

# Forms

Date \_\_\_\_\_

Dear Parents of \_\_\_\_\_  
(Student's name)

RE: Emergency Information Form (EIF)

Public Health Nursing (PHN) Branch, Department of Health, administers the school health program statewide. We are requesting your authorization for PHN to work in collaboration with your child's primary care physician in completing the Emergency Information Form (EIF) to be used during an emergency at school. This form will provide significant information about your child's health condition, precautions needed, and special management plans during an emergency at school so that prompt and appropriate care is provided to your child.

The Emergency Information Form (EIF) is enclosed for your information. Your signed consent to obtain this information from your child's physician is needed. This consent will also allow Public Health Nursing Branch to release this information to the Emergency Medical Services of the Department of Health, the Emergency Medical Services personnel (911 team), and the Emergency Facility where your child may be treated.

The completed EIF will be kept in a safe place at the school to assure confidentiality. It will be used during an emergency and provided to the Emergency Medical Services personnel (911 team).

Please review and sign the enclosed "Authorization for Use or Disclosure of Protected Health Information" form and return it in the enclosed envelope. We will mail the EIF and signed authorization form to your child's physician for completion. If there are any questions, please contact your public health nurse \_\_\_\_\_ at \_\_\_\_\_.  
(PHN name) (phone)

Sincerely,

**EMERGENCY INFORMATION FORM (EIF)**

References:

- “Emergency Preparedness for Children with Special Health Care Needs,” American Academy of Pediatrics, Committee on Pediatric Emergency Medicine, Pediatrics, Volume 104, No. 4, October 1999.
- “In Emergency, Children with Special Health Care Needs Require Individual Plans,” AAP News, October 1999.
- “ACEP Policy Statement: Emergency American Information Form for Children with Special Health Care Needs,” American College of Emergency Physicians.

**PURPOSE:** For students receiving specialized health care treatments (i.e. ventilator, tracheostomy care). To provide comprehensive medical information to Emergency Medical Services (EMS) upon arrival at the school in response to a 911 call for immediate emergency response and to give the Emergency Information Form (EIF) to the emergency room/facility where the student will receive treatment.

**POLICY:** The EIF will have pertinent medical information for medically fragile children, who require emergency care for acute life-threatening emergencies.

The EIF, developed by the American College of Emergency Physicians and the American Academy of Pediatrics, will be the standard form in use and will be kept in a safe place at the school to assure confidentiality (*Family Educational Rights and Privacy Act of 1974*).

PHN 28, Authorization for Use or Disclosure of Protected Health Information, will be used to obtain informed consent to share information with the Department of Health (DOH), Department of Education (DOE), State Emergency Medical Services System, Emergency Medical Services (EMS), 911 Personnel, and Emergency Department/Facility.

**PROCEDURES:**

1. Public Health Nursing (PHN) Branch will work with the parent(s)/legal guardian to have available pertinent medical information:
  - PHN will obtain authorization (PHN 28) to release the pertinent medical information on the EIF to DOH, DOE, State Emergency Medical Services System, EMS, and Emergency Department/Facility.
  - PHN will provide the “Dear Parent” letter and EIF to the parent(s)/legal guardian.
2. Once authorization is obtained, PHN will collaborate with the physician:
  - Forward the signed Authorization for Use or Disclosure of Protected Health Information (PHN 28) and EIF form to the physician with self-addressed envelope.
  - Communicate and collaborate with physician so the EIF is completed and returned to PHN on a timely basis.

3. PHN maintains copies of the completed EIF and PHN 28 in the student's school health record and updates EIF form with physician as the student's medical condition status changes.
4. PHN will give copies of completed EIF and PHN 28 to the parent(s) and the school.
5. PHN will work with DOE personnel involved (specific to the student) to reach agreement on the most appropriate location for the completed EIF and PHN 28 to be kept so that during the emergency:
  - all involved have knowledge as to the location of the forms, and
  - copies of the completed EIF and PHN 28 are given to EMS (911 team) when 911 is called for emergency care for the student.
6. School "911 copy" of the EIF and PHN 28 will be kept with the student's Emergency Action Plan (EAP) at \_\_\_\_\_ (specify) as agreed by the school team.

# Emergency Information Form for Children With Special Needs



American College of  
Emergency Physicians\*

American Academy of  
Pediatrics



Date form  
completed  
By Whom

Revised  
Revised

Initials  
Initials

Last Name:

<b>Name:</b>		Birth date:	Nickname:
Home Address:		Home/Work Phone:	
Parent/Guardian:		Emergency Contact Names & Relationship:	
Signature/Consent*:			
Primary Language:		Phone Number(s):	
<b>Physicians:</b>			
Primary care physician:		Emergency Phone:	
		Fax:	
Current Specialty physician: Specialty:		Emergency Phone:	
		Fax:	
Current Specialty physician: Specialty:		Emergency Phone:	
		Fax:	
Anticipated Primary ED:		Pharmacy:	
Anticipated Tertiary Care Center:			

<b>Diagnoses/Past Procedures/Physical Exam:</b>	
1.	Baseline physical findings:
2.	
3.	Baseline vital signs:
4.	
Synopsis:	
	Baseline neurological status:

\*Consent for release of this form to health care providers

Last Name: \_\_\_\_\_

<b>Diagnoses/Past Procedures/Physical Exam continued:</b>	
Medications:	Significant baseline ancillary findings (lab, x-ray, ECG):
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	Prostheses/Appliances/Advanced Technology Devices:
5. _____	_____
6. _____	_____

<b>Management Data:</b>	
Allergies: Medications/Foods to be avoided	and why:
1. _____	_____
2. _____	_____
3. _____	_____
Procedures to be avoided	and why:
1. _____	_____
2. _____	_____
3. _____	_____

Immunizations											
Dates							Dates				
OPT							Hep B				
OPV							Varicella				
MMR							TB status				
HIB							Other				

Antibiotic prophylaxis:	Indication:	Medication and dose:
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<b>Common Presenting Problems/Findings With Specific Suggested Managements</b>		
Problem	Suggested Diagnostic Studies	Treatment Considerations

Comments on child, family, or other specific medical issues:	
Physician/Provider Signature:	Print Name:

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Sample



## State of Hawaii Department of Health

### Authorization for Use or Disclosure of Protected Health Information (PHI)

Name of Individual/Organization Disclosing Protected Health Information	
Name: <i>Name of physician providing the information</i>	Address: <i>Address of physician</i>
Name of Individual/Organization That Will Receive the Individual's Protected Health Information	
Name: <i>Department of Health; Department of Education; State Emergency Medical Services System; Emergency Medical Services personnel (911 team); Emergency Dept .</i>	Address:
Client/Patient Whose Protected Health Information is Being Requested	
First Name:	Last Name:
Address:	Birth Date (if known):
I authorize that the following Protected Health Information be used/disclosed: (Be specific. Identify limits, as appropriate. Initial in the space provided if your authorization includes the use/disclosure of specially protected health information.)	
<i>Pertinent medical information about the child's medical condition, precautions needed, and special management plans. Please document this information by completing the Emergency Information Form (EIF).</i>	
<input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Abuse Treatment <input type="checkbox"/> HIV/AIDS	
The Protected Health Information is being used or disclosed for the following purposes: ( <i>At the request of the Individual is an acceptable purpose if the request is made by the individual and the individual does not want to state a specific purpose.</i> )	
<i>Information documented on the Emergency Information Form (EIF) will be used in an emergency situation at school/school activities for the provision of emergency care services, when 911 is called and/or child is taken to the Emergency Room.</i>	
Authorization Duration (This authorization will be in force and effect until the date <b>or</b> event specified below. At that time, this authorization to use or disclose this protected health information expires.)	
Authorization Expiration Date:	Expiration Event: <i>that relates to the Individual or the purpose of the use or disclosure</i>
<p>I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Department of Health. I understand that a revocation is not effective to the extent that the Department has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.</p> <p>I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. However, I understand that information related to education (FERPA 34 CFR Part 99), alcohol or drug treatment services (42 CFR Part 2) may not be disclosed or redisclosed without my authorization.</p> <p>The Entity or Person(s) receiving this information will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.</p> <p><input type="checkbox"/> The use or disclosure requested under this authorization will result in direct or indirect remuneration to the Department from a Third Party.</p>	
Individual or Personal Representative Signature:	Date:
Print Name of Individual or Personal Representative:	Description of Personal Representative's Authority:

March 16, 2004

**INSTRUCTIONS FOR REQUEST FOR ADMINISTRATION OF  
INDIVIDUALIZED HEALTH CARE PROCEDURES  
IN SCHOOL BY SPECIAL NEEDS NURSES**

1. This "Request for Administration of Individualized Health Care Procedures (IHCP) in School" is initiated when skilled nursing procedures are deemed necessary to promote the student's health and well being at school. All IHCP will be administered with completion of PHN/SH 38.
2. **PARENT** must complete SECTIONS I and II.
3. **PHYSICIAN** must complete SECTION III.
4. When SECTIONS I, II and III have been completed, PARENT Is to return this form to the Health Room or Public Health Nurse/Special Needs Nurse.

**GENERAL INSTRUCTIONS**

1. Only procedures deemed necessary to promote the student's health and well being will be performed during the school day. Determination will be made by evaluating the student's needs and health status.
2. Upon approval of this request, parent:
  - a. will be notified.
  - b. will be requested to send in all supplies and equipment needed to provide the ordered procedure(s). A list of needed supplies and equipment will be given to parents.
  - c. will be requested to provide a clear picture of the student receiving IHCP to the Special Needs Nurse (optional).
3. Should there be any significant change in treatment/procedure order(s) by the physician, a new PHN/SH 38 (order request form) must be processed. This should be sent to school with supplies/equipment needed to perform the procedure(s) in accordance with the new order(s).
4. Any modification in procedure (i.e., amount of tube feeding, time) will require a provider's prescription except on occasions when accommodations are made for off-campus activities. The parent should clear these with the physician in advance.
5. This form is good for current school year and must be renewed annually. Parent is responsible for obtaining form for the following school year.

# REQUEST FOR INDIVIDUALIZED PROCEDURES IN SCHOOL - GASTROSTOMY

SCHOOL YEAR \_\_\_\_\_

Please complete form in ink.

CHILD'S NAME (Last, First):	BIRTHDATE:	GRADE/ROOM:
ADDRESS:	ZIP CODE:	HOME PHONE:
SCHOOL:	PHN SECTION (Agency use):	BUS. PHONE: Mother:                      Father:
Please check (✓) child's health insurance plan: QUEST__ MEDICAID__ CHAMPUS__ HMSA-Private__ KAISER-Private__ Other (Specify) _____ NO INSURANCE__		

## I. AUTHORIZATION AND CONSENT FOR SERVICES

I request and authorize the Public Health Nursing personnel to administer individualized health care procedures as prescribed by my child's physician. I understand that a new request with physician's orders is to be processed should there be any change in treatment. I will provide the school with the necessary supplies/equipment to perform this service for my child. This authorization will be in effect for the above stated school year.

PARENT'S NAME: \_\_\_\_\_ PARENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(type/print)

## II. AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I authorize the release of information about the specialized health care procedures/services related to my child's condition between the child's prescribing physician, public health nurse/special needs nurse, and the school for effective service provision. This authorization will be in effect for the above stated school year.

PARENT'S NAME: \_\_\_\_\_ PARENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(type/print)

## III. PHYSICIAN'S REQUEST

DIAGNOSIS: \_\_\_\_\_ WEIGHT: \_\_\_\_\_  
FORMULA: \_\_\_\_\_ HEIGHT: \_\_\_\_\_

TUBE TYPE:	<input type="checkbox"/> Gastrostomy <table style="width: 100%; border: none;"> <tr> <td style="width: 30%; border: none;">a. Low-profile</td> <td style="border: none;"> <input type="checkbox"/> Mickey                      <input type="checkbox"/> Other  <input type="checkbox"/> Hide-a-Port  <input type="checkbox"/> Bard button                 </td> </tr> <tr> <td style="border: none;">b. Gastrostomy tube</td> <td style="border: none;"> <input type="checkbox"/> Ponsky                      <input type="checkbox"/> Other  <input type="checkbox"/> Flexiflo                 </td> </tr> </table>		a. Low-profile	<input type="checkbox"/> Mickey <input type="checkbox"/> Other <input type="checkbox"/> Hide-a-Port <input type="checkbox"/> Bard button	b. Gastrostomy tube	<input type="checkbox"/> Ponsky <input type="checkbox"/> Other <input type="checkbox"/> Flexiflo
a. Low-profile	<input type="checkbox"/> Mickey <input type="checkbox"/> Other <input type="checkbox"/> Hide-a-Port <input type="checkbox"/> Bard button					
b. Gastrostomy tube	<input type="checkbox"/> Ponsky <input type="checkbox"/> Other <input type="checkbox"/> Flexiflo					
	<input type="checkbox"/> Jejunostomy					
ADMINISTRATION:	<input type="checkbox"/> Bolus _____ ml every _____ hours. Administer over _____ minutes. Feeding times: Flush with _____ ml of water. Keep upright or elevate 30° for 30-60 minutes after feeding.					
	<input type="checkbox"/> Continuous _____ ml/hour. Feeding times: Keep upright or elevate 30° during feeding and 30-60 minutes after feeding.					
Other Special Considerations:						

PHYSICIAN'S NAME: \_\_\_\_\_ PHYSICIAN'S SIGNATURE: \_\_\_\_\_  
(type/print)

ADDRESS \_\_\_\_\_ TELEPHONE: \_\_\_\_\_ DATE: \_\_\_\_\_

## IV. DEPARTMENT OF HEALTH AUTHORIZATION

Authorization of RN: \_\_\_\_\_ Date: \_\_\_\_\_

PHN/SH 38GT (Rev. 06/02)

Public Health Nurse's Signature

**EMERGENCY ACTION PLAN: GASTROSTOMY TUBE**

School: \_\_\_\_\_ School Year: \_\_\_\_-\_\_\_\_ Grade/Room: \_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_ Insertion Date: \_\_\_\_\_  
 Medications: \_\_\_\_\_ GT Type: \_\_\_\_\_  
 Allergies: \_\_\_\_\_  No known Food/Drug Allergy

Emergency Contacts:			
Mother	(W) day phone	Cell	Home
Father	(W) day phone	Cell	Home
Alternate	(W) day phone	Cell	Home
Physician	(W) day phone	Cell	Fax
Public Health Nurse (PHN)	(W) day phone	Cell	Other
Enteral/Infusion Company	(W) day phone	Cell	Fax

**Significant Information:** \_\_\_\_\_

**If you see this:**

**Actions:**

- |  |   |  |
|--|---|--|
| <ul style="list-style-type: none"> <li>▪ G-tube falls out:</li> </ul>                      | → | <p><b>DOE staff:</b></p> <ul style="list-style-type: none"> <li>▪ Wash hands. Put on gloves.</li> <li>▪ Cover hole with gauze. Tape in place.</li> <li>▪ Contact primary caregiver, alternate, or available Public Health Nurse (PHN) for assistance.</li> </ul>   |
| <ul style="list-style-type: none"> <li>▪ G-tube (low-profile device) falls out:</li> </ul> | → | <p><b>Nursing staff:</b></p> <ul style="list-style-type: none"> <li>▪ Follow instructions on reverse side of this page.</li> <li>▪ Locate Emergency kit in student's bag. It contains foley catheters 12Fr, 14Fr, lubricant and syringe.</li> <li>▪ Once in, tape foley to secure in place.</li> <li>▪ Notify parent/guardian that tube was replaced via communication book .</li> </ul> |
| <ul style="list-style-type: none"> <li>▪ Device is not fully dislodged:</li> </ul>         | → | <ul style="list-style-type: none"> <li>▪ Secure device with tape and notify parent/guardian.</li> </ul>  |
| <ul style="list-style-type: none"> <li>▪ If unable to insert foley catheter:</li> </ul>    | → | <ul style="list-style-type: none"> <li>▪ Call parent/guardian immediately.</li> <li>▪ Tape catheter tip in opening to prevent complete hole closure.</li> </ul>  |

**INSTRUCTIONS FOR NURSING PERSONNEL  
PROCEDURES FOR GASTROSTOMY TUBE REPLACEMENT  
WITH FOLEY CATHETER**

**SUPPLIES:**

- |  |  |
|--|--|
| <input type="checkbox"/> Foley Catheter with ___ml inflate | <input type="checkbox"/> Pen marker                |
| <input type="checkbox"/> Luer-Lok Syringe                  | <input type="checkbox"/> Tape                      |
| <input type="checkbox"/> Lubricant (water soluble)         | <input type="checkbox"/> Foley plug (if available) |

**PROCEDURE:**

1. If G-tube falls out, notify Dr. \_\_\_\_\_ immediately for further instructions.
2. A) If G-tube was placed ***less than 6 months ago***, attempt to place foley but do not feed pending further instruction.  
B) If G-tube is ***more than 6 months old***, use the foley catheter for feedings until appropriate tube/device is replaced.

**DIRECTIONS FOR FOLEY PLACEMENT:**

1. Gather supplies and wash hands with soap and water. Glove.
2. Attach Luer-Lok syringe to largest foley port and inflate with \_\_\_\_\_ ml. water.
3. Check balloon for leaks.
4. Mark foley 3 inches above balloon to assure proper placement.
5. Allow water from the balloon to flow back into syringe and leave connected to balloon port.
6. Lubricate tip of catheter.
7. Gently insert catheter into stoma (stomach hole) until the marked line.  
(If tube does not slide in, select next smaller-sized catheter and repeat steps #3-7. If unable to insert any of the tubes, contact M.D. immediately and then notify family.)
8. Re-inflate the balloon.
9. Once all of the water has been pushed into balloon, hold the plunger while twisting the syringe out of the balloon port (holding plunger prevents water from back-flowing into the syringe and deflating the balloon).
10. Gently pull back on foley catheter until there is a slight "tug." This means the balloon is up against the abdominal wall.
11. Tape the foley onto the skin surface to avoid movement of the tube into the small intestines.
12. Insert foley plug into opening to prevent back-flow of stomach contents.
13. Notify parent to obtain replacement catheter from enteral/infusion company.

# REQUEST FOR INDIVIDUALIZED PROCEDURES IN SCHOOL - TRACHEOSTOMY

SCHOOL YEAR \_\_\_\_\_

Please complete form in ink.

CHILD'S NAME (Last, First):	BIRTHDATE:	GRADE/ROOM:
ADDRESS:	ZIP CODE:	HOME PHONE:
SCHOOL:	PHN SECTION (Agency use):	BUS. PHONE: Mother:                      Father:
Please check (✓) child's health insurance plan: QUEST__ MEDICAID__ CHAMPUS__ HMSA-Private__ KAISER-Private__ Other (Specify) _____ NO INSURANCE__		

## I. AUTHORIZATION AND CONSENT FOR SERVICES

I request and authorize the Public Health Nursing personnel to administer individualized health care procedures as prescribed by my child's physician. I understand that a new request with physician's orders is to be processed should there be any change in treatment. I will provide the school with the necessary supplies/equipment to perform this service for my child. This authorization will be in effect for the above stated school year.

PARENT'S NAME: \_\_\_\_\_ PARENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(type/print)

## II. AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I authorize the release of information about the specialized health care procedures/services related to my child's condition between the child's prescribing physician, public health nurse/special needs nurse, and the school for effective service provision. This authorization will be in effect for the above stated school year.

PARENT'S NAME: \_\_\_\_\_ PARENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(type/print)

## III. PHYSICIAN'S REQUEST

DIAGNOSIS \_\_\_\_\_ WEIGHT: \_\_\_\_\_  
HEIGHT: \_\_\_\_\_

TRACHEOSTOMY:	<input type="checkbox"/> Type: _____ Size: _____ <input type="checkbox"/> Artificial nose <input type="checkbox"/> If trach gets dislodged	
TREATMENT:	<input type="checkbox"/> Suction and/or irrigate with saline every _____ hours <input type="checkbox"/> Ambu Bag prn: Yes: _____ No: _____	
	<input type="checkbox"/> Oxygen at _____ liters per trach collar <input type="checkbox"/> Humidification	<input type="checkbox"/> Continuous <input type="checkbox"/> Prn
	<input type="checkbox"/> Pulse Oximeter: Check every _____ hours <input type="checkbox"/> Maintain oxygen saturation between _____ %	
Other Special Considerations:		

PHYSICIAN'S NAME: \_\_\_\_\_ PHYSICIAN'S SIGNATURE: \_\_\_\_\_  
(type/print)

ADDRESS \_\_\_\_\_ TELEPHONE: \_\_\_\_\_ DATE: \_\_\_\_\_

## IV. DEPARTMENT OF HEALTH AUTHORIZATION

Authorization of RN: \_\_\_\_\_ Date: \_\_\_\_\_  
Public Health Nurse's Signature



## State of Hawaii Department of Health

### Authorization for Use or Disclosure of Protected Health Information (PHI)

<b>Name of Individual/Organization Disclosing Protected Health Information</b>	
Name:	Address:
<b>Name of Individual/Organization That Will Receive the Individual's Protected Health Information</b>	
Name:	Address:
<b>Client/Patient Whose Protected Health Information is Being Requested</b>	
First Name:	Last Name:
Address:	Birth Date (if known):
I authorize that the following Protected Health Information be used/disclosed: (Be specific. Identify limits, as appropriate. Initial in the space provided if your authorization includes the use/disclosure of specially protected health information.)	
_____ Mental Health      _____ Substance Abuse Treatment      _____ HIV/AIDS	
The Protected Health Information is being used or disclosed for the following purposes: ( <i>At the request of the Individual is an acceptable purpose if the request is made by the individual and the individual does not want to state a specific purpose.</i> )	
Authorization Duration (This authorization will be in force and effect until the date <b>or</b> event specified below. At that time, this authorization to use or disclose this protected health information expires.)	
Authorization Expiration Date:	Expiration Event:
<p>I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Department of Health. I understand that a revocation is not effective to the extent that the Department has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.</p> <p>I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. However, I understand that information related to education (FERPA 34 CFR Part 99), alcohol or drug treatment services (42 CFR Part 2) may not be disclosed or redisclosed without my authorization.</p> <p>The Entity or Person(s) receiving this information will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.</p> <p><input type="checkbox"/> The use or disclosure requested under this authorization will result in direct or indirect remuneration to the Department from a Third Party.</p>	
Individual or Personal Representative Signature:	Date:
Print Name of Individual or Personal Representative:	Description of Personal Representative's Authority:

March 16, 2004

## **POLICIES AND GUIDELINES FOR REQUEST FOR ADMINISTRATION/STORAGE OF MEDICATION IN SCHOOL**

1. Medication(s) ordered for chronic illnesses and/or life threatening conditions shall be accepted for administration at school.
2. Order for antibiotics will NOT be accepted unless there are no other alternatives. Reasons why it must be administered in school must be included.
3. Order for over the counter medications will NOT be accepted unless the order is accompanied with reasons why it must be administered in school.
4. Administration of medication at school mandates the written order on form PHN/SH 36, "Request for Medication/Storage of Medication," with parental approval signified by signature and date. No medication will be administered by school health aide, PHN, or DOE staff without the proper completion of the form PHN/SH 36.
5. Medication must be dispensed as stipulated in Hawaii Revised Statutes HRS 328-16 with label bearing the following:
  - name,
  - business address,
  - telephone of the seller,
  - name of person for whom drug was prescribed,
  - serial number of prescription,
  - date the prescription was prepared,
  - name of the practitioner,
  - name, strength, and quantity of drug,
  - number of refills, if available, and
  - specific directions for the drug's use.
6. The written script must state "For School Use." Example:  
**Vial #1 Ritalin 5 mg BID**  
**Vial #2 For School Use**  
**Ritalin 5 mg. Take one tablet at 11 :00 am**  
**Total Count: Sixty (#60)**
7. The Pharmacist will generate an ancillary label to be placed over the original label on the second container (Vial #2) labeled, "For School Use."  
Label: **SCHOOL USE ONLY**  
**Take/Use \_\_\_\_\_ at**  
**\_\_\_\_\_ AM and at \_\_\_\_\_ PM**
8. The Pharmacist will dispense estimated twenty (20) day supply for school time dosing in the second container (Vial #2) with the ancillary label. This process will NOT generate a second third party insurance claim.
9. A new form PHN/SH 36, "Request for Administration/Storage of Medication," must be completed with any change in medication.
10. Medication order is valid for the current school year. Parent is responsible to obtain the form for the following school year.

If there are questions or more information is required, please contact Chief, Public Health Nursing Branch at 586-4620. Policies and form PHN/SH 36 are available at the website address: [www.hawaii.gov/doh](http://www.hawaii.gov/doh), click on "Family/Child Health", then "Public Health Nursing" OR <http://doe.k12.hi.us> click on "Parent/Community", then "Public Health Nursing".

## REQUEST FOR ADMINISTRATION/STORAGE OF MEDICATION

AT \_\_\_\_\_ SCHOOL FOR \_\_\_\_\_ - \_\_\_\_\_ YEAR

**Please complete form in ink.**

CHILD'S NAME (Last, First):	BIRTHDATE:	GRADE/ROOM:	BUS. PHONE: Mother:
ADDRESS:	ZIP CODE:	HOME PHONE:	Father:
Please check (✓) child's health insurance plan: QUEST__ MEDICAID__ CHAMPUS__ HMSA-Private__ KAISER-Private__ OTHER (specify) _____ NONE__			

### I. PARENT'S REQUEST AND AUTHORIZATION

I, the undersigned, request and authorize the Public Health Nursing Branch (PHNB) personnel to administer/store medication as prescribed by my child's physician. I request and authorize release of health information between the school, the Public Health Nurse, the prescribing physician, and pharmacist pertinent to my child's condition. I understand that a new request is to be processed should there be any change in medication.

PARENT'S/LEGAL GUARDIAN'S

NAME: \_\_\_\_\_  
(type/print)

PARENT'S/LEGAL GUARDIAN'S

SIGNATURE: \_\_\_\_\_  
DATE: \_\_\_\_\_

### II. PHYSICIAN'S REQUEST

DIAGNOSIS: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

**POLICY: Medications for chronic illnesses and/or life threatening conditions shall be administered during the school day. An order for other medications requires reason(s) for its administration during the school day.**

SCHEDULED MEDICATIONS FOR CHRONIC ILLNESS AND/OR LIFE THREATENING CONDITION:

MEDICATION Name/Dosage	EXACT TIME OR RANGE OF TIME TO BE GIVEN	SPECIAL INSTRUCTIONS	REASON(s) Medication Needs to be Given during the School Day

PRN MEDICATION:

MEDICATION Name/Dosage/Frequency	SPECIFIC INDICATIONS FOR USE	REASON(S) WHY PRN MEDICATION IS NEEDED IN SCHOOL (REQUIRED RESPONSE)

Physician's Signature: \_\_\_\_\_

DATE: \_\_\_\_\_

Physician's Name: \_\_\_\_\_  
(type/print)

ADDRESS: \_\_\_\_\_

Telephone: \_\_\_\_\_ FAX: \_\_\_\_\_

Physician Emergency Contact Number: \_\_\_\_\_

PHN/SH 36 (Rev. 6/05)

<p><b>DEPARTMENT OF HEALTH AUTHORIZATION</b></p> <p>Authorization to SHA/LPN by:</p> <p>_____ PHN</p> <p>DATE</p>
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SEE ON BACK (Page 1 of 2)

## INSTRUCTIONS FOR REQUEST FOR ADMINISTRATION/STORAGE OF MEDICATION IN SCHOOL

### GENERAL INSTRUCTIONS:

1. Medications for chronic illnesses and/or life threatening conditions shall be administered during the school day. Medications should be given at home as much as possible.
2. Antibiotics will not be administered unless there are no other alternatives and physician provides reasons why it must be administered during the school day.
3. Over the counter medications (OTC) will not be administered unless the physician provides reasons why it must be administered during the school day.
4. **No medication will be stored in the Health Room or administered by the authorized Public Health Nursing Branch and/or DOE personnel without the completion of this form, PHN/SH 36, Rev. 6/05, and prior approval by PHNB personnel. This applies to OTC medications, if prescribed.**
  - a. Parent/Legal Guardian must complete Section I, Parent's Request and Authorization.
  - b. Physician must complete Section II, Physician's Request.
  - c. Parent/Legal Guardian is to return this completed form to the Health Room at the school or to the Public Health Nurse.
5. Medication must be in a container/vial dispensed by the Pharmacist with instructions "**FOR SCHOOL USE**" with the name of the student, name of the medication, dosage, strength, time of administration, and name of prescribing physician. **This applies to OTC medications, if prescribed.**
6. Parent/Legal Guardian is responsible to send medications to Health Room at school. If there are concerns in getting the medication to the health room safely, parents should call the PHN. Parent/legal guardian is to:
  - a. Send the container/vial of medication labeled "FOR SCHOOL USE." Medication(s) will only be accepted if medication is in the container/vial labeled by the Pharmacist, which is the same as the written request (PHN/SH 36) by your child's physician.
  - b. Send in refills in a timely manner in properly labeled container/vial before medication runs out.
  - c. Provide a picture of your child to the School Health Aide/Special Needs Nurse.
  - d. Remind child to report to the Health Room at the designated time.
7. Should there be any change in medication order(s) by the physician, a new "Request for Administration/Storage of Medication in School" (PHN/SH 36 Rev. 6/05) must be processed. The form should be sent to school with a new container/vial of medication to reflect the new order(s).
8. If the Public Health Nursing personnel/ School Health Aide are not on duty or if your child is off-campus, **NO MEDICATION WILL BE GIVEN FOR THAT DAY unless prior arrangement has been made between parent/legal guardian and school.**
9. This form is good for the current school year and needs to be renewed yearly. Parent/legal guardian is responsible to obtain the form for the following school year.
10. Policies and Guidelines for Administration/Storage of Medications developed by the Hawaii Chapter of Academy of Pediatrics-PHNB-DOE (H-AAP-PHNB-DOE), the PHN/SH 36 form, and General instructions are available at the website address:  
<<http://www.hawaii.gov/health/family-child-health/publichealthnursing/index.html>>.  
Or contact your Public Health Nurse.

**EMERGENCY ACTION PLAN – CONTACT LIST**

**Name:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Routine Medications:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_  **No Known Food/Drug Allergy**

**Emergency Contacts:**

Father/Guardian: _____	Day Phone: _____
	Pager/Cell: _____
Mother/Guardian: _____	Day Phone: _____
	Pager/Cell: _____
Physician: _____	Work Phone: _____

**Medical Insurance:** \_\_\_\_\_ **Policy #** \_\_\_\_\_

**Emergency Medications:**

	Name	Amount	When To Use
1.	_____	_____	_____
2.	_____	_____	_____

*We, the undersigned, have read and agreed to the terms outlined above and attest that the information provided is, to the best of our knowledge, truthful and accurate.*

Parent/Guardian	Date	Public Health Nurse	Date
Principal/Principal Designee	Date	Other Participant	Date
Other Participant	Date	Other Participant	Date

**Distribution:** \_\_\_\_\_

**Date of next review:** \_\_\_\_\_

**Other demographic information:**

Home address: \_\_\_\_\_

School: \_\_\_\_\_ Grade level: \_\_\_\_\_ Home Phone: \_\_\_\_\_

**Other Emergency Contacts:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Day Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Day Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Day Phone: \_\_\_\_\_

**This form should be filled out along with the appropriate Emergency Action Plan.**

**EMERGENCY ACTION PLAN for SEVERE ALLERGY TO \_\_\_\_\_**

School: \_\_\_\_\_ SY: \_\_\_\_\_ - \_\_\_\_\_

**Name:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

Medications: \_\_\_\_\_

Other Allergies: \_\_\_\_\_

Emergency Contacts:			
Mother	(W) day phone	Cell	Home
Father	(W) day phone	Cell	Home
Alternate	(W) day phone	Cell	Home
Physician	(W) day phone	Cell	Fax
Public Health Nurse (PHN)	(W) day phone	Cell	Other

**Significant Information:** \_\_\_\_\_

**If you see this:**

**Actions:**

- Difficulty breathing
- Wheezing/coughing
- Severe headache
- Nausea/vomiting
- Swelling of lips, tongue and throat



1. Administer EpiPen immediately per physician's order.
2. Call 911.
3. Keep student quiet.
4. Allow student to get into a position of comfort.
5. Stay with student until emergency personnel arrives.
6. Have someone wait for ambulance to arrive and direct to where student is.
7. Notify School Health Aide.
8. Call parents.

- Student has above signs and symptoms but eventually **STOPS BREATHING.**



**Start CPR.**

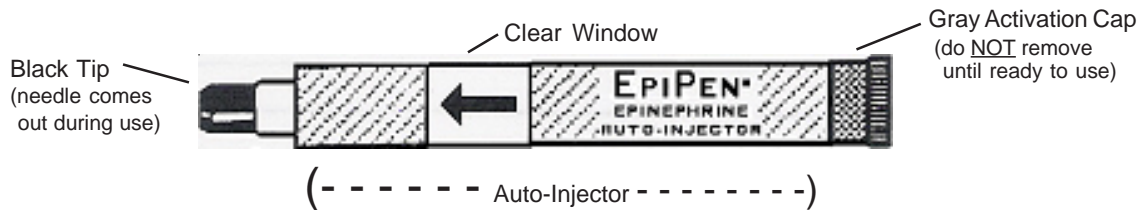
**Names of School Personnel Trained:**

**Date of Training:**

## EpiPen ADMINISTRATION

0.15 mg (EpiPen Jr.) for Students 33-66 lbs

0.3 mg (EpiPen) for Students 66 lbs and over

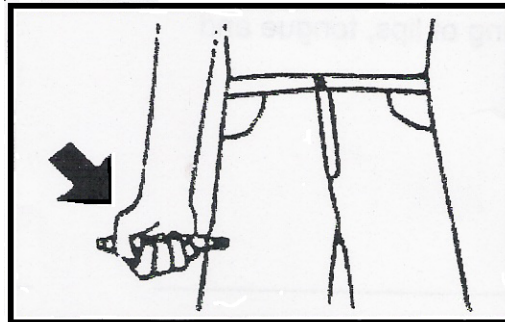
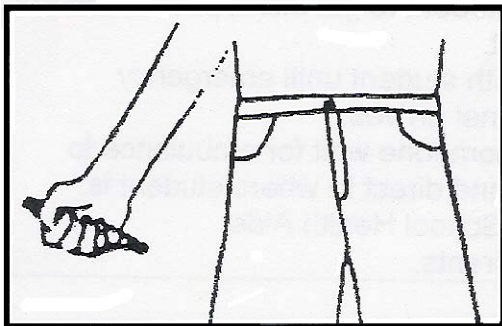


1. Form fist around auto-injector (black tip down).
2. Pull off gray activation cap.

**DO NOT PUT FINGERS OVER BLACK TIP.**



3. Hold black tip near outer thigh (always apply to thigh).
4. Swing and jab firmly into outer thigh so that auto-injector is perpendicular (at 90 degree angle) to the thigh. Hold in place and count to 10.



5. Remove the auto injector from the thigh.
6. If needle is exposed dose was given. If not repeat steps #3 to 5.
7. Have student massage injection site for several seconds if able.
8. Discard unit in sharps container.

Source: DEY ([www.epipen.com](http://www.epipen.com)) and The Food Allergy & Anaphylaxis Network ([www.foodallergy.org](http://www.foodallergy.org))

PHN/SH Rev 08/04

**REQUEST FOR ADMINISTRATION/STORAGE OF MEDICATION  
RESCUE MEDICATION FOR ASTHMA**

AT \_\_\_\_\_ SCHOOL FOR \_\_\_\_\_ – \_\_\_\_\_ YEAR

**Please complete form in ink.**

CHILD'S NAME (Last, First):	BIRTHDATE:	GRADE/ROOM:	BUS. PHONE:
ADDRESS:	ZIP CODE:	HOME PHONE:	
Please check ( ) child's health insurance plan: QUEST__ MEDICAID__ CHAMPUS__ HMSA-Private__ KAISER-Private__ OTHER (specify)_____ NONE__			

**I. PARENT'S REQUEST AND AUTHORIZATION**

I, the undersigned, request and authorize the Public Health Nursing Branch (PHNB) personnel to administer/store medication as prescribed by my child's physician. I request and authorize release of health information between the school, the Public Health Nurse, the prescribing physician, and pharmacist pertinent to my child's condition. I understand that a new request is to be processed should there be any change in medication.

PARENT'S/LEGAL GUARDIAN'S  
NAME: \_\_\_\_\_  
(type/print)

PARENT'S/LEGAL GUARDIAN'S  
SIGNATURE: \_\_\_\_\_  
DATE: \_\_\_\_\_

**II. PHYSICIAN'S REQUEST**

DIAGNOSIS:    ASTHMA     
WEIGHT: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

**POLICY: Medications for chronic illnesses and/or life threatening conditions shall be administered during the school day. An order for other medications requires reason(s) for its administration during the school day.**

SCHEDULED MEDICATIONS FOR CHRONIC ILLNESS AND/OR LIFE THREATENING CONDITION:

MEDICATION Name/Dosage	EXACT TIME OR RANGE OF TIME TO BE GIVEN	SPECIAL INSTRUCTIONS	REASON(s) Medication Needs to be Given during the School Day

PRN MEDICATION:

MEDICATION Name/Dosage/Frequency	SPECIFIC INDICATIONS FOR USE	REASON(S) WHY PRN MEDICATION IS NEEDED IN SCHOOL (REQUIRED RESPONSE)
<b>Medication:</b> * Give 2 puffs, 1 min apart; wait 15-20 min -if symptoms continue give 2 puffs, 1 min apart. May Repeat.	Sequence, if needed up to total of 8 puffs or as prescribed on SH 36***. If no relief, call parent. If symptoms worsen at any time, call 911 and parent.	Quick relief for asthma symptoms.

OR specify:

**\*BASED on Nat'l Asthma Education and Prevention Guidelines**

Physician's Signature: \_\_\_\_\_

DATE: \_\_\_\_\_

Physician's Name: \_\_\_\_\_  
(type/print)

ADDRESS: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

<p>DEPARTMENT OF HEALTH AUTHORIZATION</p> <p>Authorization to SHA/LPN by:</p> <p>_____ PHN</p> <p>DATE _____</p>
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## REQUEST FOR INDIVIDUALIZED PROCEDURES IN SCHOOL: STUDENTS WITH DIABETES

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

Medical Insurance (Check one [✓]): QUEST\_\_ MEDICAID\_\_ CHAMPUS\_\_ HMSA-Private\_\_ KAISER-Private\_\_  
Other (Specify) \_\_\_\_\_ NO INSURANCE\_\_

### I. PARENT'S REQUEST AND AUTHORIZATION

I, the undersigned, request and authorize the Public Health Nursing Branch personnel to provide health services to my child with diabetes during the school day. I request and authorize release of health information between the school, the PHN, the prescribing physician, and pharmacist pertinent to my child's condition. I will provide the necessary supplies and equipment, and notify the School PHN if there is a change in my child's health status, attending physician, or health services in school.

PARENT'S/GUARDIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

### II. PHYSICIAN'S REQUEST

#### 1. Blood Glucose Testing

- Before lunch/meals
- For suspected hypoglycemia
- At student's discretion
- No blood glucose testing at school
- Expected blood glucose range while at school \_\_\_\_\_

#### 3. Hypoglycemia - Refer to Algorithm for Blood Glucose Results for Summary of Treatment Procedures (see next page)

- Assistance for all lows
- Ok to use glucose gel inside cheek if conscious
- Glucagon\*  0.5 cc/mg wt < 44 pounds
- 1.0 cc/mg wt > 45 pounds

\*Must complete Act 207 Glucagon Consent Form

#### 4. Hyperglycemia – Refer to Algorithm for Blood Glucose Results for Summary of Treatment Procedures (see next page)

- Check Ketones:
  - Urine  Blood
- Other: \_\_\_\_\_

#### 5. Meal/Snacks

- Adult supervision to assure student eating
- AM snack time: \_\_\_\_\_
- PM snack time: \_\_\_\_\_
- Lunch time: \_\_\_\_\_ Other: \_\_\_\_\_
- Extra food allowed:
  - Vigorous exercise
  - Bus rides over 30 minutes

#### 2. Insulin Orders:

Administration time: \_\_\_\_\_

- Before Breakfast  Before AM Snack
- Before Lunch  PM Snack

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

#### Insulin administration via:

Brand name and type: \_\_\_\_\_

- Syringe and vial  Insulin pen
- Insulin pump  Other: \_\_\_\_\_

#### Dosage:

- Standard lunch time dose: \_\_\_\_\_ units
- Sliding scale:
  - Blood Glucose from \_\_\_\_\_ to \_\_\_\_\_ = \_\_\_\_\_ units
  - Blood Glucose from \_\_\_\_\_ to \_\_\_\_\_ = \_\_\_\_\_ units
  - Blood Glucose from \_\_\_\_\_ to \_\_\_\_\_ = \_\_\_\_\_ units
  - Blood Glucose from \_\_\_\_\_ to \_\_\_\_\_ = \_\_\_\_\_ units
  - Blood Glucose from \_\_\_\_\_ to \_\_\_\_\_ = \_\_\_\_\_ units

- Insulin to carbohydrate ratio: \_\_\_\_\_ # unit(s) insulin per \_\_\_\_\_ gm CHO

- Correction Factor: \_\_\_\_\_  
One unit will lower blood glucose by \_\_\_\_\_ mg/dl

#### 6. Bus Transportation (Optional)

- Blood glucose test not required prior to boarding bus
- Test blood glucose 10 to 20 minutes before boarding bus
  - Provide snack if blood glucose is < \_\_\_\_\_ mg/dl
- Other: \_\_\_\_\_
- Eat protein or carbohydrate snack if bus ride is longer than 30 minutes.

PHYSICIAN'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ (type/print) DATE: \_\_\_\_\_

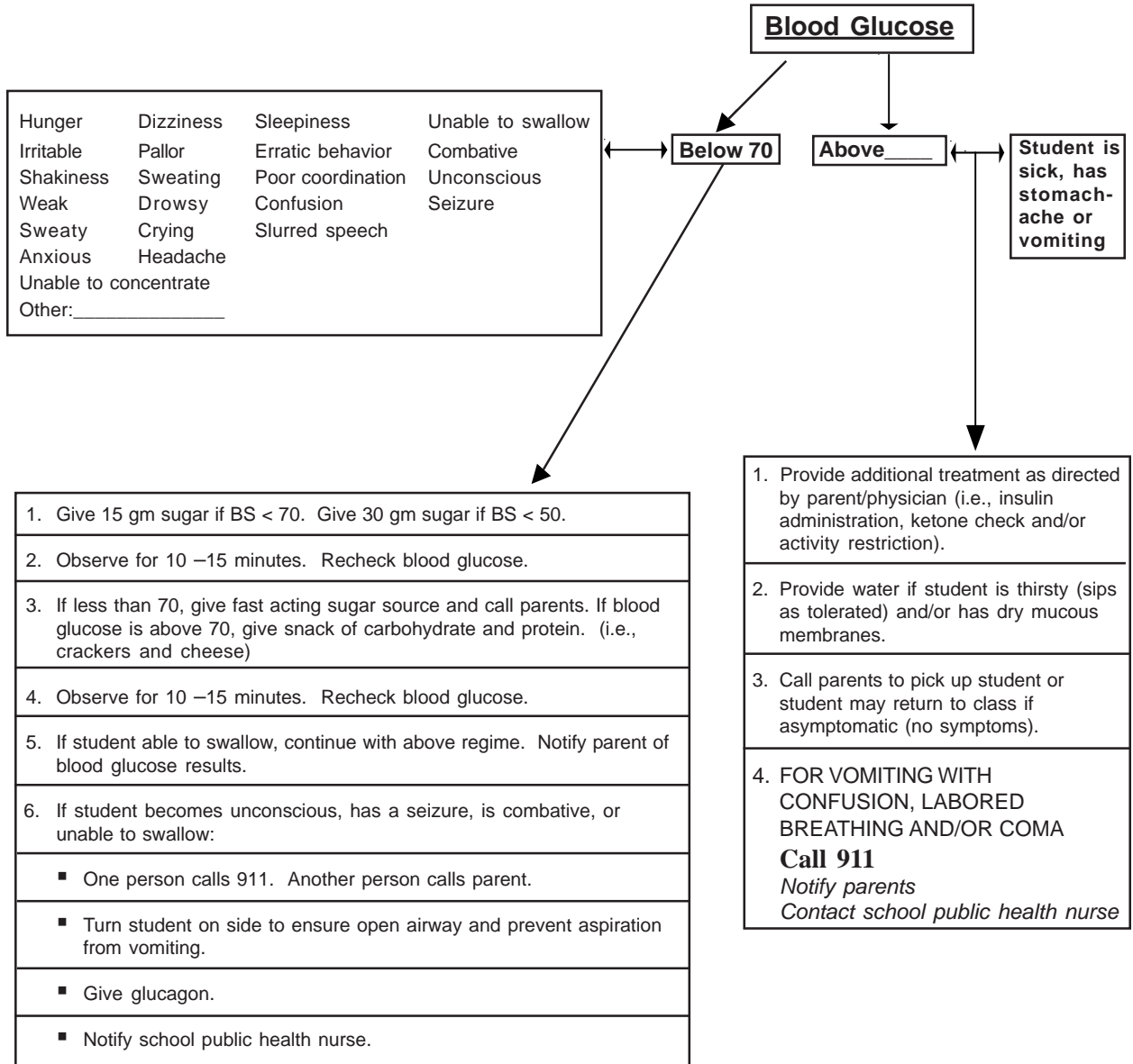
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

- I request that the School Nurse provide me with a copy of the completed Individualized School Diabetes Plan (ISDP).

III. Authorized by School Nurse (Signature): \_\_\_\_\_ Date: \_\_\_\_\_

## ALGORITHMS for BLOOD GLUCOSE RESULTS

### Summary of Treatment Procedures



<b>Fast Acting Sugar Sources (15 gms)</b>	
• 15 gm Glucose tablets	• 1/2 c. orange, apple or grape juice
• 15 gm Glucose gel	• 2/3 small tube of Cakemate gel, not icing
• 1/2 c. regular soda or sports drink	• 1 c. skim milk

**DIABETES EMERGENCY ACTION PLAN (EAP)  
HYPOGLYCEMIA (Low Blood Sugar)**

School: \_\_\_\_\_ SY: \_\_\_\_ - \_\_\_\_ Grade/Room: \_\_\_\_\_ Date: \_\_\_\_\_

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Mother	(W) day phone	Cell	Home
Father	(W) day phone	Cell	Home

<b>Warning Signs and Symptoms:</b>			
<b>Behavioral Symptoms:</b>		<b>Physical Symptoms:</b>	
Irritable	Anxious	Hunger	Dizziness      Shakiness
Drowsy	Crying	Pale appearance	Weak              Headache
Sleepiness	Unable to concentrate	Sweatiness	Numbness of lip and tongue
Erratic behavior			
Confusion	Combative	Poor coordination	Blank Stare
		Unable to swallow	Slurred speech
		Unconscious	Convulsion-like movements

IF CHILD IS ILL, CHECK THE BLOOD GLUCOSE AND CALL PARENTS.  
**NEVER SEND A CHILD WITH SUSPECTED LOW BLOOD SUGAR ANYWHERE ALONE.**

**Standard Treatment of HYPOGLYCEMIA**

**Blood Sugar Level**

**Actions**

- Keep child quiet; sit child down.
- Test child's blood sugar. Meter and test strips and supplies, i.e. glucose tabs or gel, and/or glucagon are found located at \_\_\_\_\_ .

**If blood sugar is less than 50 mg/dl**

**Give double amounts of sugar sources listed below.**

If blood sugar result is still **less than 70** mg/dl

GIVE: 2-3 glucose tabs or glucose gel (quarter size) into side of cheek or 1/2 cup juice or one cup milk or 1/2 can soda (regular not sugar-free).  
Recheck blood glucose in 10-15 min.

If blood sugar is still **less than 70** mg/dl

REPEAT above and call parent.  
Recheck blood glucose in 10-15 minutes.

**OR**

If blood sugar is **70 mg/dl or greater**

GIVE: 2 crackers and cheese or peanut butter or give meal if mealtime is soon.  
CHILD may remain in the classroom.  
Wait 10 minutes. Recheck blood sugar.

If blood glucose is still **less than 70** mg/dl  
As long as child is able to swallow

**Notify parent.**  
Continue to give sugar source by mouth.

**If at any time the child is unconscious  
OR cannot swallow**

**Lie child on side.  
Keep airway clear.  
Call 911. Administer glucagon.\***

\*Trained adult may administer glucagon.

**DIABETES EMERGENCY ACTION PLAN (EAP)**  
**HYPERGLYCEMIA (High Blood Sugar) More than \_\_\_\_\_ mg/dl \***

School: \_\_\_\_\_ SY: \_\_\_\_ - \_\_\_\_ Grade/Room: \_\_\_\_\_ Date: \_\_\_\_\_

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Mother	(W) day phone	Cell	Home
Father	(W) day phone	Cell	Home

**Hyperglycemia usually develops slowly. Immediate attention needed for students on an Insulin Pump.**

<b>Warning Signs and Symptoms:</b>		
<b>Behavioral Symptoms:</b>	<b>Physical Symptoms:</b>	
<i>(mild)</i>		
Lack of concentration	Thirst/Dry mouth	Blurred vision
Fatigue/Sleepiness	Flushing of skin	Hunger
Frequent urination	Stomach ache	Sweet fruity breath
<i>(moderate)</i>		
Nausea	Vomiting	
	Stomach cramps	
<i>(severe)</i>		
Confused	Rapid, labored breathing	
Unconscious/Comatose	Very weak	

**IF CHILD IS SICK, HAS A STOMACHACHE, OR VOMITING, CALL PARENTS**

**STUDENT MAY RETURN TO CLASS/REMAIN IN SCHOOL IF THERE ARE NO WARNING SIGNS AND SYMPTOMS**

**Intervention at mild – moderate level will prevent progression to more severe symptoms.**

1. Timing is important. Eat on time, take insulin on time, and check blood glucose on time.
2. Ensure insulin dosing is accurate. Right dose and right time.
3. Supervise and guide student about food choices, including monitoring what is being eaten.
4. Consult with parents when there will be changes in classroom snacks, meals, or exercise activities.

**Treatment of HYPERGLYCEMIA**

1. Keep quiet. Sit down.
2. Check blood glucose. Meter and test strips are located \_\_\_\_\_. Start written record with time, signs and symptoms, and results.
3. Allow free use of the bathroom.
4. Encourage drinking water or sugar-free drinks.
- 5. Follow Individual School Diabetes Plan.**
6. Check pump tubing for kinks, wetness and infusion set for dislodgment (if on pump).
7. Administer insulin.
8. Check ketones, if blood glucose is more than \_\_\_\_\_ mg/dl.\*
9. Call parent.

**Call 911 if vomiting, lethargic, labored breathing, and/or comatose.**

\* Child's doctor will determine number of mg/dl and that number should be filled in on the line.

**EMERGENCY ACTION PLAN for CONVULSIVE SEIZURES**  
(School with Health Aide)

School: \_\_\_\_\_ SY: \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Emergency Contacts:			
Mother	(W) day phone	Cell	Home
Father	(W) day phone	Cell	Home
Alternate	(W) day phone	Cell	Home
Physician	(W) day phone	Cell	Fax
Public Health Nurse (PHN)	(W) day phone	Cell	Other

**Significant Information, including triggers:** \_\_\_\_\_

**If you see this:**

**Actions:**

For school personnel:



**Clonic-tonic or jerky movements**  
in various parts of the body that could  
include head/neck, trunk, arms, and/or legs.

1. Keep calm. Time seizure.
2. **Maintain an open airway.**
3. Do not restrain.
4. Keep in a safe position and away from harmful objects.
5. Loosen clothing around neck, remove eyeglasses, and put something soft under head.
6. Do not put anything in mouth.
7. Stay with student until seizure is over.
8. **Call 911** if seizure lasts 5 minutes beyond what is routine for the student, or if the student goes from one seizure to another without recovering consciousness.
9. Notify parents or guardian.
10. Record on seizure log.

Names of School Personnel Trained: \_\_\_\_\_

Date of Training: \_\_\_\_\_

## EMERGENCY ACTION PLAN for CONVULSIVE SEIZURES (School with Licensed Nurse)

School: \_\_\_\_\_ SY: \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Emergency Contacts:			
Mother	(W) day phone	Cell	Home
Father	(W) day phone	Cell	Home
Alternate	(W) day phone	Cell	Home
Physician	(W) day phone	Cell	Fax
Public Health Nurse (PHN)	(W) day phone	Cell	Other

**Significant Information:** \_\_\_\_\_

**If you see this:**

**Actions:**

For school personnel:  
**Clonic-tonic or jerky movements**  
 in various parts of the body that could include head/neck, trunk, arms, and/or legs.

1. Keep calm. Time seizure.
2. **Maintain an open airway.**
3. Do not restrain.
4. Keep in a safe position and away from harmful objects.
5. Loosen clothing around neck, remove eyeglasses, and put something soft under head.
6. Do not put anything in mouth.
7. Swipe magnet (worn on waist or belt; remove for use) over Vagal Nerve Stimulation device, if available.
8. Stay with student until seizure is over.
9. **Call 911** if seizure lasts 5 minutes beyond what is routine for the student, or if the student goes from one seizure to another without recovering consciousness.
10. Notify parents or guardian.
11. Record on seizure log.

For licensed nurse:

12. Administer Diastat per physician's ordered for seizure lasting 5 minutes or greater, or if the student goes from one seizure to another without recovering consciousness.

**INCREASED INTRACRANIAL PRESSURE (ICP)**  
**EMERGENCY ACTION PLAN**

Description of Seizures: As pressure within the skull increases due to fluid within or surrounding the brain not draining correctly, the brain is compressed. A sudden increase in pressure may cause an emergency type of situation.

Signs and symptoms of this condition may include:

1. Change in level of consciousness (i.e., alert to drowsy/confusion, normal speaking to slowing of speech, calmness to agitation or restlessness).
2. Irregular breathing pattern.
3. Headache (constant, increasing in intensity, aggravated by movement).
4. Vomiting (recurrent, projectile).
5. Changes in pupils (unequal-one bigger than the other).
6. Dizziness, vertigo (things spinning around).
7. Seizures.
8. Weakness, numbness or inability to move limbs as ordinarily able to do.
9. Fever with above symptoms.
10. Other: \_\_\_\_\_

At first sign of these symptoms:

1. Keep child in seated position with head supported upright.
2. Contact parent.
3. Contact physician at \_\_\_\_\_.
4. Call 911 if directed to by parent or physician OR if seizure and/or loss of consciousness occurs.

Comments:

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**SCHOOL FOOD SERVICES PROGRAM**  
**MEDICAL STATEMENT FOR DISABLED CHILD SPECIAL NEEDS**

**PART I** (to be filled out by the school)

Date \_\_\_\_\_

Name of Student \_\_\_\_\_

Name of School \_\_\_\_\_

Grade \_\_\_\_\_

**PART II** (to be filled out by the physician)

Patient's Name \_\_\_\_\_

Age: \_\_\_\_\_

Diagnosis:

\_\_\_\_\_  
\_\_\_\_\_

Describe the patient's disability and the major life activity affected by the disability:

\_\_\_\_\_  
\_\_\_\_\_

Does the disability restrict the individual's diet?      YES \_\_\_\_\_      NO \_\_\_\_\_

If yes, list food(s) to be omitted from diet and food(s) that may be substituted:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the disability require texture modification?      YES \_\_\_\_\_      NO \_\_\_\_\_

If yes, describe in detail and in plain English, the modification required:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please provide detailed instruction for the SFS Personnel/Health Nurse/Aide to follow regarding the amount of food/ food supplement, brand, product, acceptable substitution, local suppliers, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When a physician and/or recognized medical authority provides a diet prescription, it is the role of the school food service personnel to fill that order properly and carefully. It is beyond the scope of the school food service personnel to change or modify the diet order. If the child's diet prescription is not detailed enough to be interpreted clearly, the school shall contact the parent for clarification. The school food service personnel cannot be asked to feed/administer the feeding.

DATE: \_\_\_\_\_

SIGNATURE OF PHYSICIAN: \_\_\_\_\_

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

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

FAX #: \_\_\_\_\_

Distribution: Original shall be kept in school file  
Copy to SFMS file  
Copy to SFMS Branch: 1106 Koko Head Ave. Honolulu, HI 96816

**PROCEDURES FOR PROFESSIONALS WHO IMPLEMENT A  
FEEDING/SWALLOWING PLAN**

<p>Students with suspected feeding problems who may be at risk for aspiration (displaying signs of aspiration such as coughing, choking, wet, raspy breathing, vomiting):</p>	<ol style="list-style-type: none"> <li>1. Contact the school speech pathologist, nurse, occupational therapist, and physical therapist to strategize interventions such as adjusting seating or posture for eating, teaching correct chewing and swallowing techniques, using utensils that can be easily managed, and modifying the environment so that it is free of distraction to help alleviate the situation.</li> <li>2. Should problems or concerns persist, contact parents and explain concerns (present documentation of behaviors which cause concern). Suggest that parents follow up with their primary care provider and ask them to share reports.</li> <li>3. Obtain written consent from parents to communicate with primary care provider and to obtain a swallowing evaluation. If all attempts to convince the parents to obtain a swallowing evaluation have failed or to contact the physician fails, the public health nurse servicing that school should be contacted to participate and assist in the process.</li> <li>4. Consult with primary care provider to develop a plan, if needed, to remedy the situation. Document in student's folder.</li> </ol>
<p>Students who are fed through a G-Tube with orders to begin an oral feeding program:</p>	<ol style="list-style-type: none"> <li>1. Obtain a medical order/prescription from the primary care physician.</li> <li>2. Collaborate/share information with private practice staff (feeding team).</li> <li>3. Carry out <b>ONLY</b> parts of the program that can be safely performed within the school environment (i.e., while the child is receiving g-tube feeding, oral stimulation exercises can be performed by trained staff).</li> <li>4. Carry out written, outlined, program utilizing trained staff only.</li> <li>5. Work with school nurse or educational staff to monitor child's weight on a monthly basis.</li> <li>6. Obtain orders signed by a Hawaii licensed physician annually or when there are changes in the child's feeding program/status.</li> <li>7. File orders in the child's school file.</li> </ol>
<p>If the school receives MD orders to orally feed a child, but the educational staff believes it is not safe:</p>	<ol style="list-style-type: none"> <li>1. Contact the Medical Doctor and state concerns, and/or</li> <li>2. Request consultation and an assessment by the school PHN who can further discuss issue(s) with the treating medical doctor.</li> <li>3. Request a second opinion (may be at school's expense).</li> <li>4. <b>MONITOR</b> and <b>DOCUMENT</b> behaviors that cause concern.</li> <li>5. Work with school nurse or educational staff to monitor child's weight on a monthly basis.</li> <li>6. Obtain signed orders annually or when there are changes in the child's feeding program/status.</li> <li>7. File orders in the child's school file.</li> </ol>

## DYSPHAGIA/SWALLOWING PLAN

Student:	Date of Plan:
Dysphagia Team Leader:	Physician:
Phone Number:	Facility/Hospital:
Special Considerations:	

### Feeding Recommendations:

Positioning:
Equipment:
Diet/Food Preparation:
Feeding Plan Techniques/Precautions:
Additional Comments:

### School Team Leader (to complete)

School Team Leader Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Position: \_\_\_\_\_ School : \_\_\_\_\_

This plan is to be given to the parent to have the hospital team complete following a dysphagia evaluation. It must be accompanied by a **consent to release information** from the school to the hospital/facility and the hospital/facility to the school.

### CAPITAL IMPROVEMENT PROGRAM (CIP)

#### Preliminary Information for Table R Form

*Fax (733-4865) or Mail to: Facilities and Support Services Branch, Attn: CIP Section*

**School Name:** \_\_\_\_\_ **School District:** \_\_\_\_\_

**School Code:** \_\_\_\_\_ **Representative District:** \_\_\_\_\_ **Senate District:** \_\_\_\_\_

**Submitted By:** \_\_\_\_\_ **Position:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Project Title:** \_\_\_\_\_

*(i.e., Campus - Electrical System Upgrade; Bldg. A - ACM Removal)*

**Project Scope:** *(check one)*

- New  Replacement
- Renovation  Ongoing
- Addition

**Project Description:** *(Briefly describe what must be done and by when. Also, attach a copy of the school's plot plan with the project area marked.)*

**Eligibility Requirements:** *(select appropriate answer)*

Is there a CIP appropriation for this project?  Yes  No  Unsure  
If yes, Act \_\_\_\_\_ Year \_\_\_\_\_ Item No. \_\_\_\_\_

Does the project meet Education Specifications?  Yes  No  Unsure

Do you have a cost estimate from DAGS for this project?  Yes  No

If yes, please attach a copy of the DAGS cost estimate.

What CIP Priority Matrix category is this project? \_\_\_\_\_ *(i.e., 1A, 2A, 1B, etc.)*

*(The CIP Priority Matrix can be viewed or printed from the FSSB website.)*

**Narrative Justification:**

What present conditions necessitate this project? Identify need and evaluation of existing situation. *( i.e., enrollment growth, EdSpecs deficiencies, program need, safety, etc.)*

What alternatives have been considered and what is the impact if the project is deferred?

What improvements will take place when the project is completed?

**Project Impact of Future Operating Requirements:** *(To be completed by FSSB)*

Increase in position count: \_\_\_\_\_ Initial cost of equipment funded by operations: \_\_\_\_\_  
 Increase in annual salary cost: \_\_\_\_\_ Increase in annual maintenance cost: \_\_\_\_\_  
 Increase in utility cost: \_\_\_\_\_ Other annual expenses: \_\_\_\_\_

## Sample

### WAIPAHU HIGH SCHOOL

"Crisis Management Guide" Page 18A - Revised February 2004  
18A Evacuation Procedures for Special Needs/\*Temporarily Disabled Students

- I. Evacuation Order Issued.  
Teachers are responsible for the supervision of special needs students during an evacuation.
  
- II. During An Evacuation Drill:  
Teacher with special needs student will send a student to notify next door teacher that assistance/supervision with class coverage is needed for his/her class. Student will hand over class roll book to next door teacher. Students will join next door class and proceed with evacuation.
  - A. First Floor Classrooms:
    1. Teacher and special needs student evacuate to the triangle.
  - B. Second Floor Classrooms:
    1. Teacher of special needs student will assist student to elevator or down the nearest stairs. Designated school staff will operate the elevator. Educational Assistant meets teacher and student at elevator and assists teacher with evacuation of student to the triangle fronting Farrington Hwy.
    2. If a teacher is unable to assist student down the stairs, he/she will notify administration in writing at the beginning of the semester.
  - C. At The Triangle:
    3. Teacher checks in student with designated teacher.
    4. Teacher proceeds to evacuation site and assumes responsibility of class.
    5. EA remains and assists with special needs students.
  - D. Evacuation Route:  
Teacher and student will proceed to front walk through gate/driveway gate to the triangle. Designated teachers and EAs prepare for move to next evacuation site(s). The initial site is the Mormon Church parking lot across Farrington Highway. The final evacuation site is August Ahrens Elementary School.
  
- III. During a Crisis Situation:  
Follow evacuation directions from the person-in-charge.

#### **Crisis Management Plan:**

Submit Crisis Management Plan for each special needs student to the principal. CMP includes the student's schedule, evacuation route, and name of designated teacher and Educational Assistant. Plan must be approved by administration and the School Safety Office and reviewed by the Honolulu Police Department.

\*Note: A temporarily disabled student is one who has difficulty walking on his/her own (i.e.. fractured leg).