication regime to the medication clerk and school nurse.

Field Trips

It is the responsibility of the parent/guardian to provide physician authorization for administering the medication that exceeds the school day or requires weekend administration. If a student needs medication during field trips, weekends, or overnight school-related activities, the principal will designate an individual to administer the medication during the field trip. The designee must review the CCS Medication Protocol and transport the medication dosage in an individual container (Ziploc bag or envelope) prepared by the primary medication clerk or principal's designee with the following identifiers:

- Student's name
- Name, dosage, and route of medication
- Time to be administered

A copy of the CCS Physician's School Medication form(s) or approved emergency action plan will accompany the student on the field trip.

Best Practices for Completing Medication Paperwork

- The physician must write a complete order including the name of the medication, dosage, time, route, and frequency.
- Orders must be completed on the current CCS School Medication Form.
- Orders must have a specific dose, or they will not be accepted.
- An unacceptable order would be written as follows:
    - 2-4 puffs or 1-2 pills.
- Orders must have a specific time for administration, or they will not be accepted.
    - Lunchtime or Breakfast is unacceptable.
    - Orders for as-needed medication must have a specific interval between doses.
        - Give prn "three times a day" is unacceptable.
        - Give prn "every eight hours" is acceptable
- Orders that are not legible with a matching pharmacy label or fail to communicate medication instructions, and pertinent information will be rejected.

Emergency Transport for Exceptional Children

- In limited circumstances, a student who cannot self-administer their emergency medication may need an adult to be responsible for transporting the prescribed medicines to and from school for medical reasons.
- Medication Clerks will contact their school nurse to submit special approval for bus driver transport to the parent/guardian. Such instances will be reviewed by the Director of Health Services and School Nurse Supervisor before permission is granted.
- Upon approval, an emergency transport log will be issued to ensure the student's safety and medication.
- When transporting medicine on the bus, it must be stored in a secure container. Staff should hand off the emergency medication to the bus driver or transportation aide, who can then hand it to the parent/guardian when the student returns home. The chain of custody will be 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/guardian must bring the prescribed medication to the school in the original pharmacy labeled container. Parent/guardian is required to complete a CCS Short-term Medication Form to include:

- Student's name
- Name, dosage, and route of medication
- Time to be administered
- A signed Release of Liability.

In addition to the above:

- Short-term prescription medications may not exceed 14 calendar days.
- All unused, short-term medications will be picked up by the parent/guardian.
- Medication that remains after the 14-day allowance will be discarded within two weeks.

CUMBERLAND COUNTY SCHOOLS
SHORT-TERM MEDICATION FORM Rev. 05/2018
May Not Exceed 14 Calendar Days

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 <u>first</u> 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 longer. Before the acceptance of medications, the parent/guardian must have a completed CCS School Medication Form.
- Directions on the CCS Physician's School Medication Form must match the pharmacy-labeled container.

Over-the-Counter (OTC) medications (non-prescription medications) must be accompanied by a completed CCS Physician's School Medication Form with a matching pharmacy label

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 are controlled substances that are used for short-term relief from pain. Examples are Tylenol w/codeine, Percocet, etc. Non-narcotic controlled substances may be prescribed for more extended periods of time. Examples are Adderall, Ritalin, and Focalin.

CCS requires the following for controlled substances:

- The CCS Controlled Substance Accountability Form will list the type of controlled substance, dosage, and number of doses furnished and shall indicate: the date and hour of administration; the name of the student; the name of prescribing physician; the quantity administered; the balance on hand after each administration; and the signature of the administering CCS employee.
- Discrepancies will be reported to the parent/guardian, safety and security, the administrator, and the Office of Health Services.
- The school administration, school nurse, CCS Director of Safety and Security, CCS Director of Health Services, and Public Health School Nurse Supervisor will review reports of missing medications and take steps to adjust protocols to prevent future occurrences.

Intravenous Medication

Due to the increased number of students with chronic health conditions attending school, schools are being asked to administer medications intravenously more frequently. These types of medications are typically vital for the health and safety of the student. Therefore, schools will only administer intravenous (IV) drugs, which cannot be administered at another time of day. With technological advances, these medications can be safely administered in school settings but require a Registered Nurse. Intravenous medication requests will be reviewed on a case by case basis by the Office of Health Services.

Missed Doses

- Staff may only administer doses as ordered per the medication order.
- Medication may be administered 30 minutes before or 30 minutes after the scheduled dose.
- A parent/guardian's request to administer medication, not on the CCS Physician's School Medication Form will not be honored (to include phone requests).
- School staff will complete a CCS Medication Administration Incident Report copy and notify the required staff. Parent/guardian, school nurse, and physician if necessary must be notified of missed doses immediately.

Student Non-compliance

When a student refuses to cooperate with a staff member who is administering medication, the following process will be followed:

- **First Incident:** the primary medication clerk or principal designee shall telephone the parent/guardian to explain the concern. Staff will note concerns on the CCS Student Medication Administration Non-compliance Individual Medication Documentation Form.
- **Second Incident:** a parent/guardian conference will be held at the school with the following people: principal, medication clerk, school nurse, and parent/guardian. Staff will note concerns on the CCS Student Medication Administration Non- Compliance Individual Medication Documentation Form.
- **Third Incident:** the principal will inform the parent/guardian that the student has remained non-compliant with medication administration regulations and that school staff will no longer administer the prescribed medication. Staff will note concerns on the CCS Student Medication Administration Non-compliance Individual Medication Documentation Form.

Allergies and Anaphylaxis

The most critical step to preventing life-threatening allergic reactions is to avoid student contact with food/substances to which they are allergic. Without a physician's written dietary order, the parent/guardian must complete a Temporary Special Nutritional Needs form with assistance from the school nurse or medication clerk and submit it to the cafeteria manager.

Students with life-threatening allergies must have a CCS Severe Allergy Medication Plan and/or CCS Emergency Self-medication Authorization Form. The Emergency Self-medication Authorization Form may be approved for student's grade 4 or higher. Prescription labels must match the order. Students with provider orders and written parent/guardian consent to carry and administer medication must also be permitted to carry and use their medication on the bus.

- The parent/guardian of students with food allergies will submit the CCS Medical Statement for Students with Unique Mealtime Needs for School Meals to cafeteria staff, principal, and school nurse within 30 calendar days.
- The parent/guardian of students with food/substance allergies is requested to supply the classroom teacher with appropriate snacks.
- Students and staff must use effective hand washing techniques before and immediately following food consumption.
- The school nurse will provide staff training regarding the administration of emergency medication.
- The school nurse or healthcare provider will complete an emergency action plan.
- In the absence of emergency medication, the school staff will call 911 if a severe allergic reaction occurs.

Temporary
Unique Mealtime Needs Request Form

The Temporary Special Nutritional Needs Form may be submitted by a parent/guardian and the school nurse to inform the cafeteria manager of dietary restrictions for a student with special nutritional needs due to a medical condition (Example: allergies). **This form is for temporary purposes only**. **A Medical Statement for Students with Unique Mealtime Needs for School Meals must be completed by a medical authority and submitted to the cafeteria manager of the school or Child Nutrition Services within 14 calendar days of the initial request.**

Student's Name: _____ Grade: _____

Name of Parent/Guardian: (please print)_____

School: _____ Teacher's Name: _____

This section must be completed by a parent/guardian.

State the medical or dietary need that restricts the student's diet:
List the food item(s) to be restricted:
Substitutions will be based on product availability in the cafeteria. List the requested food item(s) to be substituted:
I understand that Child Nutrition Services is charged with the role of preparing school meals and does not provide student supervision. I understand that Child Nutrition Services will assist my child with identifying food items offered by the cafeteria that comply with the restrictions listed on this form and that Child Nutrition Services is not responsible for monitoring my child during meals, snack times, or other possible opportunities for exposure to food items that may not comply with the restrictions. I verify that the student has a diagnosed medical condition that requires a diet modification/restriction**. I understand that this form is for temporary purposes only and agree to submit a completed Medical Statement for Students with Unique Mealtime Needs for School Meals within 14 calendar days.** Signature of Parent/Guardian: _____ Date: _____ Phone number: _____ Physician: _____

This section should be completed by the school nurse (if the school nurse is unavailable, this section can be completed by the primary medication clerk).

Course of Action: Was the parent provided a copy of the Medical Statement for Students with Unique Mealtime Needs for School Meals? _____ yes _____ no Was the parent/guardian made aware that the Medical Statement for Students with Unique Mealtime Needs for School Meals must be completed and submitted within 14 calendar days? ____ yes ____ no
Special Notes/Instructions:

Name of School Nurse/Primary Medication Clerk: (please print): _____

Signature: _____ Date: _____

Title: _____ Phone: _____

Directions for completing the Temporary Special Nutritional Needs Form

- When a parent/guardian informs the school or school nurse of a student with allergies (or other medical condition which requires diet modification) and the student will be receiving breakfast, lunch or snacks through Child Nutrition Services the parent and/or school nurse should complete a temporary special nutritional needs form and submit it to the cafeteria manager. **This form is for temporary use (14 calendar days) and should only be used when a medical authority has not completed a Medical Statement for Student's with Unique Mealtime Needs for School Meals.**

- If a school nurse is not available, the primary medication clerk may complete the Temporary Special Nutritional Needs Form. A copy of the form should be provided to the school nurse and the cafeteria manager.

- Once the cafeteria manager receives the form, the cafeteria manager will make a note on the student's account (for example: if the student is allergic to peanuts the note on the account should state "no peanuts") and the form should be filed in the HACCP notebook, located in the cafeteria manager's office. The cafeteria manager may provide ingredient information to the student, parent, nurse, teacher and/or primary medication clerk to help ensure that the student is making the appropriate food selections.

- The school nurse parent/guardian is aware that a Medical Statement for Student's with Unique Mealtime Needs for School Meals (signed by a medical authority) must be submitted to the cafeteria within 14 calendar days after submitting the temporary unique mealtime needs form. A copy of the Medical Statement for Student's with Unique Mealtime Needs for School Meals can be found on the Child Nutrition Services website http://cn.ccs.k12.nc.us/special-diets-and-food-allergies/.

- If a parent contacts the cafeteria manager regarding their student's allergy, the cafeteria manager should provide the parent/guardian with the Medical Statement for Student's with Unique Mealtime Needs for School Meals. If the parent/guardian requests that reasonable accommodations/restrictions be made immediately to the student's meal (for example if a student has an allergy or if exposure to the food/substance results in an anaphylactic reaction and an Epipen is needed), the cafeteria manager should refer the parent to the primary medication clerk or school nurse to complete the Temporary Unique Mealtime Needs Form.

Questions/Answers:

Who can complete the Temporary Special Nutritional Needs Form?
The school nurse and the student's parent/guardian should complete the form. If the school nurse is not available and diet modifications are requested immediately, the parent/guardian and the primary medication clerk may complete the form.

When should this form be filled out?
The form should be completed if the student has an immediate need for a diet modification/restriction. The form is used for temporary purposes only. A Medical Statement for Students with Unique Mealtime Needs must be completed and signed by a medical authority within 14-calendar day.

Epinephrine

In case of a severe, life-threatening allergic reaction (anaphylaxis) a student may require an injection of epinephrine (Adrenalin) or EpiPen administration. Severe allergic reactions can occur within minutes of exposure to the allergen. Therefore, immediate action is necessary if the student has severe allergic symptoms such as swelling of eyes, lips, face, or throat, raised rash (hives), difficulty breathing, loss of consciousness, etc.

Each school is equipped with emergency epinephrine to provide emergency care for students/staff experiencing an anaphylactic event. Stock EpiPens must be 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 <u>five</u> 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: _____

<u>Transportation to and from school</u>:

☐ 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. ___

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

List other milder allergies and reactions: _____

Other health problems: _____

Current medications: _____

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.

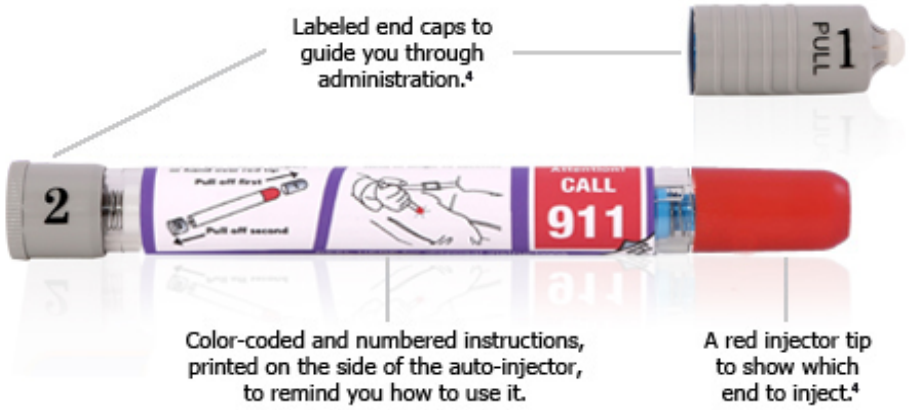
INSTRUCTIONS FOR PERSON INJECTING EPINEPHRINE

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.

Please note: brands differ and some require different delivery times for injection. Always read the enclosed instructions that accompany the auto-injector.



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

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 are required for a student to self-carry and administer medication at school and after-school activities:

- Self-administration of medication is permitted only for emergency medication such as inhalers, glucagon, and epinephrine.
- To be considered for approval of self-administration of emergency medication, the student must be grade four or higher.
- The student will demonstrate the skill level necessary to use emergency medication to the school nurse.
- Students who are approved to self-administer must have backup medication signed into the front office in the event they forget, misplace it, or are unable to communicate where their emergency medication is.
- Medicines the students carry will be labeled with the student's name and must remain in the original container with the original pharmacy label.
- Students must always keep a copy of the CCS Emergency Self-Medication Authorization Form with them.
- Medications must be carried safely, preferably in a purse or fanny pack.
- The student will keep the emergency medication in their possession and shall not leave it in a place accessible to other students.
- If students are diagnosed with a chronic disease that warrants they self-carry emergency medicines, the parent must immediately go to the school office to inform the medication clerk or school nurse. Students in crisis are encouraged if their health permits 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 as needed. If an EpiPen® (epinephrine injection) is administered, a call will be placed to 911 immediately.
- Students will be responsible for carrying their medication to all off-campus school-related functions independently of the front office.
- The parent/guardian must consent 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 the appropriate, periodic nursing evaluation of the student's technique and self-assessment skills.
- The parent/guardian of students who self-medicate during the school day are held liable if another student takes the medication. The school system will assume no liability for students who self-medicate.
- The parent/guardian must deliver backup medicine before a student in grade four or higher is permitted to self-carry emergency medications.
- House Bill 496 parent/guardians require backup emergency medication must provide backup medicine for all students who self-administer.

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 contains the essential information the school staff needs to know to help a student who has seizures. In addition, it includes information on first aid, parent/guardian, and health care provider contacts and medications specifically for that child. CCS Seizure Care Plans are an essential tool that helps parents, guardians, and school staff partner to keep children safe and healthy during the school day.

Diastat or diazepam is a prescription medication used to treat seizures. It is administered rectally and generally is given to stop a seizure once it has begun. The provider order will specify on the CCS Seizure Care Plan when the medication will be administered. A student will not be able to self-administer such medicines during a seizure. Staff will contact the school nurse or medication clerk at the onset of a seizure for support and emergency medication.

Diastat / Prescribed Emergency Medication

Diastat, as per instructions on the drug package insert, is given under specific circumstances.
Diastat or prescribed medication will be administered by the school nurse or trained staff who:

- can distinguish the distinct (*prolonged or) cluster of seizures.
- have been instructed and judged competent to administer the treatment rectally.
- understand explicitly which seizure manifestations may or may not be treated with diastat or prescribed emergency medication.

In addition to the above:

- ❖ The school nurse will develop emergency care plans for students with health and safety conditions (e.g., seizure disorders) that require potential health care interventions in the school setting.
- ❖ The school nurse will provide specific steps to care for students having prolonged seizures when the school nurse is in the setting and when the school nurse is not in the setting (e.g., on a school bus).
- ❖ It is recommended that the first dose of rectal diastat or prescribed emergency medication not be administered in the school setting. The physician, family, and school nurse should be aware of the effects of medications on students before they are given in school.
- ❖ A CCS Seizure Care plan signed by the doctor and the parent/guardian must be in place to direct the care of the student with a history of prolonged seizures.
- ❖ The school staff contacts 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 ☐ Behavioral outburst ☐ Staring ☐ Twitching ☐ Other: _____	☐ Sudden cry or squeal ☐ Falling down ☐ Rigidity/stiffness ☐ Thrashing/jerking ☐ Loss of consciousness ☐ Loss of bowel or bladder control ☐ Gurgling or grunting noises ☐ Other: _____ ☐ Stops breathing ☐ Blue color to lips ☐ Froth from mouth ☐ Shallow breathing	➢ Seizure lasts more than 5 minutes ➢ Another seizure starts right after the 1st seizure ➢ Loss of consciousness ➢ Stops breathing ➢ If the student has diabetes ➢ If the seizure is the result of an injury or child is injured during the seizure ➢ If the student is pregnant ➢ If the student has never had a seizure before ➢ Other:	☐ Tiredness ☐ Weakness ☐ Sleeping, difficult to arouse ☐ Somewhat confused ☐ Regular breathing ☐ Other: _____ **All of the above can last a few minutes to a few hours.**

IF YOU SEE THIS		
	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.	**MD Stamp Below**
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 approved to treat focal or partial seizures that do not respond to seizure medications. VNS may prevent or lessen seizures by sending regular, mild pulses of electrical energy to the brain via the vagus nerve. Upon notification from the parent/guardian of a VNS device, the school nurse will train staff on best practices and review the care plan with staff.

Individual Health Care Plans

The individual health care plan is developed as a result of a cooperative effort between the parent/guardian, health care providers, and school personnel. Each plan is designed with the specific needs of an individual student. The parent/guardian will provide school staff with a doctor's approved care plan within 30 calendar days of school being notified.

Asthma

The Asthma Medication Plan is required for students diagnosed with asthma who may need a rescue inhaler or nebulizer during the day or before physical activity.

- Asthma Medication Plan must include the frequency of the nebulizer treatment/ medication, the dose, and the procedures to follow if the student's condition does not improve.
- The parent/guardian will provide a nebulizer machine and prescribed medication for nebulizer administration.
- Replacement tubing and mouthpieces for nebulizer treatment are the responsibility of the parent/guardian. School staff will clean the mouthpiece with hot water and allow it to air dry after administration.
- The parent/guardian will provide training regarding the administration of nebulizer treatment to the designated school staff and nurse.

Diabetes

Students with a diagnosis of diabetes will be required to have an approved Diabetes Care Plan on file at school. Each care plan will be updated annually and some care plans may be updated at each physician visit. Parents/guardians are required to provide the school with all medication and equipment required by the student for diabetes management and all updated physician's orders.

CUMBERLAND COUNTY SCHOOLS
Asthma Medication Plan

Rev. 06/2020

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/brand name: _____ or ☐ Levalbuterol/Xopenex

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
DIABETES CARE PLAN
Physician's Orders for Student with Diabetes

Rev. 08/2018

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	**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**:		
		100-149	Give	units
	Insulin sensitivity factor: _____	150-199	Give	units
☐ Fix dose { Breakfast _____ units		200-249	Give	units
Lunch _____ units	1 unit per _____ points > _____	250-299	Give	units
Dinner _____ units		300-349	Give	units
Snacks _____ 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 3 hours due to the risk of low blood sugar.	450-499	Give	units
		> 500	Give	units
Inject insulin { ☐ before eating		Other	Give	units
☐ after eating				

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

Rev. 08/2018

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 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

CUMBERLAND COUNTY SCHOOLS
Asthma Medication Plan

Rev. 06/2020

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 prescription 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. in grade four or higher,
  2. have submitted a completed CCS Emergency Self-Medication Authorization Form, and
  3. have demonstrated to the school nurse that they have the skill level necessary to use their emergency medication. (A back-up inhaler should also be signed into school.)
- 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.
- A 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: _____

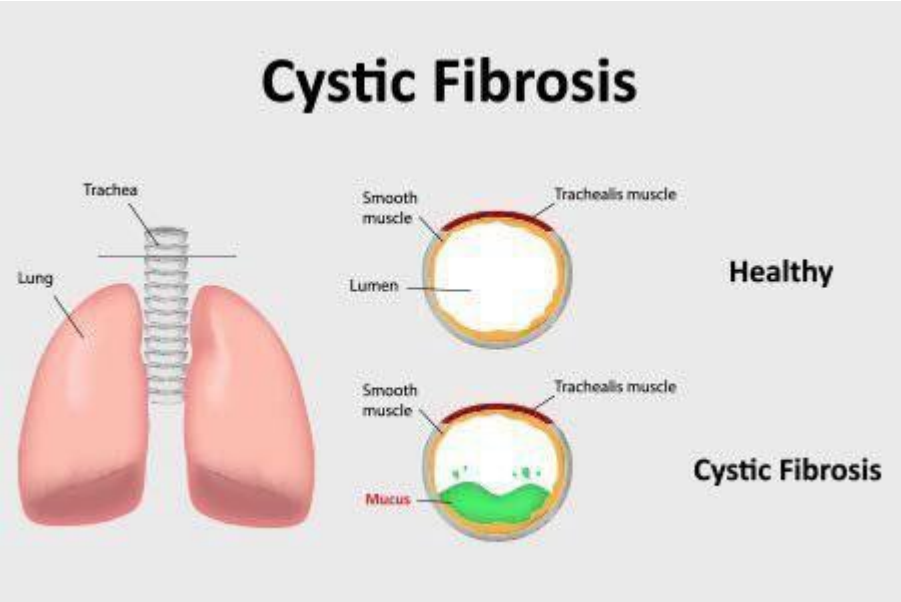
DISPOSITION OF MEDICATION: Date medication was picked up _____ or date medication was discarded _____

by Staff Name: Staff Signature: Witness:

Cystic Fibrosis

There is no typical child with cystic fibrosis. Please bear in mind that cystic fibrosis affects each child in different ways with varying degrees of severity, and each child's health can change considerably from month to month or even day to day. It is possible to replace most of the missing enzymes with a substance called pancreatin. There are several preparations in capsule form. Usually, they are to be taken with all snacks and meals to ensure proper absorption and maximum nutritional benefit. CCS staff will follow physician directives.

Enzymes are not medications; they are supplements that should be taken by a child with cystic fibrosis immediately before meals and snacks (and sometimes while eating). They are often taken in large numbers, which can look alarming but is, in fact, very safe.
Students in grades four or higher with cystic fibrosis can carry these enzymes in a suitable container for use as necessary. The parent/guardian must also complete a **Cystic Fibrosis Self-Carry Authorization Form** for grades four or higher. No special storage is required. Smaller children need supervision to ensure they take their enzymes at the appropriate times. A physician's school medication form must accompany enzymes when presented to the medication clerk.



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

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 Case of Poisoning

School staff will call poison control for suspected poisoning.
School staff will call 911 as directed by poison control.
The parent/guardian will be notified of the emergency. 1-800-222-1222 American Association of Poison Control Centers

Children with Disabilities

It is and shall remain the policy of Cumberland County Board of Education not to discriminate based on 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.)

Additional Information

The individual designated to ensure district compliance with Section 504 may be contacted at (910) 678-2433.