APPENDIX B

INDIVIDUALIZED HEALTH CARE PLAN
# Appendix B – Health Care Plan

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STUDENTS NEEDING INDIVIDUALIZED HEALTH CARE PLANS (IHCP)

1. An Individualized Health Care Plan is needed for students who have:
   A. Daily/ongoing medical procedures that need to be performed at school
      - Seizure disorder that is not controlled
      - Encopresis requiring regular care from staff
      - Diabetes
      - Catheterization
      - Tube feeding
      - Suctioning
      - Severe latex allergies
      - Asthma requiring peak flow meter or nebulizer treatments
      - Use of oxygen/oxygen supplies during school hours
      - Tracheostomy care
      - Organ transplants
   B. A life threatening condition that occurs as a result of a health concern
      - Seizures ending in status elepticus
      - Documented episodes of severe breathing difficulties
      - Exposure to allergens that may cause anaphylaxis

2. Initiation of the IHCP process
   A. If the eligibility team for a new student determines that the student has a health concern that may need an IHCP, or if the physician makes a recommendation for an IHCP, a team member will contact the Regional School Health Coordinator (registered nurse) assigned to the student’s school. The registered nurse (RN) will assess the child’s health need and initiate the process. The Regional School Health Coordinator will contact the School/Community Health Coordinator at Central Office for assistance.
   B. If a special education student transfers into the county with significant medical needs, the clinic aide will review the emergency care card and contact the Regional School Health Coordinator to determine if the student may need a Health Care Plan. A physician’s authorization form will be sent to the child’s health care provider to gather pertinent health care information. The RN will review this information and coordinate with the special education teacher to initiate the health care plan meeting.

3. Initial Individualized Health Care Plans
   A. The Special Education teacher, in coordination with nursing staff, will schedule the meeting and invite the parents, school staff and nursing staff. (See letter to parent.)
   B. Training for IHCP is done by a registered nurse following guidelines from the physician and input from the parents. The special education teacher or the RN will invite parents to the training. Documentation of training is recorded and filed appropriately in the student’s file.
4. Yearly IHCP Plan assessment after initial plan

A. All amendments to the Health Care Plan for special education students can be done in association with IEP. Any changes in medical status and training must be discussed with the registered nurse. Yearly training for staff will be scheduled by the special education teacher in consultation with Regional School Health Coordinator. Parents should be invited to all training regarding their child. (See letter in Health Care Plan Section).

B. Any questions regarding amendments may be directed to the facilitators, the Regional School Health Coordinator, or the School/Community Health Services Coordinator.
Dear Physician:

We are in the process of developing an Individualized Health Care Plan for one of our students. Attached is a form upon which you can provide input in regard to health or emergency procedures that need or may need to be performed in the school setting. This information is critical in developing a school plan to best keep your patient healthy and safe during school hours. We will train staff based upon this information.

If you have any questions regarding this form, please call me at (540) 245-5133. Your assistance is greatly appreciated in this matter.

Sincerely,

Catherine A. Brown, RN, BSN
School/Community Health Coordinator

STUDENT___________________________

SCHOOL ____________________________

DATE SENT _________________________
Physician’s Request for Specialized Health Care Procedures/Treatment

Whenever possible, it is desirable for treatments and procedures to be scheduled at times other than school hours. However, individual needs will be taken into consideration to meet a student’s health care during school hours.

Protocol for procedures/treatments include the following:

1. Written and signed physician’s orders stating details of treatment/care needed during school hours.
2. Written parental consent requesting that the school comply with the physician’s order.
3. Provision of necessary supplies and equipment by parent/guardian to the school nurse for performance of the treatment/procedure.

**PHYSICIAN, please complete and sign this form.**

<table>
<thead>
<tr>
<th>Student:</th>
<th>School:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Date:</td>
<td>Diagnosis:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure/Treatment:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Time/Duration:</th>
<th>Frequency:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Specific Directions:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Duration of Order:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Precautions/Emergency Procedures:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Comments:</th>
</tr>
</thead>
</table>

Physician Name: ____________________________ Date: ____________________________

Signature: ____________________________ Phone: ____________________________

I give permission for the school nurse to contact the prescribing physician and/or that office regarding this treatment for my child. I will notify the school immediately if there are changes in my child’s physician, health status, or change/cancellation of the procedure.

Parent Name: ____________________________ Date: ____________________________

Signature: ____________________________
Augusta County Public Schools  
6 John Lewis Rd.  
Fishersville, VA 22939  
(540) 245-5133

Date

Dear Parent,

We have received the information from your physician regarding the health needs of your child. A meeting with you and the school staff will be held to develop an Individualized Health Care Plan for ________________________________. This meeting will be held on ________________, at ____________________, at ________________.

(Date) (Location) (Time)

Please feel free to call me at (540) 245-5133 if you have any questions. I look forward to seeing you at the meeting.

Sincerely,

Catherine Brown, RN, BSN  
School/Community Health Coordinator
INDIVIDUALIZED HEALTH CARE PLAN

Date of Plan: ______________________

Student: ________________________  Parent/Guardian: ________________________
Date of Birth: ____________________  Address: ____________________________

Home Phone: _____________________  Work Phone(s): _______________________  

Emergency Contact Person: ________________________________________________

Relationship to Child: ________________________  Phone: _____________________

Physician: __________________________  Phone: ____________________________

Other: ______________________________  Phone: ____________________________

Health Concern(s):

Medication(s) Location/Personnel:

Specific Health Precaution(s):

Feeding/Nutritional Needs:

Transportation:

Plan for Staff/Student Absence:

Accessibility Needs:
Child Training Needs:

Staff Training Needs: Who to be Trained, Who to Perform Training:

Any Other Needs:

Participants in Plan Development:

______________________________ Parent
______________________________ Administrator
______________________________ Nursing Staff
______________________________ Agency Staff
______________________________ Teacher
______________________________ Others

Date of Review: __________________________

Subsequent Plans are to be reviewed in conjunction with IEP.

Note: Parents are responsible for providing health/medical supplies and equipment needed for their child.

Attach Emergency Procedures and Physician’s Authorization Form to Plan.
Emergency Care Procedures for School Staff

Student: ___________________________  Parent: ___________________________
DOB: ___________________________  Phone: ___________________________
School: ___________________________  Emergency #: ___________________________

<table>
<thead>
<tr>
<th>If you see this</th>
<th>Do this</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If an Emergency Occurs:

1. Stay with student
2. Call or designate someone to call the nurse or clinic aide.
   - State who you are:
   - State where you are:
   - State problem:
3. If the school nurse of clinic aide is unavailable, the following staff members have been trained to deal an emergency and can initiate the emergency plan:

________________________________________________________________
________________________________________________________________
________________________________________________________________
Emergency Care Procedures for School Staff

Student: ___________________________             Parent: ___________________________
DOB: _______________________________       Phone: _____________________________
School: _______________________________ Emergency #: ___________________________

_____ is newly diagnosed with Juvenile Onset/Insulin Dependent Diabetes. He is doing well with his new
diagnosis, but will need support and supervision at this time. Currently, _____’s monitor and supplies
will be kept in the clinic. He will have snacks in his classrooms. He will need to go to the clinic to check
his blood sugar 5-10 minutes prior to lunch, and anytime he has symptoms of low or high blood sugar
(BS).

### Emergency Plan

<table>
<thead>
<tr>
<th>Signs of Hypoglycemia</th>
<th>Do this</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiousness, shaking</td>
<td>Encourage _____ to check blood sugar</td>
</tr>
<tr>
<td>Sweating</td>
<td>• Send with adult or designated “buddy” to clinic</td>
</tr>
<tr>
<td>Weakness/fatigue</td>
<td>• Prompt to eat instant sugar source</td>
</tr>
<tr>
<td>Irritability/inappropriate behavior</td>
<td>1. 3-4 glucose tablets</td>
</tr>
<tr>
<td>Poor coordination</td>
<td>2. ½ cup of juice (orange, apple)</td>
</tr>
<tr>
<td>Drowsiness/Sleepiness</td>
<td>3. ½ cup non diet soda</td>
</tr>
<tr>
<td></td>
<td>4. 3 lifesavers</td>
</tr>
<tr>
<td></td>
<td>5. 15 skittles</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signs of Hyperglycemia</th>
<th>Do this</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extreme thirst</td>
<td>Encourage _____ to check blood sugar</td>
</tr>
<tr>
<td>Frequent urination</td>
<td>• Send with adult or designated “buddy” to clinic</td>
</tr>
<tr>
<td>Dry skin</td>
<td>• Mom will be notified if BS &lt;80 or &gt;250</td>
</tr>
<tr>
<td>Increased hunger</td>
<td>• Will check Ketones if BS&gt;250</td>
</tr>
<tr>
<td>Nausea/abdominal pain</td>
<td>• Communication with clinic staff will assist</td>
</tr>
<tr>
<td>Difficulty concentrating/hyperactivity</td>
<td>_____ and classroom teacher of any</td>
</tr>
<tr>
<td></td>
<td>interventions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If _____ Becomes Unconscious</th>
<th>Do this</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stay with _____ and send someone for</td>
<td>Supplies for _____ kept in labeled container on</td>
</tr>
<tr>
<td>supplies/glucagon in clinic</td>
<td>cart under refrigerator</td>
</tr>
<tr>
<td>Roll onto side to protect airway</td>
<td>Trained staff will assist/give Glucagon. Give</td>
</tr>
<tr>
<td></td>
<td>0.5 mg of Glucagon in deltoid (upper arm)</td>
</tr>
<tr>
<td></td>
<td>muscle</td>
</tr>
<tr>
<td></td>
<td>Office will be alerted to call 911 and parent</td>
</tr>
</tbody>
</table>

If an Emergency Occurs:

4. Stay with student
5. Call or designate someone to call the nurse or clinic aide.
   - **State who you are:**
   - **State where you are:**
   - **State problem:**
6. If the school nurse or clinic aide is unavailable, the following staff members have
   been trained to deal an emergency and can initiate the emergency plan:
NOTICE TO PARENTS OF HEALTH CARE PLAN TRAINING

School Letterhead here

Date_________________

Dear Parent:

We will be training school staff regarding your child, _________________’s Individualized Health Care Plan. It will take place at _______________________(time) on _______________________(date) at _______________________(place). If you have any questions, please call me at _______________________.

Sincerely,

Special Education Teacher
INDIVIDUALIZED HEALTH CARE PLAN
DOCUMENTATION OF STAFF TRAINING

Note: Principal is to designate staff needing training.

Student: ___________________________ Date of Birth: _________________

Date of Training: _______________________

Person(s) Performing Training: __________________________

Topic of Training:

Staff Trained (Signatures):
INDIVIDUALIZED HEALTH CARE PLAN AMENDMENT

STUDENT __________________________ SCHOOL __________________________
DATE OF LAST IHCP ________________ DATE OF UPDATE ________________

Changes/amendments to IHCP: (check where appropriate)

____ 1. Change in medical status (attach updated information)
____ 2. Change in need for training (new staff, new procedures)

Dates for training: ______________________
Staff needing training: ______________________
Topic of training: ______________________
Document staff trained (see attached form)

Describe all changes in medical status or training; attach emergency care procedures page(s).

Approved by: ____________________________ Parent
______________________________ Administrator
______________________________ Teacher
______________________________ Nursing staff
______________________________ Other
HEALTH SERVICES -- AUGUSTA COUNTY SCHOOLS
PARENT QUESTIONNAIRE
ALLERGIES

To the Parent/Guardian of: ___________________________________________ Grade: ____________________________

Date of Birth: __________________ School: ____________________________ Teachers: ____________________________

You have checked on the Emergency Care Card that your child has an allergy. Please complete this form and return it to the school nurse/clinic aide tomorrow. If your child's allergy could be life threatening, then the nurse/clinic aide will be developing an emergency plan for use during the school day. Please remember it is the responsibility of parents to provide special food and medicine needed at school, and to notify the school of any changes in your child’s health status. If you have questions, you may call the nurse/clinic aide at your child's school.

COMPLETE THE BOX FOR ANY ALLERGY YOUR CHILD HAS:

<table>
<thead>
<tr>
<th>INSECT STINGS (TYPES):</th>
<th>FOOD (types):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the allergy life threatening: ______ yes ______ no</td>
<td>Is the allergy life threatening: ______ yes ______ no</td>
</tr>
<tr>
<td>What symptoms does your child show during an allergy attack?</td>
<td>What symptoms does your child show during an allergy attack?</td>
</tr>
<tr>
<td>______ Difficulty breathing/swallowing</td>
<td>______ Difficulty breathing/swallowing</td>
</tr>
<tr>
<td>______ Rash/hives</td>
<td>______ Rash/hives</td>
</tr>
<tr>
<td>______ Sneezing</td>
<td>______ Sneezing</td>
</tr>
<tr>
<td>______ Nausea/vomiting</td>
<td>______ Nausea/vomiting</td>
</tr>
<tr>
<td>______ Cough</td>
<td>______ Cough</td>
</tr>
<tr>
<td>______ Sweating</td>
<td>______ Sweating</td>
</tr>
<tr>
<td>______ Blueness of lips and skin</td>
<td>______ Blueness of lips and skin</td>
</tr>
<tr>
<td>______ Feeling of Fear</td>
<td>______ Feeling of Fear</td>
</tr>
<tr>
<td>______ Swelling: how much?</td>
<td>______ Swelling: how much?</td>
</tr>
<tr>
<td>______ Which body part?</td>
<td>______ Which body part?</td>
</tr>
<tr>
<td>______ Other (describe)</td>
<td>______ Other (describe)</td>
</tr>
</tbody>
</table>

Has emergency medical treatment been needed in the past for this allergy?

| Yes (when)___________ | No |

Is a doctor currently treating this allergy?

| No |

Yes (Doctor: _____________ Phone: _____________ |

<table>
<thead>
<tr>
<th>MEDICATIONS (types):</th>
<th>OTHER (types):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the allergy life threatening: ______ yes ______ no</td>
<td>Is the allergy life threatening: ______ yes ______ no</td>
</tr>
<tr>
<td>What symptoms does your child show during an allergy attack?</td>
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</tr>
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</tr>
<tr>
<td>______ Rash/hives</td>
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<td>______ Sneezing</td>
</tr>
<tr>
<td>______ Nausea/vomiting</td>
<td>______ Nausea/vomiting</td>
</tr>
<tr>
<td>______ Cough</td>
<td>______ Cough</td>
</tr>
<tr>
<td>______ Sweating</td>
<td>______ Sweating</td>
</tr>
<tr>
<td>______ Blueness of lips and skin</td>
<td>______ Blueness of lips and skin</td>
</tr>
<tr>
<td>______ Feeling of Fear</td>
<td>______ Feeling of Fear</td>
</tr>
<tr>
<td>______ Swelling: how much?</td>
<td>______ Swelling: how much?</td>
</tr>
<tr>
<td>______ Which body part?</td>
<td>______ Which body part?</td>
</tr>
<tr>
<td>______ Other (describe)</td>
<td>______ Other (describe)</td>
</tr>
</tbody>
</table>

Has emergency medical treatment been needed in the past for this allergy?

| Yes (when)___________ | No |

Is a doctor currently treating this allergy?

| No |

Yes (Doctor: _____________ Phone: _____________ |

Thank you for your assistance.
HEALTH SERVICES -- AUGUSTA COUNTY SCHOOLS
PARENT QUESTIONNAIRE
ASTHMA

To the Parent/Guardian of: ___________________________ Grade: ___________________________

Date of Birth: _______________________ School: ___________________________ Teachers: ___________________________

You have checked on the Emergency Care Card that your child has asthma. Please complete this form and return it to the school nurse/clinic aide tomorrow. If your child's asthma involves daily intervention with a nebulizer or peak flow meter, or if the asthma is not well under control, the nurse/clinic aide may be developing an emergency plan for use during the school day. Please remember it is the responsibility of parents to provide special equipment or medicine need at school, and to notify the school of any changes in your child's health status. If you have questions, you may call the nurse/clinic aide at your child's school.

What triggers your child's asthma attacks? Describe the symptoms your child experiences.

(Check any that apply) (Check all that apply)

Illness ______ Emotions ______ Medications ______ Cigarette or other smoke ______ Other:

Weather ______ Exercise ______ Foods ______ Fatigue ______ Chemical odors

ASThma HISTORY:
How long has your child had asthma? ___________________________

How many times has your child been hospitalized overnight for asthma in the past year? ___________________________

Please rate the severity of his/her asthma. (circle)

(Not Severe) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

How many times has your child been treated in the emergency room for asthma in the past year? ___________________________

How many days would you estimate he/she missed school last year due to asthma? ___________________________

MEDICATIONS.TREATMENTS

Please list the medications your child takes for asthma (every day or as needed).

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Route</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(In School)

(Physician and parental/guardian permission is needed for any medication given at school.)

(At Home)

Has your child been taught to use an extension tube, pulmonary aid, inspirase kit or other device with his/her inhaler? ______________

Does your child use a nebulizer? ___________________________

What, if any, side effects does your child have from his/her medications? ___________________________

What does your child do at home to relieve the symptoms during an asthma attack? ___________________________

If your child does not respond to medication, what action do you advise school personnel to take? ___________________________

OTHER INFORMATION:

How often does your child see his/her doctor for routine asthma evaluations? ___________________________

Do you know what your child's baseline peak flow rate is? No_____ Yes____ Rate ___________________________

Do you think your child holds him/herself back from participating in any activities at school because of his/her asthma? If so, Please describe. ___________________________

Thank you for your assistance.
HEALTH SERVICES -- AUGUSTA COUNTY SCHOOLS
PARENT QUESTIONNAIRE
SEIZURES

To the Parent/Guardian of: ___________________________ Grade: ___________________________

Date of Birth: _______________ School: ___________________________ Teachers: ___________________________

You have checked on the Emergency Care Card that your child has seizures. Please complete this form and return it to the school nurse/clinic aide tomorrow. An emergency care plan will be developed for use during the school day. Please remember it is the responsibility of parents/guardians to provide any medication needed at school, and to notify the school of any changes in your child's health status. If you have questions, you may call the nurse/clinic aide at your school.

How long has your child had seizures? _____________________________________________

What type seizures does your child have? ___________________________________________

Describe any warning and/or behavior changes before the seizure begins. ___________________________________________

Describe what happens during the seizure. _____________________________________________

What triggers the seizure? _______________________________________________________

How long does the seizure usually last? _____________________________________________

How often does your child have a seizure: _______Daily _______Weekly _______Monthly _______Yearly

Usual time of day seizure(s) occur _______________________________________________

Date of last seizure _______________________________________________________________

First aid if seizure(s) occur at school _______________________________________________

Student's reaction to seizures(s) ___________________________________________________

MEDICATIONS

Please list the medications your child takes for seizures (every day or as needed).

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Route</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>(In School)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(At Home)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Physician and parental/guardian permission is needed for any medication given at school.)

What, if any, side effects does your child have from his/her medication? _________________________

OTHER INFORMATION:

How often does your child see his/her doctor for routine seizure evaluations?

What is the best way for us to communicate about your child's seizure(s), medications(s), and other concerns (e.g. calendars, diary, written notes, or calls)? _____________________________________________

Thank you for your assistance.
Emergency Alert and Health Care Plan for ALLERGIES
Staunton, Augusta County, Waynesboro Public Schools

POSSIBLE SYMPTOMS: Generalized feeling of impending doom or fright, weakness, sweating, sneezing, shortness of breath, nasal itching, hives, vomiting, cyanosis (bluish discoloration of lips and skin), cough, restlessness, shock, hoarseness, swollen tongue and/or severe swelling.

Student Name: ___________________________ DOB: ___________________________

Name of Physician: ___________________________ Office Phone Number: ___________________________

This student is highly allergic to ___________________________

TREATMENT IF EXPOSED TO ALLERGEN (perform even if no symptoms present):
1. Assess situation, remain calm, make student comfortable, move student ONLY for safety reasons.
2. Call rescue squad (911) at the beginning of the crisis!
3. Send someone immediately to:
   ♦ Obtain student’s medication: ___________________________ from ___________________________
   ♦ Notify persons trained to administer injection if needed: 1. ___________________________ 2. ___________________________ 3. ___________________________
   ♦ Notify parent/guardian.
   ♦ Notify physician.
4. Administer medication ___________________________ Amount ___________________________ Route of administration ___________________________
5. Apply ice pack to sting site, if applicable
6. Maintain open airway; perform rescue breathing and CPR as needed. Persons trained: 1. ___________________________ 2. ___________________________
7. Transport to nearest medical facility (per rescue squad).
8. Record the following information, copy this card, and give to person transporting:
   ♦ Time and site of incident (sting/ingestion/exposure). Time: ___________________________ Site: ___________________________
   ♦ Dosage and time of administration of medication named above: Dosage: ___________________________ Time: ___________________________

The preceding information is in accordance with our medical recommendations for the above named student.

______________________________ ___________________________
Physician’s Signature Date

Directions for Use of ADA-Kit:
1. Remove plastic needle cover.
2. Hold syringe upright; push plunger until it stops (this expels air)
3. Rotate plunger ¼ turn to the right.
4. Wipe site with alcohol swab.
5. Insert needle straight into upper arm or upper thigh.
6. Push plunger until it stops. (FOLLOW INSTRUCTION SHEET as children under the age of 12 will require a smaller dose of the medication.
7. Remove needle and massage area for 10 seconds.
8. Steps 3-7 may be repeated after 10 minutes, if ordered by Physician and needed by the student.

Directions for Use of EPI Pen:
1. Remove cap.
2. Place black tip on thigh.
3. Press hard until auto-injector activates. HOLD in place for several seconds.
4. Massage area for 10 seconds.

I give permission for school personnel to provide the emergency treatment to my child. I assume the responsibility for providing to the school the prescribed medication emergency kit and subsequent replacement kits. I relieve the Staunton City, Augusta County, and Waynesboro School Boards, their employees, and agents of any liability that may pertain to them for any injury, damage, loss, or accident that may be occasioned through the treatment of my child. I approve this Health care Plan for my child. I am aware that should I move from the Staunton, Augusta, or Waynesboro area, I will need to work with the new locality to develop a new health care plan for my child.

______________________________ ___________________________
Signature of Parent/Guardian Date

Review and revision of Health Care Plan (done annually or as needed if student has a significant change in health status):

<table>
<thead>
<tr>
<th>School Year</th>
<th>Revision Necessary</th>
<th>Date</th>
<th>Signature of Parent/Guardian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
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<td>Yes</td>
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<td>Yes</td>
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<tr>
<td>Yes</td>
<td>No</td>
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</tr>
</tbody>
</table>

APPENDIX B Page 18 Rev. 07/03
Emergency Alert and Health Care Plan for ASTHMA
Staunton, Augusta County, Waynesboro Public Schools

POSSIBLE SYMPTOMS: Shortness of breath (usually of a choking nature), chest wheezes, cough, profound exhaustion, anxiety, and fear. Lips and fingernails may become bluish and the child may perspire profusely. The chest and neck may pull in with breathing. The attack may last from minutes to several days.

Student Name: ____________________________________________  DOB: ________________________________

Name of Physician: ____________________________________________  Office Phone Number: ________________________________

TO BE COMPLETED BY PHYSICIAN

This student has been diagnosed with asthma. During school, the following will be necessary:

DAILY ASTHMA MANAGEMENT PLAN

1. Identify the things which start an asthma episode (check each that applies to student)
   - Exercise
   - Pollen/Molds
   - Food
   - Respiratory Infections
   - Change in Temperature
   - Strong odors/fumes
   - Carpets
   - Dusts
   - Other

2. Peak Flow Monitoring
   - Time(s) to be done: ____________________________
   - Student’s Personal Best Baseline
     - Green (Good Control) Zone: _____________ to _____________ Peak Flow Rate (80-100% of personal best)
       - Continue Daily Management Plan (medications, monitoring, etc.)
     - Yellow (Caution) Zone: _____________ to _____________ Peak Flow Rate (50-79% of personal best)
       - Refer to the Emergency Plan
     - Red (Danger) Zone: _____________ to _____________ Peak Flow Rate (below 50% of personal best)
       - Refer to the Emergency Plan

3. Daily Medication(s)

<table>
<thead>
<tr>
<th>Name</th>
<th>Amount</th>
<th>How Administered (oral, inhaled, nebulizer)</th>
<th>Time or frequency to be Given</th>
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4. For Inhaled Medications:
   - _______ Student is able to perform procedure alone
   - _______ Student is able to perform procedure with supervision
   - _______ Student requires a school staff member to perform procedure
   - _______ Student is able to carry inhaler

EMERGENCY ACTIONS

Emergency action is necessary when the student has the following symptoms:
   - Persistent Coughs
   - Respirations less than
   - Child is struggling to breathe
   - Lips or fingernails are gray or blue
   - Chest or neck is pulled in with breathing
   - Trouble walking or talking
   - No improvement in ________ minutes after initial treatment with medication and relative cannot be reached
   - Has a peak flow reading of ________

A. Steps to take during an asthma episode:
   1. Give medication as listed:

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   2. May return to classroom if:

   3. Contact parent/guardian if:

Physician Signature: ____________________________  Date: ____________________________

I give permission for school personnel to provide the emergency treatment to my child. I assume the responsibility for providing to the school the prescribed medication emergency kit and subsequent replacement kits. I relieve the Staunton City, Augusta County, and Waynesboro School Boards, their employees, and agents of any liability that may pertain to them for any injury, damage, loss, or accident that may be occasioned through the treatment of my child. I approve this Health Care Plan for my child. I am aware that should I move from the Staunton, Augusta, or Waynesboro area, I will need to work with the new locality to develop a new health care plan for my child.

Signature of Parent/Guardian: ____________________________  Date: ____________________________

Review and revision of Health Care Plan (done annually or as needed if student has a significant change in health status):

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Emergency Alert and Health Care Plan for DIABETES  
Staunton, Augusta County, Waynesboro Public Schools

POSSIBLE SYMPTOMS OF: becomes shaky, nervous, and/or unable to concentrate, headache, irritability, pounding heart, changes in vision, hunger, restlessness, tiredness, drowsiness, combativeiveness, poor coordination, confusion, convulsions.

Student Name: ___________________________________________ DOB: __________________________

Name of Physician: ___________________________ Office Phone Number: __________________________

This student has been diagnosed with diabetes. During school, the following will be necessary:

1. **INSULIN ADMINISTRATION:**
   - Dose: ___________________________ Time: ___________________________
   - Student is able to self-administer insulin.
   - Student requires adult supervision when self-administering insulin.
   - Student requires administration of insulin by school staff.

2. **DIET**
   - Student does not require monitoring for food choices
   - Student does require monitoring for food choices.
   - Specific instructions: Breakfast ___________ Lunch ___________ Morning Snack ___________ Afternoon Snack ___________

3. **EXERCISE**
   - No restrictions.
   - Restrictions. DO NOT exercise if blood sugar is above ___________ or below ___________.
   - Responsible adults should have emergency glucose (sugar) available in case low blood sugar develops during or after exercise.

4. **BLOOD GLUCOSE MONITORING**
   - Time(s): ___________________________ Type monitor: ___________________________ Location of monitor: ___________________________
   - NOTIFY PARENTS if blood sugar is below ___________ or above ___________.
   - Student is able to perform procedure with supervision.
   - Student requires a school staff member to perform procedure with supervision.
   - Student requires a school staff member to perform the procedure.

   Persons trained to perform the procedures: 1. ___________________________ 2. ___________________________ 3. ___________________________

   Continued on back of form

5. **INSULIN REACTION (LOW BLOOD SUGAR)**
   1. Check blood sugar if possible. Stay with the student at all times.
   2. Give source of instant sugar. Examples are ½ cup of fruit juice, 6 oz. Of regular soda, 2 packets of sugar
   3. If symptoms IMPROVE, give the student a more substantial snack that includes protein. Examples include a glass of milk and peanut butter crackers.
   4. If symptoms DO NOT IMPROVE within 15 minutes, repeat the treatment. If symptoms DO NOT IMPROVE with the second treatment, call 911.
      - Notify parents and ___________________________, MD.

5. **EMERGENCY MANAGEMENT – GLUCAGON:**
   - If the student is unresponsive or drowsy and unable to swallow:
     - Call 911
     - Administer Glucagon: Dose: ___________________________ Route of administration: ___________________________
     - Location of Glucagon Kit: ___________________________
     - Notify parents and physician
     - Persons trained to administer the injection: 1. ___________________________ 2. ___________________________ 3. ___________________________

6. **KETONE CHECKS**
   - Time(s): ___________________________ Notify parents if the value is: ___________________________
   - Other instructions:
     - a. ADDITIONAL INSTRUCTIONS:

[Signature of Parent/Guardian]

I give permission for school personnel to follow the plan and to use the designated medications on my child in accordance with the instructions above. I understand that I am responsible for providing to the school the prescribed medication, the glucose monitoring equipment and any snacks needed by my child. I hereby release the Staunton City, Augusta County, and Waynesboro School Boards, their employees, and agents of any liability connected with their reliance on this permission and agree to indemnify, defend and hold them harmless from any such claim or liability connected with such reliance. I am aware that should I move from the Staunton, Augusta, or Waynesboro area, I will need to work with the new locality to develop a new health care plan for my child.

[Signature of Parent/Guardian]

**Review and revision of Health Care Plan (done annually or as needed if student has a significant change in health status):**

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Emergency Alert and Health Care Plan for TONIC CLONIC SEIZURE DISORDERS
Staunton, Augusta County, Waynesboro Public Schools

POSSIBLE SYMPTOMS OF: sudden cry, fall, rigidity, muscle jerks, shallow breathing, bluish skin, possible loss of bladder or bowel control.

Student Name: _______________________________ DOB: _______________________________

TO BE COMPLETED BY PHYSICIAN

Name of Physician: __________________________ Office Phone Number: ___________________

This student has been diagnosed with a tonic clonic/grand mal seizure disorder.

Age of Diagnosis: ___________________________ Average frequency: ______ daily ______ weekly ______ monthly ______ yearly

<table>
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<tr>
<th>Medication(s)</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Time of Day</th>
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What triggers the seizure: __________________________ List any warning signs and/or behavior changes that may occur before the seizure: __________________________

How long does it last? __________________________ Usual time of day seizure(s) occurs: __________________________ Date of last seizure: __________________________

TO BE COMPLETED BY PARENT AND PHYSICIAN

Check any special considerations related to this child’s seizure disorder while at school and describe them briefly:

Educational concerns: __________________________
Behavioral concerns: __________________________
Emotional concerns: __________________________
Physical education concerns: __________________________
Sports precautions: __________________________
Recess precautions: __________________________
Special considerations for field trips: __________________________
Special transportation to and from school: __________________________
Other: __________________________

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EMERGENCY ACTIONS

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<th>SEIZURE TYPE</th>
<th>WHAT TO DO</th>
<th>WHAT NOT TO DO</th>
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<tr>
<td>Generalized tonic-clonic</td>
<td>Protect from hazards. Loosen ties/shirt collars. Protect head from injury. Turn on side to keep airway clear. Reassure afterwards. If single seizure lasted less than 5 min., ask if hospital evaluation is wanted. Call 911 – if multiple seizures, the seizure lasts longer than 5 min; if pregnant, injured or diabetic.</td>
<td>Don’t put any hard implement in the mouth Don’t try to hold tongue. It cannot be swallowed. Don’t try to give liquids during or just after. Don’t use artificial respiration unless breathing is absent after muscle jerks subside. Don’t restrain.</td>
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This plan is accordance with this student’s medical management.

Physician’s Signature __________________________ Date __________________________

I give permission for school personnel to provide the emergency treatment to my child. I assume the responsibility for providing to the school the prescribed medication needed by my child. I agree to notify the school if a change in my child’s condition occurs and I agree to allow this information to be shared with the adults responsible for my child’s care. I relieve the Staunton City, Augusta County, and Waynesboro School Boards, their employees, and agents of any liability that may pertain to them for any injury, damage, loss, or accident that may be occasioned through the treatment of my child. I am aware that should I move from the Staunton, Augusta, or Waynesboro area, I will need to work with the new locality to develop a new health care plan for my child.

Signature of Parent/Guardian: __________________________ Date: __________________________

Reviewed by: __________________________ Date: __________________________

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