

**Emergency Medical Care Forms**

**ASTHMA ACTION PLAN**

**PARENT/GUARDIAN AUTHORIZATION**

Student: \_\_\_\_\_ Grade/Teacher: \_\_\_\_\_ DOB: \_\_\_\_\_

List routine, daily meds taken to control ASTHMA/Allergies: \_\_\_\_\_

Physician Name/Phone: \_\_\_\_\_ / \_\_\_\_\_

Medical Condition - **ASTHMA:**     Controlled     Chronic     Acute when ill     Seasonal \_\_\_\_\_

**MEDICATION ADMINISTRATION –REQUIRES PRESCRIPTION LABEL**

ADMINISTER INHALER/Medication \_\_\_\_\_, \_\_\_\_\_ PUFFS every \_\_\_\_\_ hour.

This medication is to be administered under what special conditions: \_\_\_\_\_

INHALER WILL BE STORED IN SCHOOL OFFICE.

Other emergency medication: \_\_\_\_\_

**ASTHMA TRIGGERS, SYMPTOMS AND INTERVENTIONS**

**Check Triggers:**  Exercise     Animals     Cold Weather     Molds     Respiratory Illness     Chalk     Dust

Pollen     Odors     Perfumes     Trees/Grass     Latex     Food: \_\_\_\_\_

**Check Symptoms:**     Coughing     Wheezing     Labored/Difficulty Breathing     Other: \_\_\_\_\_

Nebulizer Inhalation Therapy:     YES     NO

**If YES,** Parent provides all equipment including clean tubing, nebulizer and medications with prescriptive label.

DAILY/Frequency \_\_\_\_\_ When Symptomatic \_\_\_\_\_ Other \_\_\_\_\_

Medication #1 (Name and Dosage): \_\_\_\_\_

Medication #2 (Name and Dosage): \_\_\_\_\_

Time of day to administer if daily: \_\_\_\_\_

Potential side effects: \_\_\_\_\_

In the event of a crisis requiring immediate intervention, a trained school employee will administer the *prescribed* medication. The undersigned understands that the employee administering the *prescribed* medication is not a licensed healthcare professional. The undersigned hereby consents to the intervention of the employee under these circumstances. The undersigned agrees to hold the Board of Education, its members and employees, and the intervening staff member harmless for any injuries resulting from medication administration and emergency care unless injury was caused by the employee’s negligence.

Parent/Guardian hereby gives consent for the child’s medical records and reports to be shared with the Oldham County Board of Education and its employees, and for the child’s physician to discuss his or her medical condition referenced above with school or District personnel to assist them in planning for my child’s care while at school or school events.

\_\_\_\_\_  
*Signature of Parent/Guardian*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Home Phone*

\_\_\_\_\_  
*Cell Phone:*

\_\_\_\_\_  
*Work Phone*

\_\_\_\_\_  
*Emergency contact:*

\_\_\_\_\_  
*Phone:*

\_\_\_\_\_  
*Relationship:*

**Emergency Medical Care Forms**

**PHYSICIAN/PARENT AUTHORIZATION for SELF ADMINISTRATION**

Student: \_\_\_\_\_ DOB: \_\_\_\_\_

School/Grade: \_\_\_\_\_ Current Age: \_\_\_\_\_

**PHYSICIAN AUTHORIZATION for SELF-ADMINISTRATION BY STUDENT  
Physician and Parent/Guardian Signature required per KRS 158.834**

Diagnosis – **ASTHMA:**     Controlled     Chronic     Acute when ill     Seasonal

Medication/Inhaler: \_\_\_\_\_ Dosage: \_\_\_\_\_

This student has been instructed by PHYSICIAN regarding the care, storage and use of this prescribed medication and has the ability to determine appropriate administration of the medication. The medication must be carried on the student’s person and will be labeled with the student’s name.

This student had been instructed by PHYSICIAN that if symptoms are not relieved by medication administration, STUDENT must notify a school staff member or other supervising adult immediately.

\_\_\_\_\_  
*Printed Name of MD, DO, ARNP or PA*

\_\_\_\_\_  
*FAX number*

\_\_\_\_\_  
*Signature of MD, DO, ARNP or PA*

\_\_\_\_\_  
*Telephone*                      *Date*

**PARENT/GUARDIAN AUTHORIZATION FOR SELF-ADMINISTRATION BY STUDENT**

Signing this form shall release Oldham Co. Board of Education and its employees from liability for any injuries resulting from your student carrying, maintaining, and self-medicating. Parent/guardian agrees to hold harmless OCBE employees from any claim resulting from student’s self-administration of medication to treat Asthma per state law KRS 158.834. Parent/Guardian gives consent to Oldham County Board of Education employees to discuss the medical condition referenced above with physician to assist in planning for the student’s care while at school or school events. Permission for self-administration of medication shall be effective for the school year in which it is granted by Physician and Parent and shall be renewed each following school year.

Parent/Guardian of \_\_\_\_\_ AGREES that it is the responsibility of the parent/guardian to require the student to be in possession of the above prescribed medication during the school day, extracurricular activities and during field trips. Replacement of expired medication is the responsibility of the parent/guardian.

\_\_\_\_\_  
*Signature of Parent/Guardian*

\_\_\_\_\_  
*Home Phone and Cell*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Emergency contact:*

\_\_\_\_\_  
*Phone:*

\_\_\_\_\_  
*Relationship:*

**EMERGENCY PLAN OF ACTION for STUDENTS WITH ASTHMA**

- 1. CALL EMS 9-911** if wheezing or coughing has not improved after medication administration by student; student is having difficulty breathing; student has trouble walking or talking; student’s fingernails, lips or gum line (darkened) are blue/ashen; student has any of the above symptoms and does NOT have access to medication documented above.
- 2. NOTIFY** school personnel trained in CPR/AED to care for student and initiate CPR/AED if needed prior to EMS arrival. Notify parent/guardian or emergency contact. If student is transported via EMS, a school staff member must accompany student.

**Emergency Medical Care Forms**

**SEIZURE ACTION PLAN**

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade/Year: \_\_\_\_\_ School: \_\_\_\_\_

Treating Physician: \_\_\_\_\_ Office Number: \_\_\_\_\_

Type/s of Seizure: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_

**SEIZURE INFORMATION:**

<i>Date of Last Known Seizure</i>	<i>Seizure Type</i>	<i>Description</i>

Seizure triggers or warning signs: \_\_\_\_\_

Student's likely characteristics during and reaction after seizure: \_\_\_\_\_

**EMERGENCY RESPONSE**

**SEIZURE EMERGENCY PROTOCOL (check all that apply):**

- Time seizure
- Contact School Nurse/office at: \_\_\_\_\_
- Administer emergency medication if indicated below
- Notify parent or emergency contact
- Other: \_\_\_\_\_

**CALL 911 if:**

- Emergency medication is administered (911 is required if emergency med given)
- Respiratory distress
- Student has repetitive seizures

- Other: \_\_\_\_\_

**TREATMENT PROTOCOL DURING SCHOOL HOURS:**

**Will student require Emergency Medication at school?**  YES  NO

**Does student take daily seizure medication at home?**  YES  NO

If yes, please list: \_\_\_\_\_

**Does student have a Vagus Nerve Stimulator?**  YES  NO

If yes, describe use of magnet: \_\_\_\_\_

**Basic Seizure First Aid:**

- Stay calm and track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child
- Record seizure in log
- Protect head (for grand mal)
- Keep airway open
- Turn on side

A seizure is generally considered an **Emergency** when:

- A convulsive seizure is **longer than 5 min**
- Repeated seizures without regaining consciousness
- First time seizure
- Student injured or diabetic
- Breathing difficulties
- Seizure in water

## Emergency Medical Care Forms

**PRESCRIBED EMERGENCY MEDICATION FOR SCHOOL: (Please select and complete directions for use)**

**DIASTAT** Rectal Gel For school staff:  Green ready band visible and locked with correct dose

Dose: \_\_\_\_\_ MG PER RECTUM to be administered \_\_\_\_\_ minutes after onset of seizure

Other directions: \_\_\_\_\_ Expires: \_\_\_\_\_

**KLONOPIN** Buccal Tab

Dose: \_\_\_\_\_ MG to be administered between cheek and gum \_\_\_\_\_ minutes after onset of seizure

Other directions: \_\_\_\_\_ Expires: \_\_\_\_\_

**NAYZILAM** (Midazolam) Nasal Spray

Dose: \_\_\_\_\_ MG single spray into one nostril \_\_\_\_\_ minutes after onset of seizure

Other directions: \_\_\_\_\_ Expires: \_\_\_\_\_

**VALTOCO** (Diazepam) Nasal Spray

Dose: \_\_\_\_\_ MG single spray into one nostril \_\_\_\_\_ minutes after onset of seizure

Other directions: \_\_\_\_\_ Expires: \_\_\_\_\_

**This medication can be kept:**  On Student  Classroom  Office/Health Room

**This medication is required to be available on the bus:**  \*YES \* See transportation directives on page 2

NO

## Emergency Medical Care Forms

### TRANSPORTATION DIRECTIVES:

In the event of a seizure during transport, student will remain in seat with breathing and airway status monitored by bus staff. **If respiratory distress is noted, or seizure does not subside, 911 will be called.**

### IS EMERGENCY MEDICATION TO BE ADMINISTERED ON THE SCHOOL BUS ROUTE TO AND FROM SCHOOL?

YES\*    NO

\*If an emergency medication is prescribed by the physician to be administered during bus transportation to/from school, two trained staff members are required and available only on a "specially equipped" bus.

### IS EMERGENCY MEDICATION TO BE ADMINISTERED DURING BUS TRANSPORTATION ON FIELD TRIP EVENTS?   YES\*   NO

\*For regular education students with a prescribed emergency medication: transportation will be provided on a 'specially equipped' bus for field trip events unless parent and physician sign the Waiver of Special Transportation below.

### Parent Liability Waiver and Release of Information

I understand that the employees of the Oldham County Board of Education to whom health services are delegated may not be licensed healthcare professionals. In the case of an emergency that requires immediate intervention at school or at a school event, employees who have been delegated health services will undertake to do their best to comply with the recommended protocols developed by the student's physician, in accordance with training conducted by a Registered Nurse. I hereby consent to the interventions of the employee in accordance with the instructions above/attached. Additionally, in accordance with KRS 156.502 and 158.383(4), I agree to hold staff members harmless for any injuries resulting from the emergency care, medication administration, or reaction to any medication administration unless the injury was caused by the Board of Education employee's negligence.

I further hereby give my consent for medical records and reports to be shared with the Oldham County Board of Education and for my child's physician, referenced above, to discuss my child's medical condition with designated District personnel to assist them in planning for my child's care while at school or at school events.

Parent/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_ Phone: \_\_\_\_\_



**Emergency Medical Care Forms**

**\*Waiver of Specially-Equipped Transportation and Release of Liability\***

I hereby request waiver of special transportation for field trips during the current school year. I understand that my child is entitled to special transportation due to my child’s medical condition and that special transportation has been offered by the district at no additional cost to me.

I understand that declining special transportation will result in my child being transported by regular school bus unless the students are travelling by charter bus. The space limitations and configuration of bus seats on a regular bus pose additional safety risks to my child and especially in the event that Diastat is the prescribed medication to be administered. I have evaluated the risks to my child and determined that it is in my child’s best interest to be transported by regular bus.

To the extent allowable by law I, for myself, my spouse, my child and our heirs, hereby indemnify and hold harmless my child’s school and Oldham County Board of Education, their members, officers, employees, agents, insurers, successors and assigns from any liability, damages, or injury sustained by my child as a result of the administration of Diastat or other Emergency Medication on a regular school bus while traveling to and from school field trips.

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I have reviewed the child’s medical condition and the risks associated with traveling on a regular school bus and I agree with the parent’s request to waive specially-equipped transportation during school field trips.

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

For Office Use Only:

Medication brought in by:

\_\_\_\_\_ Date: \_\_\_\_\_

Medication picked up by: \_\_\_\_\_

Date: \_\_\_\_\_

Reviewed by OCBE RN: \_\_\_\_\_

Date: \_\_\_\_\_

## Emergency Medical Care Forms

### STUDENT ACCIDENT REPORT FORM

School \_\_\_\_\_ Date \_\_\_\_\_

Name of Injured \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ Grade \_\_\_\_\_ Age \_\_\_\_\_ Instructor \_\_\_\_\_

#### ACCIDENT INFORMATION

Time of Accident \_\_\_\_\_ A.M. \_\_\_\_\_ P.M. Supervised Activity \_\_\_\_\_ Yes \_\_\_\_\_ No

#### NATURE OF INJURY

_____ Abrasion	_____ Contact-Toxic Substance	_____ Heat Exhaustion
_____ Animal/Insect Bite	_____ Cut	_____ Laceration
_____ Asphyxiation	_____ Dental	_____ Puncture
_____ Bruise	_____ Dislocation	_____ Shock, Fainting
_____ Burn	_____ Foreign Body	_____ Sprain
_____ Head Trauma	_____ Fracture (potential)	_____ Other _____
_____ Fall		

#### PART OF BODY INJURED

<u>HEAD</u>	<u>TRUNK</u>	<u>ARMS</u>	<u>LEGS</u>
_____ Scalp	_____ Chest	_____ Shoulder	_____ Hip
_____ Back	_____ Abdomen	_____ Upper Arm	_____ Upper Leg
_____ Front	_____ Back	_____ Elbow	_____ Knee
_____ Eyes		_____ Lower Arm	_____ Lower Leg
_____ Ear		_____ Hand	_____ Foot
_____ Nose		_____ Fingers	_____ Toes
_____ Mouth			
_____ Teeth			
_____ Neck			

#### LOCATION OF ACCIDENT

_____ Athletic Field	_____ Hallway	_____ Shower
_____ Cafeteria	_____ Lab	_____ Stairs
_____ Classroom	_____ Playground	_____ Shop
_____ Gym	_____ Restroom	_____ Other _____

#### CONTRIBUTING CAUSES

<u>ENVIRONMENTAL FACTORS</u>	<u>HUMAN FACTORS</u>	<u>AGENTS</u>
_____ Crowding	_____ Active Game	_____ Animal/Insect
_____ Doors	_____ Fatigue	_____ Electricity
_____ Drinking Fountain	_____ Fighting	_____ Fire
_____ Equipment	_____ Horseplay	_____ Gases
_____ Floors	_____ Improper Attitude	_____ Liquids
_____ Surface	_____ Lack of Training	_____ Phys. Ed. Equip.
_____ Lighting	_____ Preoccupation	_____ Pencil
_____ No Handrail	_____ Running	_____ School Equipment
_____ Mechanical Defects	_____ Violation of Rules	_____ Solids
_____ Ventilation	_____ Other _____	_____ Student
_____ Weather		_____ Vehicle
_____ Other _____		_____ Other _____

### Emergency Medical Care Forms

#### STUDENT ACCIDENT REPORT FORM

##### ACCIDENT DESCRIPTION

Describe the accident in your own words. Please give all details so that this accident report may be used to prevent other similar accident.

---



---



---



---



---



---

##### POST ACCIDENT INFORMATION

Was first-aid given?  Yes  No By Whom? \_\_\_\_\_

Was parent or other responsible person notified?  Yes  No Time \_\_\_\_\_

If no, explain \_\_\_\_\_  
\_\_\_\_\_

Was student sent home?  Yes  No

If yes, was he/she accompanied?  Yes  No

Was student sent to physician?  Yes  No Name of physician \_\_\_\_\_  
\_\_\_\_\_

Was student sent to hospital emergency room?  Yes  No

Hospital sent to \_\_\_\_\_

Method of Transportation \_\_\_\_\_

##### ACTION TAKEN TO PREVENT SIMILAR ACCIDENT

###### INSTRUCTIONAL

###### POLICY OR CORRECTIVE ACTION

Discussed at Staff Meeting

Corrected Operation Procedure

Discussed in Class

Notified School Safety Committee

Discussed with Parent

Repaired Faulty Equipment

Personal Instruction Given to Student

Safety Specialist Invited to School

Personal Instruction Given to Personnel to Assist in Safety

Presented as Subject of Assembly

Safety Rules Amended

Other \_\_\_\_\_

No Action Taken

Signed \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Other Witness \_\_\_\_\_

### Emergency Medical Care Forms

#### ALLERGY CARE PLAN/PRESCRIBED EPINEPHRINE

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

School: \_\_\_\_\_ School Year: \_\_\_\_\_ Teacher: \_\_\_\_\_

**ACTION PLAN TO BE COMPLETED AND SIGNED BY HEALTHCARE PROVIDER**

**ALLERGIC TO:** \_\_\_\_\_

Asthma:      Yes (Higher risk for severe reaction)      No

Date of last reaction: \_\_\_\_\_ Symptoms: \_\_\_\_\_

History of anaphylaxis?      \*Yes      No      \*If yes, give date \_\_\_\_\_

**STUDENT TO SIT AT NUT FREE TABLE:**      Yes      No

**SEVERE SYMPTOMS**  
**FOR ANY OF THE FOLLOWING SEVERE SYMPTOMS:**

**LUNG:** Short of breath, wheeze, repetitive cough  
**HEART:** Pale, bluish skin, faint, weak pulse, dizzy, confused  
**THROAT:** Tight, hoarse, trouble breathing or swallowing  
**MOUTH:** Significant swelling of the tongue or lips  
**SKIN:** Many hives over body, widespread redness  
**GUT:** Repetitive vomiting, severe diarrhea



**WHAT TO DO:**

1. Call 911 and parent  
**INJECT EPINEPHRINE IMMEDIATELY**
2. Give additional medications, if prescribed
3. Monitor student until EMS arrives
4. If symptoms do not improve or return, a second dose can be given 5 minutes or more after last dose
5. It is highly recommended to transport to ER, even if symptoms resolve. If parent refuses transport, student will be sent home for the day

**MILD SYMPTOMS**

**NOSE:** Itchy or runny nose, sneezing  
**MOUTH:** Itchy mouth  
**SKIN:** A few hives, mild itch  
**GUT:** Mild nausea or discomfort



**WHAT TO DO:**  
**FOR MILD SYMPTOMS FROM MORE THAN ONE BODY SYSTEM AREA-GIVE EPINEPHRINE IMMEDIATELY**

**FOR MILD SYMPTOMS FROM A SINGLE BODY SYSTEM AREA, FOLLOW DIRECTIONS BELOW:**

1. \*Give antihistamine, if prescribed
2. Notify parent, stay with student
3. Watch for changes.
4. If symptoms worsen, **GIVE EPINEPHRINE IMMEDIATELY**  
 \*If antihistamine given, student will be sent home for observation

**MEDICATIONS**

Epinephrine (list type): \_\_\_\_\_ Expires: \_\_\_\_\_  
 Dose      0.15      0.30

Antihistamine (type and dose): \_\_\_\_\_ Expires: \_\_\_\_\_  
 Other: \_\_\_\_\_ Expires: \_\_\_\_\_

**Location of Medication:**

School Office/Health Room  
 \*Carried by Student \*Physician has instructed student in proper care, storage and use of this medication (KRS 158.834)

\_\_\_\_\_  
*Physician Name and Signature (required)*      \_\_\_\_\_  
*Date*      \_\_\_\_\_  
*Phone*

I have read and agree with above physician orders for my child:

\_\_\_\_\_  
*Parent Signature*      \_\_\_\_\_  
*Date*

### Emergency Medical Care Forms

#### ALLERGY CARE PLAN/PRESCRIBED EPINEPHRINE

**EMERGENCY CONTACT INFORMATION:**

It is the responsibility of the parent/guardian to provide current contact information that includes working phone numbers for parents, guardians and emergency contact persons.

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

\*If medication is to be kept on student’s person, the guardian agrees that the medication will be carried in a secure, protective container and that the medication will be labeled with student’s name. Guardian also agrees that the replacement of expired medication is the responsibility of the guardian. When a student is authorized by their physician and parent/guardian to possess a prescribed life-sustaining medication, it is recommended that an additional dose of medication is kept in the school office. In the event the prescribed medication is discontinued by the physician, the parent/guardian will notify their student’s school office by providing a written statement from the prescribing physician. **The parent/guardian understands that it is the student’s responsibility to be in possession of prescribed medication during the school day, while attending field trips and while participating in extracurricular activities. See: Medication Policy 9020.01 – AR. School staff do not verify possession of medication when students are authorized to carry on their person.**

In the event of a crisis requiring immediate intervention, a trained school employee will administer an injection or other prescribed drug. The undersigned understands that the employee administering the prescribed medication is not a licensed healthcare professional. The employee will make his or her best effort to comply with the recommended procedure developed by the child’s physician, and in accordance with the training conducted by a registered nurse. The undersigned hereby consents to the intervention of the employee under these circumstances.

Additionally, the undersigned agrees to hold the Oldham County Board of Education, its members and employees, and the intervening staff member harmless for any injuries resulting from the emergency care unless the injury was caused by the employee’s negligence. The parent/guardian further agrees to indemnify and hold harmless any employee and the Oldham County Board of Education and its members from any claim resulting from the student’s self-administration of medication per state law. The permission for self-administration of medication shall be in effect for the school year in which it is granted and shall be renewed each following school year. (KRS-158.834)

Parent/Guardian hereby gives consent for the child’s medical records and reports to be shared with the Oldham County Board of Education and its employees, and for my child’s physicians to discuss his/her medical condition referenced above with school or District personnel to assist them in planning for my child’s care while at school or school events.

\_\_\_\_\_  
*Parent/Guardian Signature (mandatory)*

\_\_\_\_\_  
*Date*

**Office Use Only**

Care Plan rec’d by: \_\_\_\_\_ Date: \_\_\_\_\_

Medication rec’d by: \_\_\_\_\_ Date: \_\_\_\_\_

Medication rec’d by: \_\_\_\_\_ Date: \_\_\_\_\_

Medication brought in by: \_\_\_\_\_ Date: \_\_\_\_\_

Medication brought in by: \_\_\_\_\_ Date: \_\_\_\_\_

Medication picked up by: \_\_\_\_\_ Date: \_\_\_\_\_

**Care Plan Reviewed:**

RN Signature \_\_\_\_\_ Date: \_\_\_\_\_

## Emergency Medical Care Forms

### INDIVIDUAL DIABETES HEALTH CARE PLAN

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ School Year: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Type 1 Diabetes

Type 2 Diabetes

Other condition requiring blood glucose monitoring: \_\_\_\_\_

#### HYPOGLYCEMIA MANAGEMENT (LOW BLOOD SUGAR):

GLUCAGON                      BAQSIMI                      EXPIRATION DATE: \_\_\_\_\_

LOCATION:                      OFFICE/HEALTH ROOM:                      ON PERSON

- SIGNS & SYMPTOMS: *hunger, staring, dizzy, crying, headache, clammy, sweating, nervous, confused, shaky, blurry vision, restless, weak, disoriented, sleepy, change in personality*

LOW BLOOD SUGAR FOR THIS STUDENT REQUIRES INTERVENTION IF LESS THAN \_\_\_\_\_.

1. If exhibiting symptoms of hypoglycemia OR if blood sugar is less than \_\_\_\_\_ mg/dl, provide 15 grams of simple sugar (examples include 15 skittles, one juice box, 3-4 glucose tablets)
2. Wait 15 minutes and recheck blood sugar.
3. If blood sugar level is less than \_\_\_\_\_ mg/dl, repeat steps 1 and 2.
4. If blood sugar greater than \_\_\_\_\_ mg/dl, provide a 15-gram complex carbohydrate or LUNCH if scheduled within \_\_\_ minutes.
5. Student is not to load PM bus, leave campus, or drive if blood sugar is less than: \_\_\_\_\_
6. Notify parent/guardian if student does **not** respond to treatment. Notify school

nurse. **EMERGENCY PLAN OF ACTION:**

1. If student is able to follow command, offer sips of juice, milk, soft drink with sugar.
2. If student is unconscious, unresponsive or has a seizure, CALL EMS -911 and administer emergency medication. Notify school personnel trained in CPR
3. Position student on their side in the recovery position, due to potential of vomiting. Monitor airway.
4. Contact Parent/Guardian or emergency contact. OCBE employee must accompany student to medical facility.

#### HYPERGLYCEMIA MANAGEMENT (HIGH BLOOD SUGAR):

- SIGNS & SYMPTOMS: *dry mouth, frequent urination, thirsty, headache, nausea, vomiting, hungry, fruity smelling breath, sleepy*

HIGH BLOOD SUGAR FOR THIS STUDENT REQUIRES INTERVENTION IF GREATER THAN \_\_\_\_\_  
(*encourage sugar free liquids such as water, allow frequent restroom breaks*)

1. Student is not to ride a PM bus or drive if blood sugar is greater than \_\_\_\_\_ Notify parent
2. Can student correct a high blood sugar with insulin other than at lunch?  
yes\*    no                      \*directive \_\_\_\_\_
3. Does student check ketones at school?                      yes\*    no                      (Call parent if ketones present)  
**\*See Ketone supplementation formula under insulin therapy**
4. If blood sugar is greater than \_\_\_\_\_, do not participate in PE, exercise or sports.

## Emergency Medical Care Forms

### INDIVIDUAL DIABETES HEALTH CARE PLAN

#### INSULIN THERAPY:

Type: \_\_\_\_\_

Insulin Delivery Device:            insulin pen            insulin pump            syringe

Insulin – to – Carbohydrate Ratio (lunch only): 1 unit of insulin per \_\_\_\_\_ grams of carbohydrates

Should insulin calculations be rounded?

Yes\*                      No

\*Half unit              Whole unit

#### High Blood Sugar Correction prior to lunch (if applicable):

Increase insulin by \_\_\_\_\_ unit(s) for every \_\_\_\_\_ points above \_\_\_\_\_ If blood sugar is \_\_\_\_\_ to \_\_\_\_\_ give \_\_\_\_\_

If blood sugar is \_\_\_\_\_ to \_\_\_\_\_ give \_\_\_\_\_ If blood sugar is \_ to \_\_\_\_\_ give \_\_\_\_\_

#### If blood sugar is low prior to lunch, will student administer lunch time insulin after meal is eaten?

YES                      NO

#### Low blood sugar correction prior to lunch (if applicable):

#### SNACKS:

Does student require a **SCHEDULED** snack during the day?            Yes\*            No

Snack time: \_\_\_\_\_ \*If yes, will insulin be required with snack?            Yes            No

Insulin order for snack: \_\_\_\_\_

Foods to avoid, if any: \_\_\_\_\_

#### EXERCISE AND PHYSICAL ACTIVITY:

Check blood sugar before exercise?            Yes            No

Check blood sugar after exercise?            Yes            No

Snack before exercise?            Yes            No

Snack after exercise?            Yes            No

Directives regarding PE or exercise:

Does your student participate in after school activities such as Band, Cheer, Dance, Academic Teams, Sports Teams, Clubs or other organized activities in which staff supervising your student would require emergency medication administration training?

Yes                      No

If yes please list all activities:

---



---

## Emergency Medical Care Forms

### INDIVIDUAL DIABETES HEALTH CARE PLAN

#### DISEASE MANAGEMENT SKILLS: (to be completed by physician or licensed member of provider staff)

A1C results: \_\_\_\_\_ Date last completed: \_\_\_\_\_

Can student administer own insulin injections?      yes      no

Can student calculate carbs and determine the correct amount of insulin?      yes      no

Can student determine high/low correction doses and treat accordingly?      yes      no

Can student dial correct dose of insulin?      yes      no

Is student independent in insulin pump function to include re-insertion and troubleshooting problems?      yes      no

Has student demonstrated use of blood glucose monitoring equipment, including meter, lancet device, test strips, test sites/protocol to ensure accurate readings to manage disease?      yes      no

Does the student have your permission to carry all diabetes management supplies including Glucagon Kit, insulin, and sharps?      yes      no

Can the student perform ketone monitoring and evaluate results?      yes      no

Has the student demonstrated understanding of blood sugar readings and can treat high/low results?      yes      no

#### SCHOOL/CLASSROOM ACCOMMODATIONS

- Please provide a person to accompany student with Diabetes to the school office when:  
\_\_\_\_\_
- Students with Diabetes are offered the following accommodations across **ALL** school environments:
  1. Restroom privileges
  2. Access to foods, water/sugar-free liquids (includes during transportation)
  3. Check blood sugar in accordance with Physician Authorization/Diabetes Health Care Plan
  4. Phone Privileges in school office
  5. Access to diabetes care supplies in accordance with Physician Authorization/Diabetes Health Care Plan
  6. Encouraged to perform and treat blood sugar levels prior to national, state, and classroom assessments.

#### PHYSICIAN SIGNATURE AND CONTACT INFORMATION:

A licensed member of my staff or I has witnessed the student demonstrate the disease management skills to determine competency. The information was not determined solely by parent report. Changes or updates to this health care plan will be made available when requested by licensed medical personnel of the Oldham County Board of Education.

\_\_\_\_\_  
*Physician Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Physician Printed Name*

\_\_\_\_\_  
*Telephone*

\_\_\_\_\_  
*Fax*

## Emergency Medical Care Forms

### INDIVIDUAL DIABETES HEALTH CARE PLAN

**PARENT/GUARDIAN CONTACT AND RELEASE OF INFORMATION, DISCLOSURE:**

PARENTS WILL PROVIDE ALL DIABETIC CARE SUPPLIES INCLUDING: SNACKS, JUICE, BLOOD GLUCOSE METER, LANCET DEVICE, LANCETS, EMERGENCY GLUCOSE, EMERGENCY MEDICATION AND ANY OTHER NEEDED SUPPLIES.

I hereby give my consent for medical records and reports to be shared with the Oldham County Board of Education and for the physician referenced below to discuss my child’s medical condition referenced above with school or District personnel to assist them in planning or providing care for my child while at school or school events.

In the event of a crisis requiring immediate intervention, a trained school employee will administer an injection or other prescribed drug. The undersigned understands that the employee administering the prescribed medication is not a licensed healthcare professional. The employee will make his or her best effort to comply with the recommended procedure developed by the child’s physician, and in accordance with the training conducted by an OCBE Nurse. The undersigned hereby consents to the intervention of the employee under these circumstances.

Additionally, the undersigned agrees to hold the Board of Education, its members and employees, and the intervening staff member harmless for any injuries resulting from the emergency care unless the injury was caused by the employee’s negligence. The parent/guardian further agrees to indemnify and hold harmless any employee and the Board and its members from any claim resulting from self-administration of medication per state law.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**It is the responsibility of the parent/guardian to notify school personnel regarding changes in contact information:** Parent/Guardian

Print Name: \_\_\_\_\_

Daytime phone: \_\_\_\_\_

<b>GLUCAGON RECEIVED</b>	
<b>BAQSIMI RECEIVED</b>	
_____	_____
<i>OCBE staff</i>	<i>Date</i>
_____	_____
<i>Parent/guardian</i>	<i>Date</i>
<b>*CARE PLAN REVIEW:</b>	
_____	
<i>OCBE Health Services RN</i>	

**Emergency Medical Care Forms**

**INDIVIDUAL DIABETES HEALTH CARE PLAN**

**PARENT/GUARDIAN CONTACT AND RELEASE OF INFORMATION, DISCLOSURE:**

**PARENTS WILL PROVIDE ALL DIABETIC CARE SUPPLIES INCLUDING: SNACKS, JUICE, BLOOD GLUCOSE METER, LANCET DEVICE, LANCETS, EMERGENCY GLUCOSE, EMERGENCY MEDICATION AND ANY OTHER NEEDED SUPPLIES.**

I hereby give my consent for medical records and reports to be shared with the Oldham County Board of Education and for the physician to discuss my child's Diabetes with school or District personnel to assist them in planning or providing care for my child while at school or school events.

In the event of a crisis requiring immediate intervention, a trained school employee will administer an injection or other prescribed drug. The undersigned understands that the employee administering the prescribed medication may not be a licensed healthcare professional. The employee will make his or her best effort to comply with the recommended procedure developed by the child's physician, and in accordance with the training conducted by an OCBE Nurse. The undersigned hereby consents to the intervention of the employee under these circumstances.

Additionally, the undersigned agrees to hold the Board of Education, its members and employees, and the intervening staff member harmless for any injuries resulting from the emergency care unless the injury was caused by the employee's negligence. The parent/guardian further agrees to indemnify and hold harmless any employee and the Board and its members from any claim resulting from self-administration of medication per state law.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**It is the responsibility of the parent/guardian to notify school personnel regarding changes in contact information:**

Parent/Guardian

Print Name: \_\_\_\_\_

Daytime phone



**GLUCAGON RECEIVED**

**BAQSIMI RECEIVED**

**GVOKE RECEIVED**

**ZEPALOGUE RECEIVE**

\_\_\_\_\_  
OCBE staff

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

**\*CARE PLAN REVIEW:**

\_\_\_\_\_  
OCBE Health Services RN

\_\_\_\_\_  
Date

## **Emergency Medical Care Forms**

### **MANAGEMENT OF FOOD ALLERGIES**

The primary concern of the school is the prevention and appropriate treatment of the potentially severe allergic reaction, anaphylaxis. The following administrative regulations are hereby established in order to properly implement the policy pertaining to the management of food allergies:

1. Each school shall establish a method of ensuring that relevant information is transmitted to all supervising persons of a student identified with a life-threatening food allergy. It is incumbent upon the school to notify any person who may be supervising an identified student with food allergies, especially those which may be life threatening, such as peanut and tree nut allergies.
2. Parents of children having allergies must complete an individualized action plan developed by school personnel, the parent and the student's physician. (See OCBE Administrative Regulation 9009.04-F "Allergy Care Plan/Prescribed Epinephrine")
3. Most food-allergic children bring their lunch from home. However, guidelines established by the USDA Child Nutrition Division in charge of school lunches requires school food service staff to provide substitute meals to students with allergies if the parent provides written instructions from child's physician certifying the child's allergy, what foods are to be avoided, and safe substitutions.
4. Each school should consider establishing a no-food trading policy within the school.
5. Each school should encourage parents to review/preview menus in order to select foods safe for their child to eat.
6. Each school should consider the following avoidance strategies due to the fact that risk can never be fully eliminated in the school environment:
  - a. Encourage parents to instruct their children in how to avoid contact with substances to which they are allergic.
  - b. Carefully monitor identified children, especially in the younger grades.
  - c. Encourage parents of children with allergies to consider having their children eat foods that are prepared at home only.
  - d. Encourage students not to exchange foods or utensils with other students.
  - e. Wash surfaces, toys and equipment clean of allergy containing foods.
  - f. Ensure food personnel receive training from the Food Service Director about necessary measures required to prevent cross contamination during food handling, preparation and serving of food.
  - g. Check hand soap ingredients and pet foods used to be sure these do not contain peanut oils or nuts.
  - h. Establish a buddy system for identified students.
  - i. Provide staff updates at monthly faculty meetings.
  - j. Provide a peanut-free or nut-free area in the cafeteria if there are students with documented nut allergies within the school.
7. The District shall provide training for designated (school) staff in basic first aid, resuscitative techniques, identification of symptoms of an allergic reaction, and the use of epinephrine auto injections.

**Emergency Medical Care Forms****MANAGEMENT OF FOOD ALLERGIES (CONTINUED)**

8. The school shall keep epinephrine in close proximity to students at risk of anaphylaxis and, in all cases where it is administered, the school must call 911 so that the student is sent to the hospital immediately. Follow Allergy Care Plan/Prescribed Epinephrine (9009.04-F) or if no plan is filed, see Safe Schools Manual, Allergy Protocol.
9. Schools will require parents to bring in commercially prepared food items only, with the ingredients on the package, for any party, special occasion or any time that the food is intended for consumption by others instead of or in addition to their own child.
10. Fruit brought in by parents must be whole, unpeeled and washed in a nut free and otherwise allergen free environment in the school cafeteria unless directed otherwise. It may not be cut up unless it is purchased commercially prepared and sealed and labeled in accordance with paragraph-9.
11. In classrooms having students with identified allergies, only foods without the offending food ingredient may be brought in for parties, special occasions or any time that the food is intended for consumption by others instead of or in addition to their own child.
12. Food or candy distributed by school staff in classroom must not contain tree nuts, peanuts or peanut oil.
13. During field trips, foods must be monitored and emergency medication such as epinephrine must be maintained by OCBE staff who accompany students with allergies.
14. An exception to this policy may be granted for classes in which food is prepared and consumed for instructional or cultural purposes. Instructors wishing to use food as a part of their instruction should contact the principal prior to the start of each semester.

## **Emergency Medical Care Forms**

### **EMERGENCY ADMINISTRATION OF OPIOID ANTAGONIST**

Administration of naloxone/opioid antagonist in a timely manner can prevent opioid overdose-related deaths. During the period of time when an overdose can become fatal, respiratory depression can be reversed by the administration of naloxone. Pursuant to [KRS 271.186](#), trained school employees may acquire, possess, and administer naloxone to any individual suffering from an apparent opioid-related overdose. Opioids include heroin, as well as prescription medications such as morphine, codeine, methadone, oxycodone (OxyContin®, Percodan®, Percocet®), hydrocodone (Vicodin®, Lortab®, Norco®), fentanyl, and buprenorphine. The following procedures have been established to properly implement the requirements of [KRS 271.186](#) in the school setting.

Symptoms of an opioid overdose requiring administration of naloxone may include but are not limited to: extreme sleepiness (inability to awaken verbally or upon sternal rub), breathing problems that range from slow to shallow breathing in a person who cannot be awakened, fingernails or lips turning blue or purple, extremely small pinpoint pupils, slow heartbeat and/or low blood pressure. Not all signs and symptoms may be present during an opioid overdose. If the individual is non-responsive to shaking, yelling, or vigorously rubbing of the sternum, initiate naloxone administration.

### **IMPORTANT: NALOXONE IS NOT A SUBSTITUTE FOR EMERGENCY MEDICAL CARE**

1. If an opioid overdose is suspected, call 911 IMMEDIATELY and advise 911 that an opioid overdose is suspected.
2. **Always** go to the distressed individual. Do not send the distressed individual to the office or school nurse alone. Do not move an individual who appears to be in severe distress.
3. Do not leave a distressed individual alone unless there is no other means of calling 911 and getting help.
4. If the person is not breathing, or is unresponsive with infrequent breathing, initiate rescue breathing.
5. Administer naloxone intranasal spray (NARCAN® or another brand). Intranasal naloxone is for use in the nose only.
  - a. Carefully lay the distressed person on his or her back.
  - b. Remove the naloxone nasal spray from the box and open any inner packaging.
  - c. Follow directions included with the naloxone.
  - d. Move the person on his or her side after administering naloxone and observe the person closely. If the person does not respond by waking up to voice or touch, or resume normal breathing, another dose of naloxone may be given if available (alternating nostrils), repeating steps a) through d). Stay with the person and monitor for respiratory distress.

**Emergency Medical Care Forms****EMERGENCY ADMINISTRATION OF OPIOID ANTAGONIST (CONTINUED)**

- e. If the person is not breathing, or breathing continues to be shallow after 1-2 doses of naloxone have been administered, lay the person on their back and continue to perform rescue breathing while waiting for naloxone to take effect, their breathing returns to normal, or EMS arrives.
6. Verify that 911 has been called and EMS has been dispatched.
7. Direct someone to call and notify the front office and school nurse.
8. Each intranasal spray has one (1) dose of naloxone, which will continue to work from 30 to 90 minutes. After that time, overdose symptoms may return. Repeat naloxone administration if necessary.
9. Document the person's name, date, time and route of naloxone administration and provide this information to EMS.
10. Document the incident for the school's records.
11. Replace naloxone stock as soon as possible.
12. Naloxone must be stored in a secure, accessible but unlocked location within the school.

Review/Revised:2/24/2025