

SUPPORTING STUDENTS WITH PHYSICAL HEALTH NEEDS

**Office of Curriculum, Instruction and Student Support
Special Education Services Branch, Special Education Section
Department of Education • State of Hawaii • March 2006**

Foreword

“We must remember that we cannot separate health from the ability to learn. The two must go together.”

Surgeon General Antonia Novella, US Department of Health and Human Services, 1992

The African proverb, “It takes a whole village to raise a child,” is especially true for the child with physical health needs. It truly takes a team of dedicated individuals to care for, nurture, and educate these children with special health care needs.

This handbook was designed to provide general guidelines and a basic overview of key health conditions for teachers and school staff to meet the needs of students with physical health concerns. It is a joint effort by the Department of Education, Office of Curriculum, Instruction and Student Support, Special Education Services Branch, Special Education Section with the assistance of the Department of Health, Public Health Nursing Branch. It must not replace the instructions of the student’s parents, physician, or other qualified health professional. This handbook is to be used in collaboration with the child’s parents and health care providers to provide a safe and healthy learning environment.

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Supporting Students with Physical Health Needs

Introduction

In Hawaii, approximately 12 percent of public school children have a chronic health condition, as reported on their Student Health Record (Form 14). Most conditions are mild and have little impact on the child's ability to attend or participate in educational activities. Two examples of mild chronic health conditions include diabetes and asthma.

There are instances where a student is temporarily excluded from school due to specific health conditions according to the guidelines established by the Department of Health (DOH). Students with the following communicable diseases are temporarily excluded from school:

General Principles for Temporary Exclusion from School

Disease	Exclude from School
Chickenpox	For at least 5 days after the rash appears or until all vesicles are crusted
Conjunctivitis, acute, bacterial (pink eye)	For duration of acute infection
Influenza	For 7 days after onset of illness
Measles	For 4 full days after rash appears
Mumps	For 9 days after onset of swelling or parotitis
Rubella (German Measles)	For 7 full days after rash appears
Scabies	Until treatment is completed
Beta Hemolytic Streptococcus Group A infection (strep throat, etc.)	For 1 full day (24 hours) after the start of antibiotic treatment
Active Tuberculosis	Until authorized to return by the Department of Health

Source: Department of Health, Disease Outbreak and Control Division

An increasing number of students with congenital or chronic health problems, who may require individualized health care treatment/procedures during the school day, are coming to school. Students who were either born with or acquired difficulties with respiration, feeding, regulation, and other health difficulties attend school with the support of a team of professionals such as the nurse and other related services personnel, in addition to the classroom teacher. Some conditions cause mobility problems for children; others create enough fatigue to curtail the child's participation and require special remedial efforts. Illnesses and their treatments frequently lead to greater-than-usual school absence and may, in that way, also hinder educational progress.

Although medical care is beyond the scope of an educator's responsibilities, the educator should be sensitive to conditions affecting the student and family. The educator should be aware of a student's health condition (including physical limitations), safety precautions to prevent injury, first aid care, and how to access emergency care. For any child with a chronic health problem,

an interdisciplinary team approach to address the issues and concerns is best to meet the complex needs of this group of students. Such an approach allows for an exchange of information and sharing of strategies among professionals. At the school level, the team may be made up of, but not limited to:

- parent(s),
- primary care physician,
- special education teacher,
- general education teacher,
- educational assistant,
- school counselor,
- cafeteria manager,
- nurses (Public Health Nurse with Licensed Practical Nurse or Health Aide),
- school and community speech language pathologist,
- school and community occupational therapist,
- school and community physical therapist,
- nutritionist,
- school-based behavioral health personnel,
- school administrator, and/or
- case manager via Department of Human Services (refer to Case Management Services Section on page 39).

For the community sector, the team leader is usually the physician. In the school sector, the team leader or care coordinator is the teacher.

Public education services are mandated for all students, including those with physical health needs. Not all students with physical health needs require special education. They do, however, require planning to determine how their special needs will be met — via accommodations or special education and related services. A student with physical health needs poses a challenge to the family, school staff, and community agencies. A safe and appropriate educational program requires a collaborative effort by all.

An interdisciplinary team approach is best to address the issues and to meet the needs of a student with physical health needs. This approach allows for a free exchange of information, sharing of strategies among professionals, and reinforcement of needed activities for learning throughout a student's day.

Best practice suggests that partnering between public and private agencies as well as within the Hawaii Department of Education (DOE), school, complex, district, and state levels ensures a supportive infrastructure for students with physical health needs. This is essential to assure effectiveness and efficiency in planning and resource management. Coordination of services, involving collaboration between:

- classroom teachers,
- school administrator,
- district resource teachers for special education,
- District Educational Specialist for Special Education,
- Complex Area Superintendent (CAS),
- the Special Education Section of the Special Education Services Branch within the Office of Curriculum, Instruction and Student Support, and

- other State agencies such as the Department of Health (DOH) and the Department of Human Services (DHS), is needed to determine and provide those services for students with physical health needs.

Disclaimer

The information contained in this handbook is a guideline to assist educators in providing the support services for a child with physical health needs. It does not substitute for the specific medical treatment/management plan prescribed by the student's physician(s), nor does it invalidate the laws and rules established by the Board of Education and the State of Hawaii.

Educational Settings

When a child with physical health needs is eligible for special education services, the Individualized Education Program (IEP) becomes an important document that outlines the services the child needs in order to benefit from special education. For a student with physical health needs, eligible for services under Section 504, the Modification Plan (MP) becomes an important document that outlines the modifications and/or accommodations that are needed to ensure the child learns in a conducive environment.

Children with intensive medical needs may receive educational services in a wide variety of placements, from full-time placement in a general education setting to placement in a hospital or skilled nursing facility.

For the array of services provided to students with physical health needs, refer to the *Comprehensive Student Support System Operations Manual*, Department of Education, Office of Curriculum, Instruction and Student Support.

For children who reside in hospitals or skilled nursing facilities, the facility is responsible for the child's medical care, including therapy services, as prescribed by the physician. The special education teacher, who may request consultation from the DOE therapists in order that the child's educational goals can be met, is responsible for the overall implementation of the IEP.

Confidentiality

It is imperative that the educational information concerning a student be kept confidential. Only the team members who work with a student or have written parental permission to evaluate a student may discuss or have access to educational or health related information. There are numerous federal laws that protect and ensure the privacy of a student's information.

Family Educational Rights and Privacy Act (FERPA) sets out requirements designed to protect the privacy of parents and students. In brief, the law requires a school district to:

1. provide a parent access to their child's educational records;
2. provide a parent an opportunity to seek correction of records he/she believes to be inaccurate or misleading; and
3. obtain written permission of a parent before disclosing information contained in the child's educational record with the exception of school officials as defined in the FERPA notice.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the adoption of privacy and security standards in order to protect individually identifiable health information.
Relevant to school staff in regards to medical records and Medicaid billing reimbursement.

Individuals with Disabilities Education Improvement Act (IDEIA) of 2004 ensures the confidentiality of personally identifiable information under §300.123, which stipulates that “the State must have on file, in detail, the policies and procedures that the State has undertaken to ensure protection of the confidentiality of any personally identifiable information, collected, used, or maintained under Part B of the Act.”

Chapter 56, Subchapter 9, *Confidentiality of Information*, §8-56-59 stipulates that the provisions relating to the Protection of Educational Rights and Privacy of Students and Parents, FERPA, and IDEIA apply to students with a disability or students suspected of having a disability and the students’ parents.

Board of Education Policy regarding student information and confidential records states, “Information relative to students or former students in the public schools shall not be divulged or permitted by any Department personnel except as authorized by the individual student, parent, or guardian, or permitted as required by the Department of Education or by law.”

General Guidelines

Use **Universal Precautions** when working with children who require physical care.

To reduce the spread of infectious diseases (*diseases that can be spread from one person to another*), it is important to follow the **Universal Precautions**. Universal precautions are a set of guidelines that assumes that all blood and certain other body fluids are potentially infectious. It is important to follow universal precautions when providing care to any student, whether or not the student is known to be infectious. The following list describes the universal precautions:

- Regular and frequent handwashing is a simple, basic method of preventing the spread of a variety of germs that cause diseases. Wash hands thoroughly:
 - o before and after physical contact with any student (*even if gloves have been worn*);
 - o before and after eating or handling food;
 - o after cleaning; and /or
 - o after using the restroom.
- Wear gloves when in contact with blood and other body fluids.
- Wear protective eyewear when body fluids may come in contact with eyes (i.e. vomiting, spurting blood).
- Wipe up any blood or body fluid spills as soon as possible (wear gloves). Double-bag the trash in a plastic bag or place the bloody material in a ziploc bag and dispose of it immediately. Clean the area with an approved disinfectant or a bleach solution (one part liquid bleach to ten parts water).
- Send all soiled clothing (i.e. clothing with blood, stool, or vomit) home with the student in a double-bagged plastic bag.
- Do not eat, touch your mouth and/or eyes when giving any first aid.
- The video on “Bloodborne Pathogens/Universal Precautions” should be viewed annually per OSHA regulations.

IEP Considerations

The IEP is a written document developed by the IEP team, which sets out the specific instructional program and related services (which **may** include, but are not limited to: transportation, physical therapy, occupational therapy, speech language therapy, skilled nursing, etc.) to be provided to a student with a disability.

The term student with a “disability” under Chapter 56 means a student evaluated in accordance with IDEIA as having one or more of the recognized fourteen disability categories and who, by reason thereof, needs special education and related services.

IDEIA recognizes fourteen disability categories, which establish a child’s need for special education and related services. These disabilities include:

- autism,
- deaf-blindness,
- deafness,
- other hearing impairments,
- developmental delay,
- mental retardation,
- orthopedic impairments,
- other health impairments due to chronic or acute health problems, such as asthma, diabetes, nephritis, sickle cell anemia, a heart condition, epilepsy, rheumatic fever, hemophilia, leukemia, lead poisoning, tuberculosis,
- emotional disturbance,
- specific learning disabilities,
- speech or language impairment,
- traumatic brain injury,
- visual impairment including blindness which adversely affects a child’s educational performance, and
- multiple disabilities.

The special education teacher is usually the care coordinator. The teacher is the facilitator of the IEP team who develops the IEP with input from and collaboration with the other team members. In formulating the Present Level of Educational Performance (PLEP), it is highly recommended that the teacher consult with the medical professionals and other related services professionals to obtain comprehensive information on academic achievement and functional performance. The PLEP is a critical foundation on which the goals and objectives are built. In regards to specific related services, the team defers to the expertise of the respective services provider(s); however, it is the IEP team who determines if there is a need for a specific related service.

IEP Team Roles and Responsibilities

An interdisciplinary team approach is best to address the issues and to meet the needs of a student with physical health needs. This approach allows for a free exchange of information, sharing of strategies among professionals, and reinforcement of needed activities for learning throughout a student’s day. As the care coordinator, the classroom teacher is responsible for ensuring the effective implementation of the IEP. Although each related services personnel

emphasizes and focuses on his or her area of expertise, it is primarily the teaching staff who addresses the IEP goals and objectives on a consistent, daily basis within the classroom curriculum. For many of these students with physical health needs, the daily educational program includes positioning with or without adaptive equipment, utilizing specific feeding techniques, and range of motion exercises (gentle passive movements to maintain flexibility). One of the primary roles of the related services personnel is to ensure that the teaching staff are doing these activities correctly and safely. Continuing concerns regarding the roles and responsibilities for implementation of these and other activities should be brought to the attention of the school principal.

Section 504, Subpart D/Chapter 53

Section 504 of the Rehabilitation Act of 1973 protects all students with a disability from discrimination on the basis of that disability. In public schools operated by the DOE of the State of Hawaii, students with a disability who are protected by Section 504 shall have access to a Free Appropriate Public Education (FAPE) under Chapter 53.

A student may be considered disabled under Section 504/Americans with Disabilities Act if they meet the following criteria:

1. Have a mental or physical impairment that substantially limits one or more of the student's major life activities. The condition must substantially limit a major life activity in order for the individual to qualify for services under Section 504 and the impairment must impact the student's educational program.

Major life activities include functions such as:

- caring for one's self,
- walking,
- seeing,
- speaking,
- learning,
- performing manual tasks,
- working,
- hearing, or
- breathing.

2. Has a record of such impairment.
3. Is regarded as having such an impairment.

Eligibility and MP

When a student is assessed and determined eligible under Chapter 53, a FAPE is made available to the student in accordance with a Section 504 MP. The Eligibility and MP is a written document developed by the MP team. The MP ensures equal access to regular educational opportunities for a student with a disability who requires only modifications or accommodations. The plan shall include the following:

- a description of the problem.
- an evaluation to determine the student's needs or eligibility.

- the modifications or accommodations to be provided on behalf of the student.
- the projected date for the beginning of the services and the anticipated frequency, location, and duration of those services.

The MP for a Section 504-eligible student shall include:

- a list of modifications, accommodations, and/or related services to be provided for the student;
- the student's present levels of educational performance to explain why related service is necessary;
- measurable annual goals for related service(s), including benchmarks or short-term objectives, and a statement of how the student's progress toward these goals will be measured; and
- the projected date for the beginning of the services and the anticipated frequency, location, and duration of those services.

Related services means transportation and such developmental, corrective, and other supportive services as they are required to meet the individual educational needs of a student with a disability as adequately as students without a disability. Related services may include, but are not limited to:

- speech-language pathology and audiology services,
- psychological services,
- physical and occupational therapy,
- counseling services,
- medical services for diagnostic or evaluation purposes,
- school health services, and
- social work services in schools.

The care coordinator is determined by the student's MP team. The care coordinator's responsibilities are determined by the school administrator and often include facilitation of the MP team meetings, monitoring of timelines, and ensuring the implementation of procedural safeguards.

Section 504 Team

The DOE shall ensure that the Section 504 team for each student is a group of persons including:

- persons knowledgeable about the student, the meaning of the evaluation data, and the placement options;
- the parent of the student;
- the student, if appropriate; and
- related services providers, if applicable.

The team, including any related services providers, has a collective responsibility to develop, review, and revise the student's MP.

Personal Devices/Appliances

- As a general rule, the DOE is not responsible for purchasing or providing personal devices/items; i.e., ventilator or diapers that a student with disabilities may require regardless of whether the student is attending school.
- The parent should seek assistance for the purchase of personal devices/appliances from their private health insurance plan. The parent, however, may decide not to file claims against the private insurance carrier because of the possible impact it may have on the student's available lifetime medical benefits.
- If the IEP team specifies that a student needs a personal device in order to receive a FAPE, the DOE must provide the device at no cost to the student's parents.
- When referring to equipment in the student's IEP, write the generic description of the device rather than referring to the manufacturer's name. For example, write assistive standing device instead of Rifton prone stander.
- Medicaid will not pay for duplicate medical equipment primarily for school use. Therefore, if backup equipment is needed in case a device fails to work or breaks at school, the DOE may need to purchase the needed equipment.

Medical Services/Procedures

- Medical services, as provided by a licensed physician, are excluded services except for diagnostic and evaluation purposes to determine a student's medically related disability that results in the child's need for special education and related services.
- School health services refers to services provided by a qualified school nurse or other delegated nursing allied health personnel. Nursing is a related service that can be provided to a student under IDEIA or accommodations under Section 504.
- Refer to Medication Policy
 - o <http://doe.k12.hi.us> Click on "Parent/Community," then "Public Health Nursing"
 - o <http://www.hawaii.gov/doh> Click on "Family/Child," then "Public Health Nursing"

Emergency Evacuation Plan

The *Americans with Disabilities Act Accessibility Guidelines (ADAAG)* includes specifications for accessible means of egress, emergency alarms, and signage. The United States Access Board develops and maintains accessibility requirements for the built environment, among other elements, under several laws including the *Americans with Disabilities Act (ADA)*.

Administrative Directive No. 95-04, *Emergency Evacuation Plans for All State Facilities*, provides guidance and policy for planning the emergency evacuation of State buildings and facilities in an orderly and safe manner. Evacuation plans should include provisions for prompt new (and incumbent) employee orientations, annual drills, consideration of employees with special needs, and the public customer. Evacuation plans should be updated annually and maintained by the respective departments and agencies.

Each school should give special consideration in developing emergency evacuation plans for special education students and students who have physical health needs. In most classrooms

the teacher to student ratio does not allow for a one-to-one assignment for emergency evacuations. Developing a practical plan will involve other adults on campus who should be assigned to assist the classroom staff. Therefore, the evacuation plan becomes not only a classroom endeavor but also a school-wide endeavor. (See page F-23 for sample school plan.)

Schools should include in their Evacuation Plan details such as who (by name) is assigned to evacuate the child with special needs; the equipment that must be taken with the child; and where to deliver the child and/or equipment. The plan must be readily available for substitute teachers or educational assistants. In addition, a contingency plan (to address absences of primary staff assigned in the Action Plan) needs to be developed and frequently reviewed.

Adults who are not assigned to a classroom should be considered and assigned to assist the students with physical health needs. These adults may include: custodial staff, office staff, cafeteria staff, volunteers, and resource teachers (music, art, physical education, librarian). The plan should include the who, what, where, and how. *Who is assigned to go to the classroom to help? What will each adult be doing (i.e., two adults assigned to put the students in the wheelchairs while another adult begins to push a student out the classroom door, etc.)? Where is the final destination/location?* (For general instructions on how to lift, refer to page 17.)

Individual plans for evacuation should be on file in the student's confidential folder and practiced during drills for any student with physical, sensory, and/or cognitive disabilities who is unable to follow general evacuation procedures or for whom general supervision is not sufficient. During an actual emergency, students with physical or mental impairments may become disoriented or emotionally disabled and will require assistance to evacuate. Evacuation may necessitate that two adults lift and carry the student with a disability out of a building using proper methods of carrying/evacuating people.

Evacuation plans will need to include special school events, such as graduation, May Day programs, school assemblies in which the student participates, athletic contests, etc., the use of facilities such as school libraries, gymnasiums, auditoriums, stadiums, cafeterias, and multi-purpose rooms, including their use during non-school hours.

Evacuation of students with physical health needs, especially wheelchair bound students, from the second floor is problematic. Consideration should be given to relocating these students to the first floor if at all possible.

The following are guidelines to follow for various emergency evacuation situations.

Fire Evacuation

When the fire alarm is activated, act immediately to evacuate according to the fire evacuation plan. The four methods of fire evacuation from multi-story buildings are:

- *Elevator*: Check the area by the elevator. If there is no visible sign of fire or smoke, the elevator may be used to evacuate a student with a disability from the building. When elevators are not operable, everyone should proceed to the nearest exit.
- *Lateral evacuation*: Move the student with a disability away from the fire using fire barriers, separation, and other means to help contain the spread of fire.
- *Area of Rescue Assistance (or Area of Refuge)*: Go to the area of rescue assistance, if a student with a disability is able to do so on his/her own or with assistance, and remain there until the fire department arrives. Upon arrival at the scene, the fire department

personnel (when told of persons located there) will go to the area of rescue assistance immediately and evacuate the occupants. Occupants of the area of rescue assistance must wait until assistance arrives. It is important that the area of rescue assistance be predetermined, and that the fire department is aware of the location(s).

- *Full evacuation:* Fully evacuate the building if the fire threat is to the immediate area or widespread. When the entire building is evacuated, few of the options listed may work and the students with disabilities may have to be carried out. Written permission slips from parents for their children should be on file for those students that may have to be carried out of the building during an evacuation.

Never use mechanical stair climbers during evacuations since they may block the stairwell and present a hazard to others evacuating the building. Evacuation chairs may be used for those students needing assistance. If evacuation chairs are considered for use, discussion should be directed at identifying the number of evacuation chairs required, the selection of type of evacuation chairs, and training.

Bomb Threat

When the decision to evacuate a building is caused by a bomb threat, all persons shall evacuate the building to the identified evacuation sites (at least 300 feet away) or to a location with concrete barriers.

Tsunami

When a tsunami warning is issued, all persons shall evacuate the building to an evacuation site for schools located in tsunami evacuation zones and according to the school's tsunami evacuation plans.

Hazardous Materials Incident

In the event of a hazardous materials release, follow the lead fire official's orders to shelter in place or to evacuate. Evacuation is generally crosswind from the hazardous source.

Earthquake

General guidance during an earthquake is to remain indoors. Seek cover under sturdy tables, doorjamb, etc., and away from falling debris and live electrical wires until receiving instructions from emergency workers or school administration.

Note: Evacuation drills should be conducted periodically to ensure proper functioning of the evacuation plan and to determine areas in need of attention. Students with disabilities should participate in the drills although their level of participation may be accomplished by a "talk through." Training should be provided, as necessary, for key personnel assigned to specific evacuation activities. For example, employees assigned to assist students with physical health needs through the use of evacuation chairs shall be trained in their proper use. Training for evacuation assistants should also include the proper use of assistive devices. If students are unable to evacuate independently, they are to go to or be taken to the cluster of students with disabilities. Evacuation maps should be clearly posted to inform everyone about identified exit routes.

The following evacuation checklist contains general items to consider and "check off" when designing and implementing an evacuation plan. It may need to be individualized for each particular student's or school's needs.

Evacuation Checklist

For on campus evacuation:	
	Each teacher and student (as appropriate) should know the destination site and evacuation procedure.
	Each wheelchair bound student should have at least one adult assigned to him/her.
	If adults other than the classroom staff are assigned to a wheelchair bound student, the classroom teaching staff will seat the student in the wheelchair and the assisting adult will push the student to the designated site.
	Special education teacher or designee will count the students present at the destination site to ensure that all the students were evacuated.
For off-campus evacuation:	
	An alternate site should be selected that involves the least amount of physical effort and ability to reach (i.e., level walk vs. walking up a hill);
	For those students, teachers, and staff who are physically incapable of walking to the off-campus site, alternate means of evacuation should be considered:
	Use of a van.
	Use of a modified golf cart to assist with evacuation.
	Adults with physical limitations can assist students to evacuate by use of a van or modified golf cart.
	For those students/teachers/staff who are physically incapable of walking to the off-campus site, a designated shelter on campus should be assigned.
	Appropriate measures and supplies should be taken.
	Water, medication, etc., that the students require should be packed and taken with the students.
	Adults assigned to assist students to the shelter should be knowledgeable about how to secure the shelter.

Emergency Procedures for Accident or Illness

1. Assess the situation. Be sure the situation is safe for you to approach. The following dangers will require caution: live electrical wires, gas leaks, building damage, fire or smoke, traffic, or violence.
2. A responsible adult should stay at the scene and render aid until the person designated to handle emergencies arrives (i.e. fire, ambulance, police).
3. Alert the school staff designated to deal with emergencies. This person will take charge of the emergency and render any further first aid needed.
4. The responsible school authority or a designated employee should notify the parent/legal guardian of the emergency as soon as possible to determine the appropriate course of action.
5. **DO NOT** give medications unless there has been prior approval by the parent or guardian and a written order from the physician.

6. **DO NOT** move a severely injured or ill student unless absolutely necessary for immediate safety. If moving is necessary, support the head and neck and pull the student in the direction of the head without bending the spine forward. **DO NOT** drag the student sideways. Keep the student quiet and warm. Place rolled up towels/clothing on both sides of the head so that the head will not move.
7. If the parent/legal guardian cannot be reached, notify a parent/legal guardian substitute and call either the physician or the hospital designated on the Emergency Information Card so they will know to expect the injured student. Arrange for transportation of the injured student by Emergency Medical Services (EMS) if necessary.
8. A responsible individual should stay with the injured student.
9. Fill out a report for all accidents requiring the above procedures if required by school policy.
10. **DO NOT** use your personal car for transporting a student who is ill or has been injured.

Call 911

Do Not Resuscitate (DNR) Policy

DO NOT RESUSITATE (DNR) means withholding of life-sustaining measure(s) in the event of respiratory or cardiac arrest. A life-sustaining measure, familiar to DOE staff, is cardiopulmonary resuscitation (CPR) or pushing down on the middle of the chest to begin a heart beat and manual breaths to provide oxygen to the lungs when a student's heart stops or the student stops breathing.

A DNR order is a medical order or prescription written by a licensed physician in agreement with the client/parent/legal guardian to withhold life-sustaining measures. In the school setting, the decision about resuscitation is a medical, not an educational, decision.

The DOE maintains an expectation that school staff and school health care providers aid injured or ill students. Staff must act in a reasonable manner to obtain immediate care for the student in need of additional assistance to assure the safety of the student. Life threatening emergencies must be handled by calling 911. During the period between calling 911 and the arrival of emergency services personnel, school staff will provide first aid and/or CPR for all students in need. For students with physical health needs with a high probability of experiencing emergency situations during the school day, an Emergency Action Plan (EAP) should be developed so the DOE staff and all those involved with the student respond appropriately in getting emergency medical services for the student in need.

Therefore, the DNR order in the school setting is contradictory to the departmental policy of providing immediate care and to obtain emergency medical services by calling EMS or 911. If an order for DNR is presented, the school will **not accept the DNR order under any circumstances**. Please contact the Public Health Nurse (PHN) for assistance to collaborate with the parent/legal guardian and licensed physician to explain the policy of the DOE and to assure an EAP is in place for the student with physical health needs.

Excursions (Field Trips)

When planning a field trip, consideration concerning health and safety should be given to **all** students, regardless of the presence of physical health needs or being certified special education or Section 504. It is recommended that a plan for emergency preparation/evacuation be developed for both the field trip site and the bus. The IEP/MP team needs to carefully weigh all the elements involved and determine if the field trip(s) is appropriate based on the safety and educational needs of the student. The IEP/MP team needs to consider if there are alternate ways to meet the educational objectives instead of an excursion. If it is determined that only a field trip can meet an educational objective, there must be pre-planning to meet the student's physical health needs. It should be documented in the "meeting notes" section of the IEP/MP — what will be done to meet the physical health needs of the student and who will do it. It may not always be the licensed nurse who meets those needs on an excursion. Often times, a parent or legal guardian will accompany their child/student on a field trip as they are capable, willing, and legally authorized to care for the student's physical needs without a medical or nursing license.

After-School Plus (A+) Program

The A+ Program brings affordable after-school services to children in public elementary schools whose parents work, attend school, or are in job training programs, so that the high incidence of latchkey children is reduced. The program provides a safe, secure, and nurturing environment for the children after school.

The A+ Program shall be made available to all eligible children on a nondiscriminatory basis. For those disabled students who are identified by the parent or are known to the A+ program staff to have special needs, the district will provide reasonable accommodations to afford the student an opportunity to participate. Each student's needs will be assessed on a case-by-case basis by the Site Coordinator (with consultation with the District Coordinator). For DOE sites, the Principal and the A+ District Coordinator in consultation with the District Specialists for special education or special services shall determine the disposition of each case. The Review of Special Needs form will be used to address the special needs of children. The review procedure should be conducted on a yearly basis with parent involvement, input by school personnel, program modifications, and reasonable accommodations that are known to all program employees.

The A+ program is **not** an extension of the regular school day. The A+ program is not part of the student's IEP. Hence, the IEP of the regular school program will not be in effect, and the information contained in the IEP and the confidential file will not be available for the A+ program.

Mobility and Students with Physical Limitations

Students with physical limitations vary widely in mobility. Some are totally dependent and will require full physical assistance. Many students with a physical disability have equipment that enhances their participation in daily life activities, i.e., wheelchairs, crutches, orthoses (an appliance that provides support to a limb or joint).

Depending on the student's ability, type of activity, level of physical and cognitive involvement, and need for adaptations, the educational program will vary greatly. The following should be considered when designing and carrying out an educational program:

- medical diagnosis, including restrictions on certain activities or susceptibility to fractures.
- equipment currently being used/needed for mobility and positioning.
- any recent medical procedures that may affect functioning level or handling techniques.
- general mobility level.
- overall skills: gross motor, intellectual, fine motor, and visual perception.

The occupational therapist and/or physical therapist can assist in teaching the safety precautions and adaptations necessary in order for the student to participate in appropriate activities.

Many severely disabled students are unable to move volitionally, change positions, or express their need to change positions. Alignment and safe and comfortable positioning are essential services. As with any student, rest and frequent changes of bodily positions are necessary **throughout the day** (minimally once every two hours).

Proper handling and positioning facilitates the development of gross motor skills, improves range of motion, increases comfort, and addresses postural problems. For example:

- A child with severe and multiple disabilities, such as a child with cerebral palsy, may have limited voluntary movements, and may also have limited or exaggerated reactions and responses to being moved.
- If the child has spasticity, he/she will become stiffer if not handled properly when moved. This is due to the damage to the brain and the areas that coordinate movement.
- The child with athetosis, characterized by involuntary movements and constantly changing tone of muscles can easily lose his/her balance and fall.
- The child with hypotonia (low tone) is "floppy" and will need to be well supported and provided with additional hip, trunk, head, and neck support in order to be kept upright.

Due to these factors, a child with significant disabilities should be handled gently and moved slowly to allow the child to adjust to the movement. The child should be in a supportive environment which allows him/her the time to achieve his/her potential.

Lifting Students

Safety Precautions: When a child is totally dependent on others for lifting and transfers, safety precautions must be taken to prevent injury to the caregivers. **If there are any doubts, get help before starting to lift. If you question whether you can lift alone or if a student weighs more than approximately 30 pounds, use a two-man lift technique.** Always have two people present if you are transferring a student for the first time.

Management: Think Things Through Before You Start Lifting the Student

1. Assess how you will lift the student.

Decide if you are able to lift the student alone. If you have any doubt about your ability to lift the student safely, **ask someone else to help you**. It is better to wait for help and take a little longer than to rush and suffer a long-term back injury.

Check for grease, oil, moisture, and sharp edges in the surrounding area.

Decide where and how to hold the student.

2. Move the wheelchair and student as close to the transfer location as possible.

If the student is in a wheelchair, push the student close to the area you will be transferring the student to, instead of carrying the student across the room.

3. Plan your transfer and clear the path.

Check for obstacles and obstructions (i.e., furniture, electrical cords, other students, etc.).

4. Know where and how you will put the student down.

5. Lift smoothly and avoid jerky movements.

General Rules for Lifting

1. Stand as close as possible to the student.

2. Check footing. Your feet should be approximately shoulder width apart to give you a broad base of support for better balance.

3. Squat down. Get yourself “lined up” and straddle the student somewhat. Flex your back, slightly bend forward at the hips, and bend your knees.

4. Grasp the student firmly and close to you (up against your body). Be sure your grip will not slip.

5. Breathe in. Take a breath – inflated lungs help support the spine.

6. Lift with legs. Start the lift by keeping your back flexed while your knees begin to straighten (leg muscles create the upward movement). As your legs straighten, bring your back to an upright position as well (vertical). HINT: Keep knees and back somewhat flexed, not straight.

7. Hold the student firmly and close to your body.

8. Shift your feet. Shift the position of your feet to turn. **Never twist** your body.

Two-Person Lift

- **Secure transfer surfaces.** Lock wheelchair brakes.
- **Remove the footrests and armrests** (if applicable).
- **Unfasten the seat belt and any other supports.**
- **First lifter** (behind the student) folds the student's arms across his/her chest. Lifter places his/her arms under the student's armpits and grasps student's forearms above the wrists. Usually the taller adult stands behind the student.
- **Second lifter** (in front of the student) keeps his/her knees bent, back straight, slightly bends forward at the hips, and places both arms under the student's thighs.
- **Lift together by counting.** On the count of three, both adults lift simultaneously by straightening knees while holding the student closely and firmly.

It is essential to **lift in unison** with a two-person lift. Generally, the first lifter (behind the student) does the counting.

If you have questions about how to perform a two-person lift, contact the physical therapist assigned to your school.

Ceiling Hoist

If there is difficulty in lifting the student(s), it is highly recommended that a ceiling hoist be professionally installed by a factory trained technician.

- The ceiling hoist is a cordless motorized lift that utilizes a track system to easily raise and lower a student as well as move a student to various locations within the classroom.
- A sling (similar to a hammock) is placed under the student and is secured to the cross bar of the ceiling hoist via loops.
- For student(s) who are tall, heavy, have uncontrollable movements, and/or orthopedic deformities, the ceiling hoist is the easiest and safest method to lift and move a student.
- The use of a ceiling hoist requires a little more time to place the sling under the student and to detach the sling once the student has been transferred, but the extra few minutes it takes may prevent a long-term back injury.

If you have questions about how to utilize a ceiling hoist, contact the physical therapist assigned to your school.

Hoyer Lift/Mechanical Lift

In lieu of a ceiling hoist, a Hoyer lift can be utilized.

- The Hoyer lift is a mechanical device that utilizes hydraulics to lift the student (similar to a hydraulic floor jack).
- A sling (similar to a hammock) is placed under the student and is secured to the Hoyer lift via chains or bars to raise and lower the student.
- For students who are tall, heavy, have uncontrollable movements, and/or orthopedic deformities, the Hoyer lift would be an easier method compared to a two-man lift.
- The use of a Hoyer lift requires a little more time to place the sling under the student and to detach the chains/bars once the student has been transferred, but the extra few minutes it takes may prevent a long-term back injury.

If you have questions about how to utilize a Hoyer lift, contact the physical therapist assigned to your school.

Special Dietary Needs

When nutrition services are required by a child's IEP/MP, school officials need to make sure that school food services staff are involved early in the decision-making process regarding special meals.

Physician's Statement for Children with Disabilities

United States Department of Agriculture (USDA) regulations 7 CFR Part 15b require substitutions or modifications in school meals for children whose disabilities restrict their diets. A child with a disability must be provided food substitutions when a statement signed by a licensed physician supports this need. The form, "School Food Services Program, Medical Statement for Disabled Child Special Needs" (see page F-19) must be completely filled out by the physician.

The physician's statement must identify the following:

- the child's diagnosis,
- an explanation of why the disability restricts the child's diet,
- the major life activity affected by the disability, and
- the food or foods to be omitted from the child's diet, and the food or choice of foods that must be substituted.

The term child with a "disability" under Chapter 56 means a child evaluated in accordance with IDEIA as having one or more of the recognized fourteen disability categories and who, by reason thereof, needs special education and related services (see page 5).

Under *Section 504 of the Rehabilitation Act of 1973*, and the *Americans with Disabilities Act (ADA) of 1990*, a "person with disability" means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment (see page 5).

The term "physical or mental impairment" includes various diseases and conditions, a few of which may be:

- orthopedic, visual, speech, and hearing impairments,
- cerebral palsy,
- epilepsy,
- muscular dystrophy,
- multiple sclerosis,
- cancer,
- heart disease,
- metabolic diseases, such as diabetes or phenylketonuria (PKU),
- food anaphylaxis (severe food allergy),
- mental retardation,
- emotional illness,
- drug addiction and alcoholism,
- specific learning disabilities,

- HIV disease, and
- tuberculosis.

The term child with a “disability” under Chapter 56 means a child evaluated in accordance with IDEIA as having one or more of the recognized thirteen disability categories and who, by reason thereof, needs special education and related services.

Cases of Food Allergy

Generally, children with food allergies or intolerances do not have a disability as defined under either Section 504 of the Rehabilitation Act or Part B of the IDEIA, and the school food services section may, but is not required to, make food substitutions for these children.

However, when the licensed physician’s assessment indicates that food allergies may result in severe, life-threatening (anaphylactic) reactions, the child’s condition would meet the definition of “disability,” and the substitutions prescribed by the licensed physician must be made.

DOE does not provide meal substitutions for food allergies or intolerance unless it is life threatening or the condition meets the USDA National School Lunch Special Dietary Needs definition of “disability.”

Other Special Dietary Needs

The school food services section may make food substitutions, at their discretion, for individual children who do not have a disability, but who are medically certified as having a special medical or dietary need. Please contact School Food Services Branch as soon as possible regarding special meals at (808) 733-8400.

Medical Statement for Children with Special Dietary Needs

Each special dietary request must be supported by a statement, which explains the food substitution that is requested. **DOE requires a licensed physician to complete and sign the “Medical Statement for Disabled Child Special Needs” form** (see page F-19).

The medical statement must include the following:

- an identification of the medical or other special dietary condition which restricts the child’s diet,
- the food or foods to be omitted from the child’s diet, and
- the food or choice of foods to be substituted.

Food Preparation

Classroom staff should collaborate with the cafeteria manager for food preparation (i.e., chopping food, pureeing food, thickening liquids, etc.).

Feeding in School

Schools receiving federal monies for school meals are mandated (*U.S. Dept. of Agriculture-National School Lunch Program 7CFR Part 210.10 [g] [1]*) to provide substitutions at no extra cost to a child whose primary medical doctor has determined that he/she has a disability that prevents him/her from eating regular school lunch. The mandate indicates that a school is not required to purchase formula for a child's tube feedings, but it does include an expectation that the school provide appropriate foods that could be used for tube feedings. (See Appendix C: *National School Lunch Program/School Breakfast Program, Meal Substitutions for Students with Disabilities, Medical, or Other Special Dietary Needs [DRAFT].*)

When difficulties with eating, drinking or participation in mealtime activities arise, the health, safety, and well being of the student may be compromised. Children with critical medical conditions may need special assistance during mealtimes, especially when there is a transition from non-oral feeding to oral feeding. A plan for enhanced safety through proper positioning, appropriate texture of foods and liquids, and specific procedures for feeding and drinking should be established. (Refer to Dysphagia/Swallowing Plan form on page F-21.) The educational team needs to collaborate with the student's primary care physician to develop this plan. Collaboration and consultation between the hospital team and school team is essential, especially for students in the transition phase and returning to school. The educational team's goal is to focus on the student's participation in lunch or snack routines, NOT to meet medically based outcomes.

An interdisciplinary team approach is best to address issues and concerns to meet the student's need(s). Such an approach allows for an exchange of information and sharing of strategies among professionals. The team is made up of (but not limited to) parent(s), primary care physician, classroom teacher, educational aide, school and community speech pathologist, school and community occupational therapist, school and community physical therapist, nutritionist, school behavior health personnel, and administrator. For the community sector, the team leader is usually the physician. In the school sector, the team leader is usually the classroom teacher.

Dysphagia and Feeding Considerations

Dysphagia is defined as the inability to swallow or difficulty in swallowing. It is characterized by the difficulty in the oral preparation of food or saliva in the process of swallowing and/or in the movement of the materials from the mouth to the stomach. Included in this definition are problems in the positioning of food in the mouth and in the oral manipulation preceding the swallow (i.e., suckling, sucking, and mastication/chewing).

Dysphagia is NOT considered a specific eligibility for special education; however, some students may have other disabilities of which dysphagia is an accompanying disorder. Students who are at risk for dysphagia would be those who have the following:

- history of:
 - aspiration pneumonia,
 - lung disease,

- o neurological disease and/or insult,
- o head/neck tumor, surgery, or treatment,
- history of laryngeal closure problems,
- cervical spine injury,
- severely reduced mental status,
- presence of aspiration pneumonia – fever, infiltrate, secretions, etc.,
- presence of nasogastric tube or gastric tube, and/or
- presence of tracheotomy and/or ventilator.

Symptoms of Dysphagia:

- inability to recognize food,
- difficulty placing food in the mouth,
- inability to control food or saliva in the mouth,
- coughing before, during and/or after a swallow or immediately after a meal,
- gagging,
- facial grimacing,
- reddening of the face,
- audible breathing,
- recurring pneumonia,
- weight loss when no other reason can be defined,
- gurgly voice quality, and/or
- chronic low grade fever.

Primary concerns within the school system for students with dysphagia:

- adequate nutrition and hydration,
- safety of student during oral feeding,
- information on the exact nature of the student’s oropharyngeal swallowing disorder, and/or
- proper clearances on file for sharing information and referring students for needed medical follow-up related to dysphagia.

Developing a Dysphagia/Swallowing Plan

1. Contact the school speech-language pathologist, nurse, occupational therapist, and physical therapist to develop a feeding plan for the student. The plan should involve:
 - positioning to adjust seating or posture for eating;
 - equipment needed such as specific utensils that can be easily managed;
 - diet and food preparation;
 - the feeding plan techniques to address chewing and swallowing; and
 - modification of the environment so that it is free of distractions.
2. Should problems or concerns persist, it is recommended that the parents/family follow up with their primary care physician to obtain a swallowing assessment. Parents should be given a copy of the feeding plan in order that the hospital’s dysphagia team can review the information.
3. Written consent should be obtained from the parent to allow open communication and discussion between the hospital’s dysphagia team and the school team.

4. If the parent(s) refuses consent or to have the swallowing evaluation conducted, a team member who has good rapport with the parent(s) should explain the importance and value of the swallowing assessment. It should be conveyed that the school is looking after the safety and well-being of the student. After all attempts have failed to convince the family to obtain a swallowing evaluation, a feeding team member should request permission to contact the primary care physician. If permission to contact the physician is denied, the public health nurse servicing that school should be contacted to participate and assist in the process.
5. Develop the dysphagia/swallowing plan with input from the treating hospital/facility team, and ensure that all team members (especially the classroom staff) are familiar with and understand the plan.

Tube Feedings

In some children, dysphagia is so severe that the child should not or cannot swallow anything and may require permanent surgical closure of the esophagus to prevent aspiration. A tube may be surgically inserted directly into the stomach (gastrostomy), through the nose (nasogastric), or through the mouth (orogastric) to provide hydration, feeding, or administration of medication. A qualified individual can give liquid or semi-liquid foods directly through the tube. The physician prescribes the amount of food. The child's feeding, at any mealtime, should be a social event where the child can join others during their regular meals. If oral feedings are contraindicated, this must be documented in the child's confidential folder. Care of the mouth needs to continue even if the child is not eating. Teeth, gums, and tongue should be brushed daily.

Some children may use a combination of oral and tube/gastrostomy feedings. **Feeding by mouth will be done ONLY if ordered by the prescribing physician.**

Due to past trauma or discomfort experienced with dysphagia, the child may develop sensitivities or aversion to touch around the oral motor area or to food stuffs reintroduced orally. Certain health professionals, i.e., occupational therapists, nutritionists, nurses, and speech pathologists, are trained to work with feeding problems and can be consulted. Management of issues is a team effort. Continuous collaboration and consultation with community counterparts and the primary physician is essential.

Student Transportation Services

Transportation Request Procedure

Transportation is a related service that is provided for special education students as delineated in their IEPs. Arrangements for student transportation take approximately two weeks from the date the request is made by the school. To arrange for Curb-to-Curb transportation, the following procedures need to be completed:

1. School submits a request for transportation to the District Student Transportation Services Office using Form ST-11. Form ST-11 may be faxed to expedite the request.
2. Student Transportation Services Office reviews the request and assigns it to the appropriate bus company.
3. Bus company assigns the student to a specified bus route and determines pick-up time.
4. Bus company informs the parent(s) and school of starting date and pick-up time as soon as the bus route is established.
5. Bus company informs the parent(s) of estimated length of travel time and transfers, if any.

Special Instructions

Use the ST-11 form to notify the Student Transportation Services office, who will inform the bus company, bus driver and bus aide, of a student's special needs and instructions for a student's safety and welfare. Examples of student information that should be shared with the bus company are:

- medical/health conditions that may result in an emergency,
- emergency action plans,
- behavioral concerns,
- safety concerns (such as a student's ability to unbuckle the seat belt while sitting in his/her wheelchair), and/or
- if a car seat is needed.

It is also recommended that the teacher verbally inform the bus driver and bus aide of any of the aforementioned information.

How Safe Is School Bus Transportation?

School Bus Driver Licensing

All bus drivers are required to pass a physical examination, obtain traffic and criminal clearances and have the appropriate class of driver's license. Bus drivers are trained to transport students with disabilities.

School Bus Aide Training

Bus aides are provided on buses that transport students who require special attention. The aides are required to have a first aid certificate and criminal clearance. They also participate in training sessions.

Safety and Bus Service Complaints

All school buses are inspected daily by the bus driver. All safety and service complaints and concerns should be reported to the respective District Student Transportation Office.

Best Practice Suggestions for Travel

The following are general guidelines for safely transporting a student with physical health needs:

1. When traveling in a Type II school bus (the smaller yellow school buses) that the student travels in to and from school, **all children** are safest traveling on a vehicle seat, using the vehicle seat belts or in an approved child passenger restraint that complies with federal safety standards.
2. For the student with physical health needs, the safest means of traveling on a school bus is for the student to be properly restrained out of his/her wheelchair while the empty wheelchair is properly secured during the vehicle trip.
3. If transferring out of the wheelchair cannot be reasonably managed by bus personnel, the following are recommendations when the student must use his/her wheelchair as a travel seat:
 - Use transit-option or “WC-19” type of wheelchair (check with your equipment supplier).
 - All **wheelchairs** should be secured **forward-facing** in the vehicle.
 - If the student has a transit-option wheelchair, bus personnel should use the crash-tested wheelchair securement points to attach the bus tie-down straps. These tie-down straps should be used according to the manufacturer’s instructions.
 - Wheelchairs should be secured at the frame junctions on the main frame of the wheelchair.
 - When students travel seated in their wheelchairs, use a vehicle-anchored lap/shoulder seat belt to protect the person sitting in the wheelchair.
4. If the student requires the use of medical equipment during vehicle travel, secure equipment as best as possible. This process might involve placing equipment under vehicle seats or securing them with unoccupied seat belts.
5. If possible, remove and secure lap trays from the student’s wheelchair for vehicle travel to help prevent injury from the rigid edges. If this is not possible, place padding between the student and the edge of the tray. Make sure that the lap tray is also securely attached to the chair. Remember that crash forces are strong and it is important to help prevent injury from this potential projectile.
6. All other passengers should be properly secured during vehicle travel, including nursing or bus personnel. Anyone or anything not secured in a vehicle could become a projectile in the event of a crash.

Parent Responsibilities Include:

- **Morning Pick-Up**
 - o The parent must have the student at the pick-up point five minutes before the scheduled pick-up time.
 - o If the student will not be going to school, the parent must notify the driver or the bus company as soon as possible.

- **Illness**
 - If a student becomes ill at school, the parent will be asked to transport him or her home. The parent must inform the bus company or driver that they have picked up the student from school.
 - A student with a communicable disease must have a medical clearance to resume transportation service and return to school.
- **Resuming Services**
 - When a student is ready to return to school after being absent, the parent must call the bus company at least one day in advance (by 4:00 p.m). Otherwise, the driver will not resume picking up the student.
- **Moving**
 - Parent(s) must notify the school at least two weeks in advance if they are moving to a new address.
 - Until transportation has been arranged, parent(s) may be responsible for transporting their student to and from school.

When No One Is Home to Receive a Student

Parent(s) or a designated responsible person must deliver and receive their student at the designated pick-up and drop-off points.

* The following steps will be taken if the student is left unsupervised during pick-up and/or no responsible person is present to receive him/her at the drop-off time and place.

1. The parent will receive a verbal warning and a copy of a *Bus Incident Report* (Form ST-15).
2. The school official will conduct an investigation.
3. The parent may be asked to attend a meeting with representatives from the school, bus company, and Student Transportation Services personnel.
4. The student may be suspended from riding the bus.

If the parent feels that the student is responsible enough to be left unattended, the principal must approve this. The parent must obtain the *Parental Request to Leave Special Education Student at Designated Drop-off Point Without an Authorized Person to Receive Student* (Form ST-7). The parent must submit the completed form to the principal for review and approval.

In emergency situations when the parent is unable to meet the bus, the parent must arrange for another responsible person to meet the student at the drop-off point. The parent must call the bus company and provide them with the name of the authorized person and the alternate drop-off point, if needed. The bus driver will not release the student unless these arrangements have been confirmed.

If, for any reason, the bus company believes that they are unable to responsibly drop off the student, the parent may need to pick up the child from school or an agreed upon designated location.

****(This policy is being revised. Please contact the Student Transportation Services office for more information.)***

Natural Disasters and Emergency Situations

- **Before Morning Pick-Up**
The parent should keep the student at home.
- **After Morning Pick-Up**
The parent will be notified of the location of the student by the bus company staff.
- **While In School**
The student should remain in school until the all-clear signal is announced or a determination is made by school officials that students may be released.

Facilities and Specialized Equipment

Students with complex medical conditions and/or who are technologically dependent will need specialized equipment during the school day. In addition, the classroom must be assessed and equipped to handle the myriad of equipment required by the students. The following are guidelines to follow when considering placing a student with complex medical condition(s) and/or who is technologically dependent in the classroom.

Minimum Facility Requirements

1. Electrical power and a sufficient number of outlets to handle various equipment:
 - a. Dedicated electrical outlets with their own circuit breakers,
 - b. Sufficient number of electrical outlets to power various equipment for numerous students, and
 - c. Outlets with Ground Fault Interrupter (GFI) capability - requires three pronged receptacles;
2. Hot water heater;
3. Washer and dryer with electrical and plumbing hook-ups;
4. Two separate sinks with an adjoining counter:
 - a. One sink for clean equipment and items,
 - b. One sink for cleaning contaminated equipment and items, and
 - c. Adjacent counter to allow equipment to air dry;
5. Wall mounted anti-bacterial liquid soap dispenser for infection control;
6. Paper towel dispenser;
7. Paper cup dispenser;
8. Covered waste receptacle and plastic bags/lining for ease of disposal of contaminated items;
9. Accessible bathroom:
 - a. Elevated toilet seats (wheelchair height),
 - b. Roll-in shower stall with hand held showerhead, and
 - c. Elevated changing table;
10. Ceiling hoist (factory installed ceiling tracks with motorized lift — www.planetmobility.com);
11. Space Saver Mat (elevated mat that is attached to the wall);
12. IV pole for tube feeding;
13. Ramps as needed;
14. Doorway ramps as needed;
15. Storage area for oxygen tanks;
16. ADA width doorways to accommodate wheelchairs;
17. Small refrigerator for storage of medication and left over formula for Gastrostomy Tube (GT) feedings; and
18. Ambu-bag (bag-valve-mask) device to give artificial respirations.

For information about positioning and lifting equipment (ceiling hoist, Space Saver Mat, Tumbleform feeder seat, wedge, sidelyer, prone stander, supine stander/tilt table), contact the physical therapist assigned to your school.

For information about medical equipment (ventilator, nebulizer, suction machine, pulse oximeter, oxygen tanks), contact the public health nurse assigned to your school.

Equipment Recommended

Depending on the needs of the individual students, certain types of equipment may be needed in the classroom:

1. ventilator for back-up use,
2. large volume nebulizer for humidification of trach,
3. suction machine,
4. pulse oximeter,
5. oxygen concentrator,
6. various positioning equipment, and/or
7. oxygen tanks.

Oxygen Storage Requirements

1. Cylinder Storage
 - a. Do not place oxygen tank in a small or unventilated storage area.
 - b. Do not place oxygen equipment in a small storage area such as a closet or car trunk. Any venting oxygen could create a fire hazard.
 - c. Store portable oxygen cylinders lying down or in a storage rack. Cylinders should never be left standing upright without a cylinder stand.
2. Cylinder Stability

Oxygen is stored in gas cylinders under very high pressure. An oxygen cylinder needs to be secured in a special base to keep it from falling over. The weight of the cylinder can cause injury and damage property if it were to fall on someone or something. The cylinder valve could also be knocked off if the cylinder were to fall over. The high pressure coming out of a broken valve opening could then cause the cylinder to move about the room in a destructive, uncontrolled manner.
3. Avoid Heat

Keep cylinders and oxygen tubing at least five (5) feet away from any source of heat, especially open flames, stoves, or large windows.
4. Grease/Oil

Never use grease, oil, aerosols, paints, gasoline, solvents, or hand lotion on oxygen equipment.
5. No Smoking
 - a. Do not permit smoking in the same room as the oxygen equipment.
 - b. Place “No Smoking” and “Oxygen in Use” signs on outer doors of classroom.

Facility Modification Requests

Table R Form

Classroom renovation is a costly process that requires 12-15 months to complete the design and construction phases. When a modification or renovation of a classroom is required, a *Preliminary Table R* form (see page F-22) should be completed and submitted to Capital Improvement Project Planner III of the Facilities and Support Services Branch. The *Preliminary Table R* is available for downloading from <http://fssb.k12.hi.us/forms.htm>. Information regarding:

- what exact modification is being requested.
- where (school, classroom and location within the classroom) the modification is needed.
- why the modification is needed (justification).

These are required on the *Preliminary Table R* form. The form should be completed and submitted by the school administrator to the district educational specialist for district coordination and submittal to Facilities and Support Services Branch. The request may be submitted at any time; however, submissions earlier in the fiscal year are recommended.

Note that limited capital improvements program funding determines the DOE's ability to fund requests. Therefore, renovations will be funded based on statewide priority.

ADA Modifications

School requests for modifications/renovations that are needed to meet ADA requirements (i.e., wheelchair ramps, electrical outlets to power equipment, etc.) and that cost less than \$10,000 may be submitted to the Facility Planner II of the Facilities and Support Services Branch .

Students with Complex Physical Health Needs Residing in a Nursing Facility

The educational and medical needs of a medically fragile child residing in a nursing home differ from the needs of a medically fragile child who resides at home. The acute medical needs of the nursing home child prevent the child from attending public school. For the nursing home staff, the emphasis is on addressing the medical needs of the child. The special education (usually part-time) teacher serves an important role in not only providing education but also being the primary professional in monitoring the child's daily activities and needs. The special education teacher is aware of the child's global needs and must integrate all the needed services/activities into an individualized curriculum for the child. The teacher also serves as a valuable resource when generalized information is needed, i.e., information about the fit/appropriateness of a wheelchair.

Special education teachers in the nursing home carefully determine each child's interests and capabilities. The teacher adapts activities and equipment and relays information to other staff/team members. The teacher provides a daily curriculum of various activities:

- range of motion exercises,
- auditory stimulation,
- tactile stimulation,
- olfactory stimulation,
- visual stimulation,
- positioning, and
- the use of assistive technology such as switches and computers as appropriate.

The teacher is the primary individual who creates a caring, nurturing, learning environment in a medical facility.

DOE physical and occupational therapists provide resource consultation to the special education teachers concerning positioning and curricular activities. The nursing home staff provides all of the nursing services to the students.

There is a Memorandum of Agreement (MOA) between the DOE and the individual nursing home facilities which delineates the responsibilities of both the DOE and the nursing home.

Case Management Services

Students with complex physical health needs may be eligible for medically necessary services under the Medicaid Health Plan managed by DHS. One of the health benefits under the Medicaid Health Plan is Case Management Services for certain children with complex physical health needs.

Section 1905(a)(19) and 1915(g)(2) of the *Social Security Act* define Case Management as services which will assist an individual eligible in gaining access to needed medical, social, educational, and other services. Activities commonly understood to be allowable include:

- assessment of the eligible individual to determine service needs.
- development of a specific care plan.
- referral and related activities to help the individual obtain needed services.
- monitoring and follow-up.

There are various types of Case Management Services within DHS for children with complex physical health needs, which include:

- **Medically Fragile Case Management Services** are for Medicaid eligible children, birth through 20 years of age, who are able to reside safely in the community. These children have a tracheostomy and/or ventilator or complex medical/health conditions and need coordination of several multiple agencies and services.

There are specific agencies who are Medicaid Providers and certified to provide Medically Fragile Case Management Services. These agencies are:

1. Responsive Caregivers of Hawaii,
2. Aloha Care Services, Oahu,
3. Supporting Exceptional Children of Hawaii (SECOH), Oahu,
4. Blue Waters Resources, LLC, Oahu,
5. Hilo Medical Center Home Care Services, Hawaii, and
6. Public Health Nursing Branch, statewide.

The agency assigned to provide the Medically Fragile Case Management Services is the primary case manager for the child and is responsible to collaborate with public health nurses, physicians, and other community providers in coordinating the care the child will need when he/she is in the home. These services also include collaboration and coordination of non-health care services such as educational and recreational services.

- **Community-Based Waiver Programs for Children with Special Health Needs** are under the DHS. Children must be eligible for Medicaid. (Parent's income is NOT considered when making determination for Medicaid eligibility). Additionally, the child must be determined to be at a subacute or skilled nursing care facility level of care and can be cared for safely and cost effectively outside of a medical facility. Refer to the following summaries of waiver programs (see Appendix B).

- **Community-Based Waiver Program for Children and Adults with Diagnosis of Mental Retardation/Developmental Disabilities** under the DOH. Clients must be Medicaid eligible.

In addressing the comprehensive needs of the child, the DOE staff and Public Health Nurse (PHN) working with the child during the school day should include the case manager of the case management agency involved with the child and family. DOE staff and/or PHNs should work with the family to ascertain if any case management agency is involved and providing services to the child and family.

Appendix A

Allergic Reaction (Anaphylaxis)

Anaphylaxis is an extremely serious condition. It is an over-exaggerated response by the body to a substance to which a person is allergic.

All school staff should know which students have life-threatening allergies.

- An emergency plan should be developed for these children.
- Modification of the child's environment should be made as much as possible without unduly restricting the child's activities (i.e., if a student has severe peanut allergies, effort should be made to remove peanut products from the child's educational environment).
- Remember that some children may experience a delayed allergic reaction up to two hours following food ingestion, (i.e., peanuts, shellfish, or bee sting, etc.), therefore the student should be observed for any delayed reaction.
- In an extremely severe reaction, the onset is rapid and requires immediate attention to prevent death.

Symptoms of severe allergic reaction may include:

- hives all over body,
- paleness/sweating,
- seizures,
- confusion,
- feelings of apprehension,
- weakness,
- loss of consciousness or shock,
- flushed face,
- tingling around mouth or face,
- difficulty breathing, and/or
- dizziness.

Management

- Refer to student's individualized health care plan, if available.
- Give medications only as authorized in the physician's written order. Some children may have a pre-measured dose of adrenalin (Epipen or Epipen Jr.).
- Do not leave the student alone—have others notify the parents, school administrator, and health aide.
- Calm and reassure child—calming reduces the distribution of the allergen in the body.
- Have someone call the school health aide and/or emergency 911 for ambulance/rescue service according to school policy.
- In the absence of breathing and/or pulse, begin mouth-to-mouth breathing and/or cardio-pulmonary resuscitation (if trained) as indicated.
- Notify parent/legal guardian.

Call 911 immediately if any of the following symptoms occur:

- difficulty breathing,
- difficulty swallowing,
- fainting and/or collapse, or
- convulsions.

Follow the **Emergency Action Plan for Severe Allergy** to _____ (see page F-17).

Asthma

Asthma is the leading chronic disease that affects children in Hawaii. It is one of the most common reasons for hospitalization, particularly for children. Caregivers of children often overlook asthma symptoms because common symptoms do not appear to be serious. Yet, symptoms like coughing after exercising or coughing at night can be an indication of a serious problem.

Asthma is a Lung Condition

With asthma, the airways (the windpipes) are super sensitive or “twitch” (hyperactive). Asthma is a chronic condition, which means the individual will have asthma for a long time. When asthma causes disease, there are usually three problems:

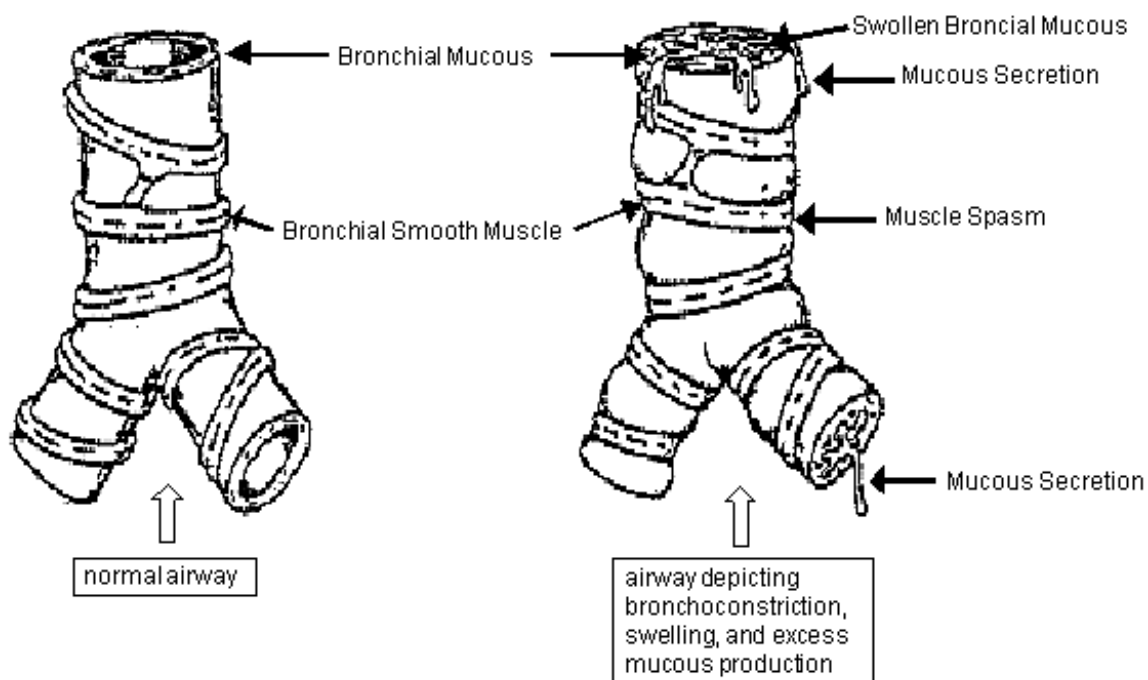
1. Hyperactivity of the airways, so the airways spasm;
2. Squeezing of the muscles around the airways (bronchoconstriction) so the airway becomes narrower than normal; and/or
3. Swelling and increased mucus inside the airway (inflammation) which also makes the airway narrower than normal.

This series of events can make it hard to breathe or may cause excessive coughing. Asthma is also called **Reactive Airway Disease (RAD)**.

What is an “Asthma Attack”?

The terms “asthma attack” and “asthma exacerbation” mean the same thing: **an acute breathing problem caused by asthma.**

Airway changes during an asthma episode:



TRIGGERS OF ASTHMA

A trigger is something that causes or initiates an asthma episode. It can start an episode at the time of contact with the trigger or later. Once triggers are identified, some of them can be avoided so that the student doesn't have asthmatic episodes. Sometimes the triggers cannot be avoided, but recognizing the trigger and warning signs allows treatment of the student at the earliest possible time. In young children, the most common trigger is a "cold" or viral upper respiratory infection. In other children, irritants or allergens can trigger asthma.

Some common triggers:

- cigarette smoke,
- smoke from a barbecue or wood burning stove,
- cleaning solutions, i.e., ammonia, bleach, PineSol, Lysol, and
- industrial solutions like paint, paint thinner, insecticides.

Other triggers:

ALLERGENS	<ul style="list-style-type: none">• Dust mites• Cockroaches• Pollen• Mold• Mildew• Pet dander (cats, dogs, birds)
HEALTH CONDITIONS	<ul style="list-style-type: none">• Colds• Flu• Sore throat• Respiratory infections
MEDICATIONS	<ul style="list-style-type: none">• For example, aspirin• Other medications
OTHER	<ul style="list-style-type: none">• Exercise• Emotional stress• Excitement• Laughing• Temperature changes

SIGNS OF ASTHMA ATTACK

Recognizing the student's symptoms early is important because they can be treated before they become severe. Common symptom's include:

- difficulty breathing,
- chest tightness or chest pain,
- coughing,
- breathing faster than normal (normal is 16–20 breaths per minute for a child 5–18 years old),
- getting out of breath easily, and/or
- cannot speak normally – only a few words at a time.

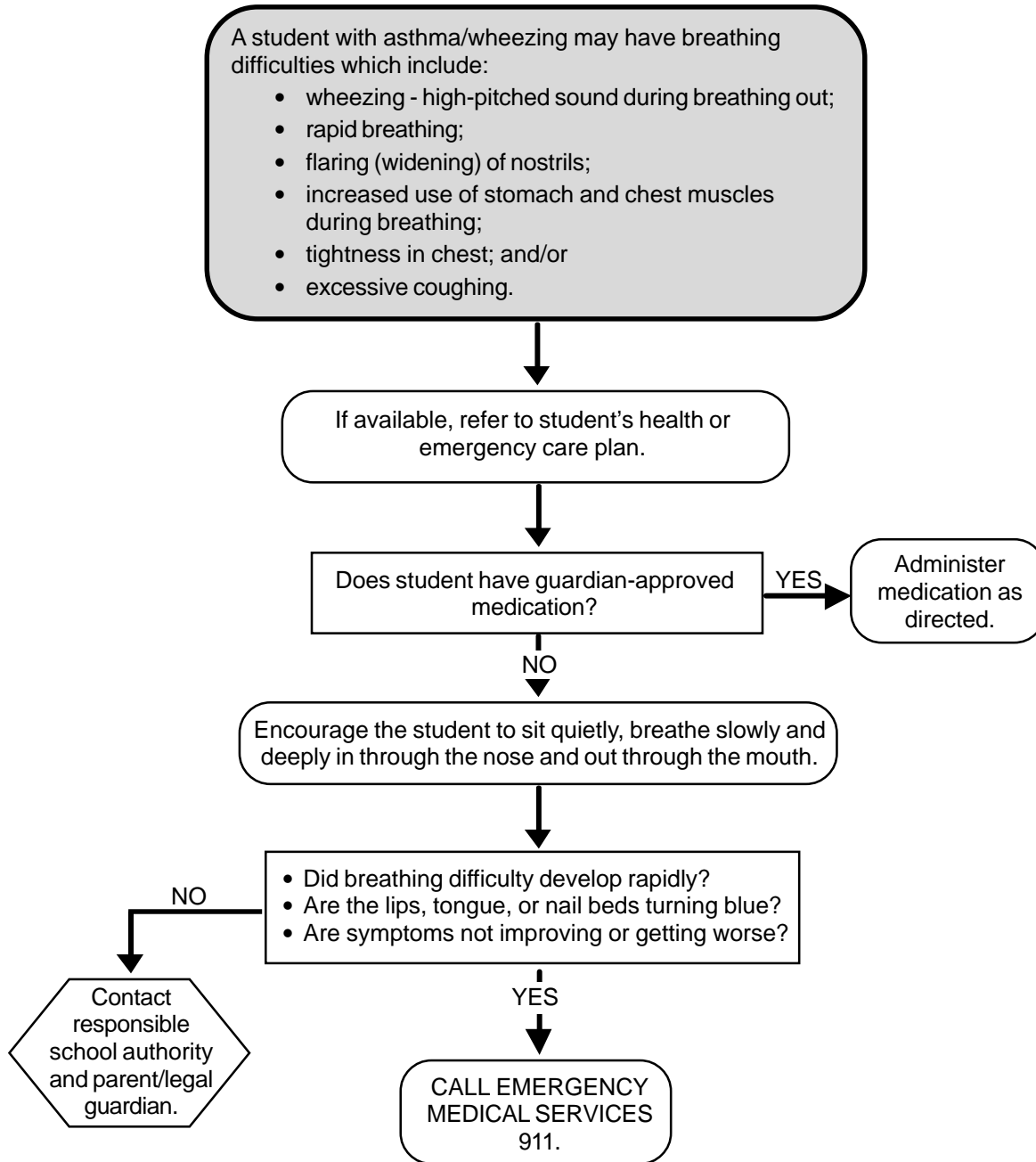
Prior to having an asthma “attack”, the child may have symptoms similar to the start of a cold. These may include:

- itchy, watery or glassy eyes,
- itchy, scratchy or sore throat,
- stroking chin or throat,
- sneezing,
- runny nose,
- congestion,
- headache,
- fever,
- change in face color,
- dark circles under eyes,
- poor appetite, and
- in very young children and babies:
 - belly breathing,
 - skin being sucked in at the top of the breast bone, between ribs, neck, shoulders,
 - skin being sucked in between ribs or breast bone,
 - grunting noise when baby exhales, or
 - nostrils flaring when baby breathes.

Follow the ***Emergency Action Plan for Severe Allergy to***____ (see page F-17), ***EpiPen Administration*** (see page F-18), and ***Request for Administration/Storage of Medication, Rescue Medication for Asthma*** (see page F-19).

Asthma/Wheezing/Difficulty Breathing

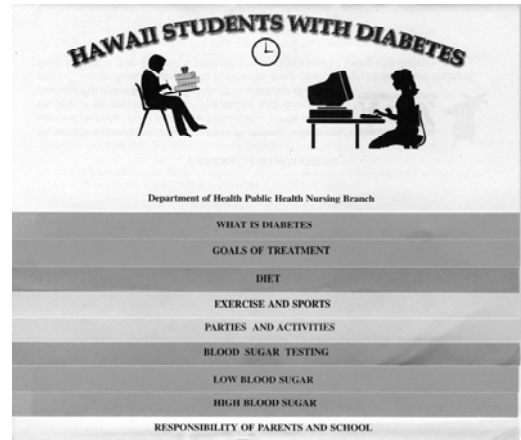
Students with a history of breathing difficulties, including asthma/wheezing, should be known to all school staff. A health/emergency care plan should be developed.



Diabetes

(Refer to “Hawaii Students with Diabetes” – Department of Health Public Health Nursing Branch.)

Diabetes is a chronic condition that prevents the body’s ability to use food (i.e., glucose) properly. Food is converted into energy for the body with the help of the hormone insulin. The student with diabetes usually has a pancreas that makes little or no insulin or the body (i.e., cells) develops resistance to the insulin. As a result, the body cannot properly use the food for energy, and blood sugar levels rise.



1. Children with diabetes usually have type-1 diabetes and need insulin injections every day. A growing number of children have type-2 diabetes, which is usually treated with pills or insulin, diet, and exercise.
2. Students with diabetes should be encouraged to participate in all usual student activities including parties and field trips. For possible activity limitations, see the Exercise and Sports section of “Hawaii Students with Diabetes.”
3. Regular class attendance should be expected. Recurrent illnesses are to be carefully evaluated by the student, parents, school staff, and physician or health care team.

The main goal of diabetes management is to MAINTAIN THE TARGET BLOOD GLUCOSE. The key to optimal diabetes control is careful balance or juggling of food, exercise, and insulin and/or oral medication. As a general rule, insulin and exercise make the blood glucose levels go down. Food makes blood glucose levels go up. Several other factors, such as stress, illness, or injury, can also affect blood glucose levels.

ROUTINE CARE: The need for assistance with diabetes care tasks will vary from student to student. Many students will be able to handle all or almost all of their routine diabetes care by themselves. *Some students will need help from school staff due to their age, developmental level, or inexperience.*

The school PHN is the most appropriate person in the school setting to oversee the care for a student with diabetes. However, because the school’s PHN is not always available to provide direct care, the school staff can and should be trained to assist students in both routine and urgent care.

The school’s PHN should write an Individual School Diabetes Plan (ISDP) to identify the specific needs of the student and all the elements of routine and urgent care necessary to assist the student in school. This plan includes the EAP that addresses how to recognize and treat hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar). (See pages F-22 and F-23.)

The ISDP is implemented by the school diabetes team (School PHN, School Health Aide, student, parent, and other school personnel).

Hypoglycemia (Low Blood Glucose)

Students may not be able to help themselves and are dependent on others to recognize that they are experiencing low blood glucose levels, and also to know how to treat the condition. Left untreated, hypoglycemia can lead to unconsciousness, seizures, and may even be life-threatening.

Hypoglycemia impairs cognitive and motor functioning. A student may be aware that he/she needs to eat but may not be able to problem-solve how to get the food, or may not have the fine motor skills to remove the juice lid or open a cracker package. Some students may become combative and/or verbally abusive. Hypoglycemia can often be mistaken for misbehavior.

Hypoglycemia is one of the most frequent complications of diabetes. If recognized and treated early, an emergency situation can be avoided. Most hypoglycemic episodes respond within 10-15 minutes after the student eats a quick acting snack (i.e., juice, crackers, fruit). School staff needs to recognize the early symptoms and always have appropriate foods accessible.

Severe hypoglycemia is rare, but life-threatening if not treated promptly. If the student is unconscious and unable to eat or swallow, nothing should be placed in the student's mouth. A glucagon injection may need to be administered per student's EAP.

Hyperglycemia (High Blood Glucose)

An isolated high blood glucose reading is cause for concern, but not alarm. Blood glucose is expected to be higher following a meal or snack.

Hyperglycemia can occur more rapidly in students with insulin pumps if a pump malfunctions or delivers less insulin. If there is insufficient insulin, there may be a breakdown in fat, causing ketones to form. Ketones may build up in the blood and may result in diabetic ketoacidosis (DKA).

High blood glucose can affect a student's general well-being. Students who do not feel well are less able to learn and participate in school activities. When glucose remains high over time or is reoccurring, serious life-limiting complications of diabetes develop. Diabetes is the leading cause of adult blindness, lower limb amputations, and kidney failure. It can also cause heart disease.

Treating high blood glucose enables students to participate fully in their education and enhances their health and future well being.

Blood Glucose Monitoring

Students need to check their blood glucose levels routinely before meals and snacks and before, during, or after exercise. Blood glucose levels should be checked during periods of stress or illness, when low or high blood glucose is suspected, or when there are changes in medication, meals, or activity.

(See pages F-20 and F-21 for **REQUEST FOR INDIVIDUALIZED PROCEDURES IN SCHOOL: STUDENTS WITH DIABETES** and **ALGORITHMS for BLOOD GLUCOSE RESULTS**.)

Seizure Disorder

Seizure or convulsion is a symptom seen in students with a medical condition called epilepsy. A student with a diagnosis of epilepsy may have frequent episodes of seizure activity not related to high fever or damage to the brain. Each student's seizure pattern is different.

There are three main characteristics of seizures:

- sudden onset,
- duration varying from a few seconds to several minutes, and
- abrupt termination.

There are varying types of seizures:

- Partial seizures: the student may be aware of seizures occurring; consciousness is not impaired.
- Petit mal seizures: the student may have brief episodes of loss of consciousness, eye or muscle fluttering without loss of body tone, or even staring spells. The student generally resumes activity when the episode is over and is unaware that anything has happened.
- Grand mal seizures: the student may have jerky bodily movements that can be described as sudden stiffening of the body with arching of the back, and then go into an unconscious state. If standing or sitting, the student may fall to the ground. There will be extreme stiffness of the body with muscle contractions. The student may lose control of urine and bowel functions. This attack may last from 2-5 minutes.

Medications are used to control epilepsy. Some students are on a single anti-seizure medication, while other students may require multiple medications.

Cognitive functions may be impaired, and processing skills may be impacted with the student taking a longer time to process information or needing more time to learn.

Management

An EAP for the student should be developed so everyone around the child is trained and prepared to respond appropriately.

GUIDELINES for the CARE OF STUDENTS WITH SEIZURES
(except convulsive seizures – see Emergency Action Plan for Seizures [pages F-24 and F-25])

Role of school staff	Role of School PHN	Role of Parents
<p>Understand the type of seizure disorder for which student has been diagnosed and what to do when seizure occurs.</p> <p>Participate in developing a care plan to address special considerations for the student when seizures occur, during school activities, and/or to maintain a safe environment.</p> <p>Request training from the health care professional or school PHN on seizure disorder and what to do in the event of a seizure.</p> <ul style="list-style-type: none"> • Guidelines: Actions for Seizures • Emergency response 	<p>Assess the health needs of the student while in school in order to address optimal participation in academic and school activities. Request primary care provider (PCP) and specialist input: [i.e., pediatric gastroenterologist, pediatric cardiologist, pediatric pulmonologist].</p> <p>Assist school staff as health care professional on the school team in developing a care plan for the student in partnership with parent. (Reference: Seizure Training for School Personnel 2005, Epilepsy Foundation)</p> <p>Develop an emergency action plan, if student experiences convulsive seizures.</p> <p>Provide general information about seizure disorder and student-specific information to school staff including: Guidelines: Actions for Seizures as well as Emergency response to convulsive seizures if necessary.</p>	<p>Partner with school and school PHN in sharing student-specific information regarding type of seizure, frequency, duration, triggers, medications, other treatments and pertinent information that will assist the school and nurse to address student's needs in school.</p> <p>Help the school team to develop a care plan and an emergency action plan, if needed.</p> <p>Participate in assisting the nurse or health care professional to train school staff, as appropriate.</p>

GUIDELINES for the CARE OF STUDENTS WITH SEIZURES

(except convulsive seizures – see Emergency Action Plan for Seizures [pages F-24 and F-25])

Types of Seizures and Signs/Symptoms	Actions
<p>1. Generalized Seizures: involves whole brain</p> <p>a. Absence or petit mal</p> <ul style="list-style-type: none"> - Pause in activity with blank stare - Brief lapse of awareness - Possible chewing or blinking motion - Usually lasts 1 – 10 seconds - May be confused with: Daydreaming Lack of attention ADD <p>2. Partial Seizures: involves part of brain and symptoms relate to the part of brain effected</p> <p>a. Simple Partial</p> <ul style="list-style-type: none"> - Consciousness is not impaired - Involuntary movements (isolated twitching of arms, face, legs) - Sensory symptoms (tingling, weakness, sounds, smells, tastes, visual distortions) - Psychic symptoms (déjà vu, hallucinations, fear, anxiety, “a feeling they can’t explain”) - Duration usually less than 1 minute - May be confused with: acting out, mystical experience, mental illness, psychosomatic illness <p>b. Complex Partial</p> <ul style="list-style-type: none"> - Altered awareness - Blank stare/dazed look - Automatism (picking at clothes, lip smacking, chewing) - Nonsensical speech or lip smacking - Clumsy or disoriented movements - Aimless walking - Picking things up - Often lasts 1 to 3 minutes - Often followed by tiredness, headache, or nausea - May be confused with: Drunkenness or drug abuse Aggressive behavior 	<p>1. Because of altered state of awareness</p> <ul style="list-style-type: none"> • Stay with student. • Time seizure. • Record on seizure log. • Reassure student when awareness returns. <p>2.a. There is no change in consciousness</p> <ul style="list-style-type: none"> • Stay calm. • Time seizure. • Record on seizure log. • Reassure student that he or she is safe • Explain to others if necessary. • Protect student’s privacy. <p>2.b. Because of altered awareness</p> <ul style="list-style-type: none"> • Speak softly and calmly. • Direct away from potentially harmful objects. • Allow for wandering in contained area. • If lasts 5 minutes beyond what is routine for student or another seizure begins before full consciousness, follow Emergency Action Plan for Seizures. • Do not restrain or grab (may result in combativeness). • Do not shout or expect verbal instructions to be obeyed.

Reference: Epilepsy Foundation, Seizure Training for School Personnel, 2005

Seizures

Seizures may be any of the following:

- Episodes of staring with loss of eye contact.
- Staring involving twitching of the arm and leg muscles.
- Generalized jerking movements of the arms and legs.
- Unusual behavior for that person (i.e., running, belligerence, making strange sounds, etc.)

A student with a history of seizures should be known to all teachers. A detailed description of the onset, type, duration, and after-effects of the seizures should be taken and kept available at all times.

If available, refer to student's health or emergency care plan.

- If the student seems off balance, place him/her on the floor (on a mat) for observation and safety.
- **DO NOT RESTRAIN MOVEMENTS.**
- Move surrounding objects to avoid injury.
- **DO NOT PLACE ANYTHING BETWEEN THE TEETH** or give anything by mouth.

Observe details of seizure for parent/legal guardian, emergency personnel or physician. Note:

- duration,
- kind of movement of behavior,
- body parts involved, and/or
- loss of consciousness, etc.

Is:

- student having a seizure lasting longer than **5 minutes?**
- student having seizures following one another at short intervals?
- student *without a known history* of seizures, having a seizure?

After seizure, keep the airway clear by placing the student on his/her side. A pillow should not be used.

NO

Seizures are often followed by sleep. The student may also be confused. This may last from 15 minutes to an hour or more. After the sleeping period, the student should be encouraged to participate in normal class activities.

YES

CALL EMERGENCY MEDICAL SERVICES 911
Contact responsible school authority and parent or legal guardian.

Hydrocephalus

Hydrocephalus is an abnormal accumulation of cerebrospinal fluid (CSF) in the brain. Hydrocephalus is sometimes called “water on the brain.” (The word “Hydrocephalus” in Greek literally means “watery head.”) This condition can arise before birth or at any age.

Hydrocephalus can be due to many causes including a birth defect, hemorrhage into the brain, infection, meningitis, tumor, or head injury. Most forms of hydrocephalus are the result of an obstructed flow of CSF into the ventricles or normal cavities in the center of the brain. Increased CSF in the brain can compress and damage the brain.

The key sign of hydrocephalus in infants is an abnormally large head. This occurs because of the constant outward pressure on the brain and skull from the CSF during the development and growth of the head. In older children, symptoms of hydrocephalus include headaches, nausea, vomiting, and blurred vision.

Contact the PHN assigned to your school for:

- Development of an EAP (see page F-26, “Increased Intracranial Pressure Emergency Action Plan”).
- Clarification from parent and child’s physician as to the student’s ability to participate in sports/activities to avoid impact to the head. Some neurosurgeons may recommend the student avoid contact sports that may impact on the head or the use of protective headgear.
- The EAP which delineates signs and symptoms to watch for. It is important to keep the student in a sitting position with head supported upright to avoid increased pressure on the brain due to improper positioning (i.e. gravity).
- Other symptoms to watch for that may impact on learning: memory loss, difficulties in engaging in learning activities, cognitive processing difficulties, etc.

Other Health Considerations

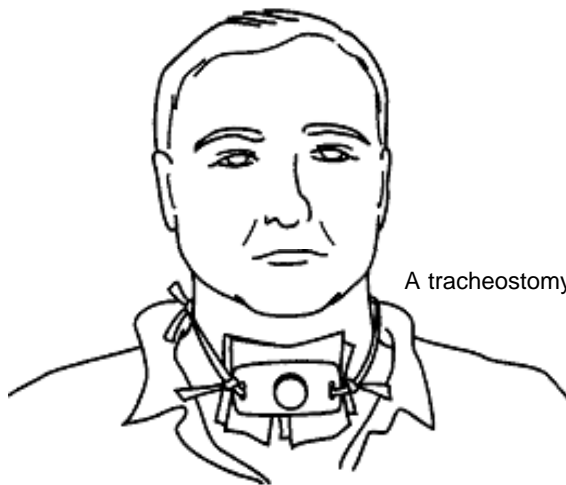
Some children may come to school with assistive medical devices/appliances that may require attention during the school hours. Many receive the skilled nursing services provided by a licensed nurse. Contact the PHN assigned to your school if you have questions or concerns.

Stomas

Anyone can have a stoma (Greek word for opening). Stomas are created surgically by a procedure known as an ostomy. A stoma is not a disease, but is required because of a congenital or chronic health condition/disability, infection, or trauma. Individuals with a stoma are no different from anyone else, but have an alternative way of breathing, eating, or eliminating waste.

Tracheostomy

An incision is made through the neck into the windpipe (trachea) to allow breathing when the normal pathways are impaired. A tracheostomy tube is then inserted into the stoma (opening), which keeps the hole open. The tracheostomy bypasses a person's nose and mouth and becomes his or her airway. People with a tracheostomy may not be able to communicate effectively with staff or family and may rely on the ability of others to read their lips or use other communication strategies such as writing or a letter board.



A tracheostomy becomes a person's airway.

Management

- Tracheostomy care involves specialized procedures and should be done by a qualified health professional. Most children who attend school probably have had their tracheostomy for several months, and if the trach tube comes out it would take days or weeks for the tracheostomy to close.
- It is not necessary for school personnel to attempt to replace the tube.
- In most situations, if the tube should fall out or be coughed out while the student is in school, the student could continue to breathe through the hole in the throat until the nurse replaces the tube or the student is taken to the doctor.

Periodic suctioning may be necessary to remove secretions that accumulate and to maintain the airway. Suctioning requires inserting a small catheter into the tracheostomy tube. To properly care for a child with a tracheostomy tube, a portable suction machine may be needed. The

frequency and extent of care needed varies with each student. The physician, in collaboration with the school nurse and parents, should develop a procedural care plan and standing orders.

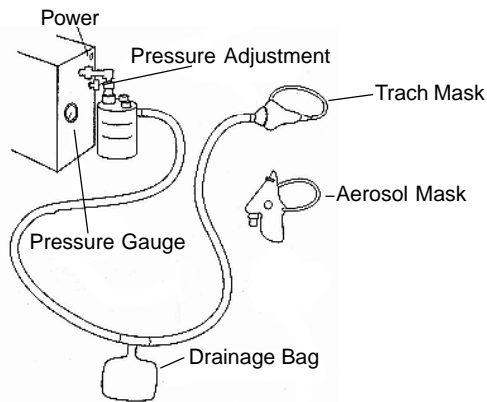
Safety Measures

- Cover the tracheostomy tubes with a cloth or ensure “artificial nose” or passymuir is attached when the student is outside in the wind or dust.
- When feeding, cover the tracheostomy with a cloth bib to prevent inhaling food into the tracheostomy.
- Do not use aerosol sprays or powder around the student.
- Control infection by washing your hands often, using clean equipment, and using aseptic techniques as appropriate (i.e. as close to germ free as possible).

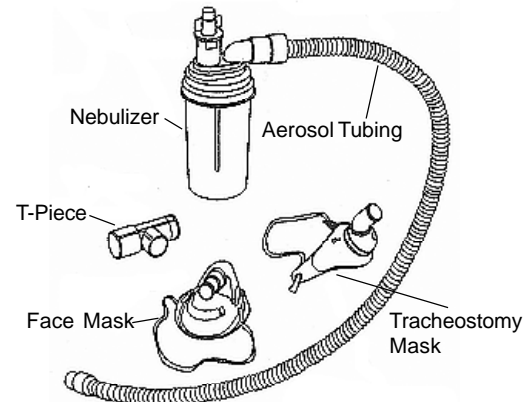
Nebulizer

A nebulizer is a device used to humidify air or deliver medication in a mist form. When breathing through a tracheostomy, the air no longer passes through the nose where it normally would be warmed, filtered, and humidified. Because of this, most patients require a nebulizer that humidifies the air delivered to the trachea and lungs. A large volume nebulizer provides this humidification and is commonly used.

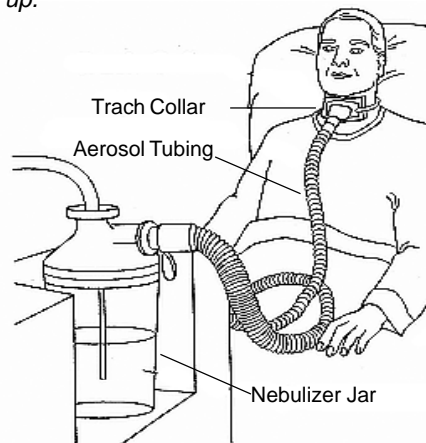
Using an Air Compressor and Large Volume Nebulizer for Continuous Mist to the Trach, Stoma, or with a Face Mask



A typical trach mist set up.



A typical nebulizer set up.



A typical mist-to-trach application.

Apria Healthcare, "Patient Instructions, Air Compressor and Large Volume Nebulizer", January 2003.

Ventilator

In some situations, a child with a tracheostomy is ventilator dependent.

- Mechanical ventilation is the use of a machine to induce alternating inflation and deflation of the lungs to assist the child with breathing.
- The ventilator is used to sustain children whose spontaneous breathing is inadequate or has stopped altogether due to acute or chronic diseases of the neuromuscular, neurologic, pulmonary system, or as a result of trauma.
- Portable ventilators allow mobility and participation in physical activities.
- The continuing need for mechanical ventilation may be total (i.e., 24 hours a day) or it may be limited to only when sleeping, or intermittently through the day.

Management

When a child is physiologically stable and able to attend school, the IEP team needs to consider placement where nursing care is available on a regular basis.

- If the child cannot perform any self-care, the child will need full support from the school staff and family.
- Some children will need full-time skilled nursing care because of the complexity of care required.
- The family is responsible to make available to the school appropriate equipment and supplies required for the care of the child during school hours.

(See page F-11 for **Request for Individualized Procedures in School - Tracheostomy**.)

Gastrostomy

When a child cannot be fed by mouth, an opening is made in the abdominal wall and a tube inserted directly into the stomach (gastrostomy). A qualified individual can give liquid or semi-liquid foods directly through the gastrostomy. The amount of food, as prescribed by the physician, varies greatly and is based on age, weight, and physical condition. The doctor may also prescribe blenderized table food for the child. The child's feeding, as at any mealtime, should be a social event where the child can join others during their regular meals.

Tube Feedings:

- To prevent vomiting, the child should be in an erect or semi-erect position during the feeding.
- A small child may be cradled.
- The liquid food is allowed to slowly run down the tube by gravity or by a mechanical pump.
- After completion of the feeding, enough water should be given to clear the tube (usually prescribed by the physician) and the free end of the tube is clamped shut.

Some students are fed with a tube inserted through the nose, which goes down the back of the throat, and into the stomach (a nasogastric tube). A tube that starts in the mouth is an orogastric tube. Nose and mouth tubes are changed by parents and healthcare professionals as prescribed by the physician to prevent irritating the lining of the nose and throat.

Some students may use a combination of oral and tube/gastrostomy feedings. Certain health professionals (i.e., occupational therapists, nutritionists, nurses, and speech pathologists) are trained to work with feeding problems and can be consulted (see dysphagia, pages 25-27).

Management

Follow any specific directions you receive for positioning the student prior to and after feeding — usually the student's head is at least at a 45-degree angle.

- Keep the tube in the proper place between feedings. The tube can be taped in an unobtrusive position under the student's clothes.
- The mouth should be cared for even if the child is not feeding orally. Teeth, gums, and tongue should be brushed daily.
- If the tube comes out or gets plugged, replacement of the tube is not an emergency. If the tube comes out, tape several pieces of gauze over the opening. The child can be taken home to have it replaced.

(See page F-9 for **Request for Individualized Procedures in School - Gastrostomy** and F-10 for **Emergency Action Plan**.)

Colostomies, Ileostomies, Urostomies

For some children with inflammatory bowel diseases (i.e., ulcerative colitis, Crohn's), cancer, congenital abnormalities, or trauma, an opening in the abdomen is required for the removal of waste products from the body. The three main types of abdominal ostomies are colostomy, ileostomy, and urostomy.

Colostomy:

- An opening in the large bowel or colon is surgically created.
- Part of the colon is removed or disconnected.
- All or part of the rectum may also be removed.
- The end of the remaining colon is brought to the surface through the abdomen.
- Discharge from a colostomy will vary in consistency, depending on the location of the colostomy.
- The colon absorbs water as stool passes through it; the more usable the colon remains after surgery, the more likely the discharge is to be solid with predictable frequency.

Ileostomy:

- The small intestine or small bowel is made up of the duodenum, jejunum, and ileum.
- In an ileostomy, a portion of the ileum is brought through an opening in the abdomen.
- The entire colon is removed.
- The discharge is fairly constant and watery, and can be irritating to the skin around the stoma.

Urostomy: The bladder, which is the storage vessel for urine, is removed or bypassed. There are two kinds of urostomies:

- The ureters (which carry urine from the kidneys) are attached to a short piece of intestine, which forms the urinary stoma.
- In an ureterostomy, one or both ureters are brought directly to the surface of the abdomen.

Management:

Because an ostomy may be a permanent condition, the basic goal is to promote personal habits and techniques that keep the skin and stoma healthy.

- Diet, proper food, and fluid intake are also an important consideration.
- Occasionally, the stoma bag may leak and need to be changed or emptied during school hours. If the student cannot manage this self-care procedure, any designated trained school personnel may assist.
- The public health nurse or physician can provide the appropriate instruction for ostomy care.
- The parents should provide all the necessary supplies: bags, cleansing pads, tape, etc., that are used at home.

Definitions

Children with Special Health Care Needs

As defined by the Maternal and Child Health Bureau (MCHB) of the U.S. Health Resources and Services Administration (HRSA): “Children with special health care needs are those who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.”

Medically Fragile Child

One end of the spectrum of children with special health care needs: those with the most severe medical problems and most complex medical service needs.

Working definition used by Kapiolani Medical Center: “The child with (a) severe (potentially life-threatening) disability(ies) who has reached his or her state of well-being which is maintained only with continuing complex interventions that are medical/nursing and/or technologic in nature.”

Definition used by the Department of Human Services under Medicaid, for Early Periodic Screening, Diagnosis, Treatment (EPSDT) Medically Fragile Case Management Services:

- Child with complex medical and/or nursing needs with/without a ventilator.
- Child with complex medical and/or nursing needs with stable cardio-pulmonary status who requires more than 10 hours of skilled nursing supervision due to the need for complex services and multiple technological interventions, not limited to catheterization, parenteral nutrition, complex enteral feeding, complex wound care, etc.

Child with Complex Medical Conditions

Child, with complex medical problems AND WITHOUT technological devices, for whom care coordination service is essential to prevent re-hospitalization. Examples: child with

- severe asthma,
- neurological sequelae,
- failure to thrive,
- prematurity/low birth weight,
- feeding difficulties,
- effects of perinatal substance use, or
- other biologic conditions.

***A Task Force was formed in 2001 to establish a common definition of medically fragile. SCR No. 15, H.D. 1: Requesting the Creation of A Coordinating Committee to Oversee The Care of Medically Fragile Children. A Specialized or Individualized Physical Health Care Plan includes those physician prescribed services that must be provided by a nurse or qualified, trained person during the school day to assist the student to benefit from education or to attend school, i.e., gavage feeding, suctioning, catheterization.*

Qualified Person

A “qualified person” can be school personnel trained and delegated to provide the nursing services by the nurse or physician in the administration of the specialized physical health care procedure(s).

Emergency Action Plan

A plan of action which is developed by the nurse in collaboration with the parent, physician, and school staff for children who have a known life threatening condition. Training on intervention(s) by the responsible parties is provided, as appropriate, by the nurse or physician.

Other Common Terminology

Aphasia

A disorder of language learning; the loss of the ability to express or understand language symbols (the spoken or written word) as a result of some central nervous system dysfunction. It can be expressive (or motor) in which the person can understand but cannot give back appropriate responses, receptive (or sensory) in which the person cannot understand language he/she hears or sees, or both.

Apraxia

A brain disorder characterized by loss of ability to manipulate and use common objects and execute planned movements.

Ataxia

The inability to coordinate the muscles in voluntary movement. **Ataxic** is often used to describe a staggering gait.

Athetosis

A condition in which slow, irregular, twisting, involuntary movements occur.

Cerebral Palsy

An “umbrella” term for a group of disorders resulting from central nervous system damage before, during, and after birth. Although non-progressive, these disorders may become more obvious as the infant grows older. Symptoms include paralysis, weakness, uncoordinated movement, and/or ataxia.

Conductive hearing loss

An interference with sound transmission in the outer part of the middle ear. Causes include wax accumulation and chronic ear infection.

Congenital

Any mental or physical trait or condition that exists at birth because of something that happened to the fetus during the time it was in the womb; it may or may not be hereditary.

Congenital hip dysplasia

An abnormality of the hip joint present from birth. It is the most common disorder that affects hip joints of children under the age of three. Congenital hip dislocation can cause abnormal joint development and permanent disability.

Cystic Fibrosis

An inherited disease of infants, children, and young adults. It causes abnormal gland secretions that are carried throughout the body in the blood. The hallmark of this condition is severe, chronic lung disease in children which is characterized by increased mucus production and thickness. It is also associated with malnutrition and diseases of the liver.

Duchenne's Muscular Dystrophy

A progressive disorder with muscle deterioration, usually beginning in childhood. The disease, mostly in males, is transmitted as a sex-linked recessive trait.

Hemiplegia

Paralysis of one side of the body. It is caused by a brain lesion involving the upper motor neurons which results in paralysis of the opposite side of the body.

Hypertonia

Excessive muscle tone.

Hypotonia

Less than normal muscle tone.

Idiopathic

Unknown cause.

Meningocele

A protrusion of the membranes around the brain or spinal cord.

Metabolic disorder

Any problem in the body that interferes with how food is built up or broken down in the body. Disorders are usually caused by an abnormality in enzyme production.

Multiple Sclerosis

A chronic, progressive disease of the central nervous system characterized by a patchy loss of myelin (fatty sheath) in the brain and spinal cord. The cause is unknown but an immunologic abnormality is suspected.

Paraplegia

Paralysis of the lower portion of the body and both legs due to a lesion or injury involving the spinal cord.

Progressive

Indicates an ongoing disease process during which the symptoms get worse. Examples of such diseases include multiple sclerosis, myasthenia gravis, brain tumor, and other rare degenerative diseases affecting the central nervous system. In certain conditions, the earliest symptoms observed are subtle changes in the higher cognitive functions. If the motor area of the brain is involved, a change in writing or physical ability may be noticed.

Quadriplegia

Paralysis of all four extremities and, usually, the trunk. The cause is an injury to the spinal cord in the cervical spine. The higher the injury, the less intact function and sensation is in the arms. An injury above the third cervical vertebra requires a mechanical respiratory device to maintain life as innervation to the diaphragm is lost.

Sensorineural hearing loss

A loss of function in the inner ear or on the path from the ear to the brain. Causes include birth defects, certain medications, and prolonged exposure to noise.

Spasticity

Increased tension/contractions of muscles causing stiff and awkward movements.

Syndrome

A group or set of symptoms that together make up a certain disease or condition.

Appendix B

GENERAL SUMMARY OF WAIVER PROGRAMS UNDER DHS

Waiver programs, part of Social Security Amendment 1915C, allow Medicaid to offer waiver funds to expand Medicaid State Plan services through home- and community-based services to those who would traditionally have been institutionalized. Waiver is not an entitlement. Services are based on funds available. The waiver program targets specific groups so there is a limitation on the number of clients accepted into the program. The focus is on alternatives to institutionalization. (The following information is from <http://www.state.hi.us/dhs/> under the heading "Social Services Division/Adult Services").

Waiver Program: **Nursing Home Without Walls (NHWW)**

Aged and Disabled Waiver

The NHWW waiver program is designed for children and adults who have significant functional/medical needs and require a variety of in-home support and services.

Eligibility Requirements

The person must:

- Be eligible for Medicaid (Parents' income NOT considered when making determination)
- Be aged or disabled
- Be Nursing Facility (NF) level of care (ICF or SNF) or Hospital level of care

This program serves all ages.

Services

People in the NHWW and their families can choose from the services below to design a package that meets their specific needs. They can also choose the case managers and other providers with whom they wish to work.

- Case Management
- Personal Assistance
- Adult Day Health
- Private Duty Nursing
- Respite Care
- Environmental Accessibility Adaptations
- Specialized Medical Equipment and Supplies
- Non-Medical Transportation
- Home Delivered Meals
- Counseling and Training
- Personal Emergency Response
- Home Maintenance
- Moving Assistance

Contact Information

For more information and to apply for services, unless indicated otherwise, call the Department of Human Services, Adult and Community Care Services Branch (ACCSB) on your island, Monday through Friday, between 7:45 a.m. and 4:30 p.m.

ACCSB Offices: (Area Code 808)

Oahu: 832-5115

Kauai: 241-3337

Maui: 243-5151 (Also covers Lanai and Molokai)

East Hawaii: 933-8820

West Hawaii: 327-6280

Waiver Program: **Developmentally Disabled/Mentally Retarded Program (DD/MR)**

The DD/MR waiver program provides home- and community-based care for persons with developmental disabilities and mental retardation who would otherwise receive such services in an Intermediate Care Facility for persons with mental retardation (ICF/MR).

The goal of this program is to reduce and prevent unnecessary institutionalization by providing home- and community-based services at a cost less than or equal to institutionalization.

Eligibility Requirements

The person must:

- Be Medicaid eligible (Parents' income NOT considered when making determination)
- Be Intermediate Care Facility - Mentally Retarded (ICF-MR) level of care
- Choose to receive home- and community-based services as an alternative to institutional placement

This program serves all ages.

Services

Persons in the DD/MR Waiver and their families can choose from the services below to design a package that meets their specific needs. They can also choose the case managers and other providers with whom they wish to work.

- Adult Day Health
- Environmental Accessibility Adaptations
- Specialized Medical Equipment and Supplies
- Supported Employment-Habilitation
- Personal Emergency Response System
- Specialized Services
- Respite Care
- Skilled Nursing
- Personal Assistance
- Habilitation
- Non-Medical Transportation

Contact Information

Admission to the program requires a referral from a Department of Health - Developmental Disabilities Division (DOH-DDD) case manager.

All individuals interested in these services but not known to DOH-DDD should contact the DOH-DDD intake office on their island as follows: (Area Code 808)

Oahu:

801 Dillingham Blvd., 2nd Floor
Honolulu, HI 96817

- CMU 1: 587-7564
- CMU 4: 587-7270
- CMU 5: 587-7685
- CMU 7: 587-7675
- CMU 8: 587-7281
- Fax: 587-7278

Oahu:

Kakuhihewa Building
601 Kamokila Blvd., Room 300
Kapolei, HI 96707

- CMU 2: 692-7485
- CMU 3: 692-7493
- Fax: 692-7502

- Lanai, Molokai, Maui: 984-8250
- Kauai: 241-3406
- East Hawaii: 974-4280
- West Hawaii: 322-4880
- North Hawaii: 887-8114

OAHU: Case Management Geographic Boundaries
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(As of 1/02/02)

- CMU 1:** Hawaii Kai, Kahala, Kaimuki through Kalihi/Kapalama/airport; this includes zipcodes: **96814, 96815, 96816, 96821, 96825, and 96826**
- CMU 2:** Ewa Beach (below Hanakahi Street/Ft. Weaver Road is the dividing line) to Waianae
- CMU 3:** Ewa Beach (Pahkapuna area below Ft. Weaver Road, Soda Creek/entry, West Loch Estates, old Ewa), Waipahu (excluding CT 87.01, 88, and 89.12) including Kunia/Village Park, Waikele Sea View/CrestView, Mililani, Wahiawa, Waialua to Turtle Bay
- CMU 4:** (a.k.a. Support Unit) Windward Oahu (Kahuku to Waimanalo); this includes zipcodes: **96717** (Hauula), **96730, 96731, 96734, 96744, 96762, and 96795**
- CMU 5:** (a.k.a. Specialized Case Management Unit) Waipahu (Census Tracts [CT] **87.01, 88 and 89.12**)
- CMU 6:** Not applicable at this time
- CMU 7:** Aiea, Pearl City, Salt Lake. This includes **96701, 96782 and 96818**
- CMU 8:** Zip codes: **96813, 96817 and 96819**

Waiver Program: **Residential Alternatives Community Care Program (RACCP)**

Aged and Disabled Waiver

The RACCP Medicaid Waiver is designed for adults [may include 18-21 year old DOE students] who have significant functional/medical needs and choose to live in an alternative community-based home because they can no longer live safely in their own home.

Eligibility Requirements

The person must:

- Be Medicaid eligible (Parents' income NOT considered when making determination)
- Be 18 years old or older
- Be Nursing Facility (NF) level of care (ICF or SNF)
- Be able to be served safely and cost effectively outside of a medical facility

Services

People in the RACCP and their families can choose the type of living environment that meets their specific needs. They can also choose the case managers and other providers with whom they wish to work.

- Case Management
- Respite Care
- Private Duty Nursing
- Specialized Supplies

Contact Information

For more information and to apply for services, unless indicated otherwise, call the licensed waiver contracted RACCP Case Manager(s) serving your island, Monday through Friday, between 7:45 a.m. and 4:30 p.m. (Click on the Residential Alternatives Community Care Program (RACCP)-Licensed Case Management Agency List.)

Waiver Program: **Medically Fragile Community Care Program (MFCCP)**

The Medically Fragile Children’s Waiver is designed for children who are born with or develop complex medical problems and whose families need support to keep them in the home or in a licensed child foster home.

Eligibility Requirements

The child must:

- Be eligible for Medicaid (Parents’ income NOT considered when making determination)
- Be under 21 years old
- Be Subacute level of care or Skilled Nursing Facility level of care (50 points on scale)
- Be able to be served safely and cost effectively outside of a medical facility

Services

MFCCP waiver services are provided in addition to authorized Medicaid State Plan program benefits such as private duty nursing, personal care, pharmaceuticals, medical equipment and supplies.

Children on the Medically Fragile Children’s Waiver and their families can choose from the services below to design a package that meets their specific needs. They can also choose the case managers and other providers with whom they wish to work.

- Case Management
- Respite Care
- Specialized Day Care
- Environmental Accessibility Adaptations
- Specialized Medical Equipment and Supplies
- Family Training
- Attendant Care
- Home Maintenance
- Moving Assistance
- Non-Medical Transportation

Contact Information

For more information and to apply for services, unless indicated otherwise, call the waiver contracted Case Manager(s) serving your island, Monday through Friday, between 7:45 a.m. and 4:30 p.m.

Hawaii:

Hilo Medical Center Home Care

1190 Waianuenu Avenue
Hilo, Hawaii 96720
Phone: 974-4720 Fax: 974-4718
Contact: Martha Miller, RN

Maui:

Responsive Caregivers of Hawaii

98-042 Kamehameha Highway
Aiea, HI 96701
Phone: 488-7391 Fax: 488-6952
Contact: Dr. Pattie Nishimoto, Administrator
Mary Lancaster, RN

Kauai:

Responsive Caregivers of Hawaii

98-042 Kamehameha Highway
Aiea, HI 96701
Phone: 488-7391 Fax: 488-6952
Contact: Dr. Pattie Nishimoto, Administrator
Mary Lancaster, RN

Oahu:

Aloha Care Services

94-216 Farrington Hwy, Suite 304
Waipahu, Hawaii 96797
Phone: 680-7955 Fax: 671-9449
Contact: Josephine Norris, RN

Oahu (continued):

Blue Water Resources, LLC

94-229 Waipahu Depot Road, Suite 401
Waipahu, Hawaii 96789
Phone: 678-3661 Fax: 678-3662
Contact: Sarah Suzuki, RN
Flora Velasquez, BSN, MSN

**Supporting Exceptional Citizens of Hawaii
(SECOH)**

708 Palekaua Street
Honolulu, Hawaii 96816
Phone: 453-1400 Fax: 453-1410
Contact: Sandy Conjugacion, Associate Dir.
Cheryl Au, RN
Gloria Iris, RN

Responsive Caregivers of Hawaii

98-042 Kamehameha Highway
Aiea, HI 96701
Phone: 488-7391 Fax: 488-6952
Contact: Dr. Pattie Nishimoto, Administrator
Mary Lancaster, RN

Waiver Program: **HIV Community Care Program (HCCP)**

Aged and Disabled Waiver

The HCCP waiver program is designed for children and adults who have significant functional/medical needs and require a variety of in-home support and services.

Eligibility Requirements

The person must:

- Be eligible for Medicaid (Parents' income NOT considered when making determination)
- Be aged or disabled
- Be Nursing Facility (NF) level of care (ICF or SNF) or Hospital level of care
- Have a diagnosis of HIV/AIDS

This program serves all ages.

Services

People in the HCCP and their families can choose from the services below to design a package that meets their specific needs. They can also choose the case managers and other providers with whom they wish to work.

- Case Management
- Personal Assistance
- Adult Day Health
- Private Duty Nursing
- Respite Care
- Environmental Accessibility Adaptations
- Specialized Medical Equipment and Supplies
- Non-Medical Transportation
- Home Delivered Meals
- Counseling and Training
- Personal Emergency Response
- Home Maintenance
- Moving Assistance

Contact Information

For more information and to apply for services, unless indicated otherwise, call the Case Managers on your island, Monday through Friday, between 7:45 a.m. and 4:30 p.m.

Oahu:
Queen's Community Based Programs
1301 Punchbowl Street
Honolulu, HI 96813
Phone: 547-4628 Fax: 547-4625
Contact: Pat LaFleur
Iwalani Moore

East Hawaii:
Big Island AIDS Project
P.O. Box 6129
Hilo, HI 96720
Phone: (808) 981-2824 Fax: (808) 981-2429
Contact: Kate Nawahine
Lisa Akana

ACCSB Offices:

Kauai: (808) 241-3337
Maui: (808) 243-5151 (Also covers Lanai and Molokai)
West Hawaii: (808) 327-6280

Appendix C

National School Lunch Program/School Breakfast Program Meal Substitutions for Students with Disabilities, Medical, or Other Special Dietary Needs

OHCNP SA DRAFT Policy: 02/13/06

Federal Child Nutrition regulations require participating School Food Authorities (SFA) to offer to all participants' breakfast, lunch, after school snacks and milk that meet the meal requirements identified in the program regulations.

Federal regulations further **require** schools to make substitutions to the standard meal requirements for students who are considered disabled and whose disability restricts their diet. See "Disabled Participants," below. CFR 210.10 (g)(1) and CFR 220.8 (d).

A SFA may, **at its discretion**, make substitutions for individual students who are not "disabled persons" but are unable to consume a food item because of medical or other special dietary needs (see "Participants With Medical or Other Special Dietary Needs" page3).

Generally, students with food allergies, intolerances or overweight students are not "disabled persons," and SFAs are not required to make substitutions for them. However, if a physician assesses that food allergies may result in severe, life-threatening reactions (anaphylactic reactions) or the over weight student is severe enough to substantially limit a major life activity, the student may then meet the definition of "disabled person," and the SFA foodservice personnel must make the substitutions prescribed by the physician.

Disabled Participants

"Disabled person" is defined as any student who has "a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment." "Major life activities" are defined as "functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working." SFAs participating in the Child Nutrition Programs are required to make substitutions or modifications to the meal requirements for those students with disabilities who are unable to consume the meals offered to non-disabled students.

Determinations of whether a student has a disability that restricts his or her diet are to be made on an individual basis by a licensed physician. The physician's medical statement of the student's disability must be based on the regulatory criteria for "disabled person" and contain a finding that the disability restricts the student's diet.

A student whose disability restricts his or her diet shall be provided substitutions in foods only when supported by a statement signed by a licensed physician. The medical statement shall identify:

1. The student's disability and an explanation of why the disability restricts the student's diet;

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2. The major life activity affected by the disability; and
3. The food or foods to be omitted from the student's diet, and the food or choice of foods that must be substituted. If the disability would require caloric modifications or the substitution of a liquid nutritive formula, for example, this information must be included in the statement. If the student's disability requires only textural modification(s) to the regular program meal, as opposed to a meal requirement modification, the medical statement is recommended but not required. In such cases, the purpose of the statement is to assist the SFA in providing the appropriate textural modification(s). Unless otherwise specified by the physician, the meals modified for texture will consist only of food items and quantities specified in the regular menus.

The SFA should provide parents or guardians with 7 CFR Part 15b.3 so that their physicians may correctly assess whether an individual disability meets the regulatory criteria. It is suggested that SFAs consider the use of the services of a Clinical Registered Dietitian in the area hospital to assist in implementing the medical statement, as appropriate.

The provisions requiring substitutions for a disabled student respond to the requirements of Section 504 of the Rehabilitation Act of 1973 and to the U.S. Department of Agriculture's implementing regulations, 7 CFR Part 15b.3, which provide that no otherwise qualified disabled individuals shall, solely on the basis of disability, be excluded from participation, [be] denied benefit of[,] or subjected to discrimination under any program or activity receiving federal financial assistance.

NOTE: Schools/Institutions should be aware that the Individuals with Disabilities Education Act (IDEA) imposes requirements on states that may affect them, including the service of meals even when such service is not required by the Child Nutrition Programs. For example, the individualized education program developed for a student under the IDEA may require a meal to be served outside of the regular meal schedule for program meals or may require a breakfast to be served in a school that does not participate in the School Breakfast Program. While the school may not claim these meals as program meals, it may use the same foodservice facilities or foodservice management company to provide these meals as it uses to provide program meals, and program funds may be used to pay for the costs associated with the IDEA-required meals.

Responsibilities of the School Food Service Operations

- SFA/school food service staff shall make food substitutions or modifications for students with disabilities.
- Substitutions or modifications for students with disabilities must be based on a prescription written by a licensed physician.
- The school food service is encouraged, but not required to provide food substitutions or modifications for children without disabilities with medically certified special dietary needs who are unable to eat regular meals as prepared.
- Substitutions for students without disabilities, with medically certified special dietary needs must be based on a statement by a recognized medical authority. A recognized medical

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authority shall be: Physician, Physician Assistant, Advanced Practice Nurse (APRN), and practicing Clinical Registered Dietitian.

- Under no circumstances are the school food service staff to revise or change a diet prescription or medical order.
- For USDA's basic guidelines on meal substitutions and accessibility, see Food & Nutrition Service Instruction 783-2, Revision 2, *Meal Substitutions for Medical or Other Special Reasons*.
- It is important that all recommendations for accommodations or changes to existing diet orders be documented in writing to protect the school and minimize misunderstandings. SFA should retain copies of special, non-meal pattern diets on file for reviews.
- The diet orders are not required to be renewed on an annual basis; however schools/institutions are encouraged to [ensure] review the diet orders often to ensure that they reflect the current needs of the student.

Participants With Medical or Other Special Dietary Needs

School food authorities may, at its discretion, make substitutions for individual participants who are not “disabled persons” but are unable to consume a food item because of medical or other special dietary needs. Such substitutions may only be made on a case-by-case basis when supported by a statement signed by a recognized medical authority. A recognized medical authority includes: Physicians, Physician Assistants, practicing Clinical Registered Dietitians, and Nurse Practitioners.

For those **non-disabled** participants, the supporting statement by the recognized medical authority shall include:

1. an identification of the medical or other special dietary need that restricts the participant’s diet; and
2. the food or foods to be omitted from the participant’s diet and the food or choice of foods that may be substituted.

School food authorities are **not** required to make substitutions for participants whose conditions do not meet the definition of “disabled person”. For example, individuals who have elevated blood cholesterol generally do not meet the definition of disabled person, and thus school districts are not required to make meal substitutions for them. In fact, in most cases, the special dietary needs of non-disabled participants may be managed within the normal program meal service when a well-planned variety of nutritious foods is available to students, and/or offer versus serve is available and implemented.

USDA Reimbursement and Meal Changes

Reimbursement for meals served with an authorized substitute food to disabled participants or to participants with other special dietary needs shall be claimed at the same reimbursement rate as meals that meet meal requirements. Furthermore, there shall not be a supplementary charge for the substituted food item(s) to either a disabled participant or to a participant with other special dietary needs.

DRAFT

In providing foodservices, recipients of federal financial assistance “may not discriminate on the basis of disability” and “shall serve special meals, at no extra charge, to students whose disability restricts their diet.” While any additional costs for substituted foods are considered allowable program costs, no additional Child Nutrition Program reimbursement is available. Sources of supplemental funding may include special education funds (if the substituted food is specified in the student’s individualized education program), the general account of the SFA, or the nonprofit school foodservice account.

Cooperation

When implementing meal substitutions, the SFA should work closely with the parent(s) or responsible family member(s) and with all other school, medical and community personnel who are responsible for the health, well-being and education of students with disabilities or with other special dietary needs to ensure that reasonable accommodations are made to allow such individuals’ participation in the meal service.

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:

Name:		Birth date:	Nickname:
Home Address:		Home/Work Phone:	
Parent/Guardian:		Emergency Contact Names & Relationship:	
Signature/Consent*:			
Primary Language:		Phone Number(s):	
Physicians:			
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:			

Diagnoses/Past Procedures/Physical Exam:	
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: _____

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

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

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

Antibiotic prophylaxis: _____ Indication: _____ Medication and dose: _____

Common Presenting Problems/Findings With Specific Suggested Managements		
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):
<p>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.)</p> <p><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></p> <p style="text-align: center;"> <input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Abuse Treatment <input type="checkbox"/> HIV/AIDS </p>	
<p>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>)</p> <p><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></p>	
Authorization Duration (This authorization will be in force and effect until the date or 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	
	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"> ▪ G-tube falls out: | → | <p>DOE staff:</p> <ul style="list-style-type: none"> ▪ Wash hands. Put on gloves. ▪ Cover hole with gauze. Tape in place. ▪ Contact primary caregiver, alternate, or available Public Health Nurse (PHN) for assistance. |
| <ul style="list-style-type: none"> ▪ G-tube (low-profile device) falls out: | → | <p>Nursing staff:</p> <ul style="list-style-type: none"> ▪ Follow instructions on reverse side of this page. ▪ Locate Emergency kit in student's bag. It contains foley catheters 12Fr, 14Fr, lubricant and syringe. ▪ Once in, tape foley to secure in place. ▪ Notify parent/guardian that tube was replaced via communication book . |
| <ul style="list-style-type: none"> ▪ Device is not fully dislodged: | → | <ul style="list-style-type: none"> ▪ Secure device with tape and notify parent/guardian. |
| <ul style="list-style-type: none"> ▪ If unable to insert foley catheter: | → | <ul style="list-style-type: none"> ▪ Call parent/guardian immediately. ▪ Tape catheter tip in opening to prevent complete hole closure. |

**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.



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:	Address:
Name of Individual/Organization That Will Receive the Individual's Protected Health Information	
Name:	Address:
Client/Patient Whose Protected Health Information is Being Requested	
First Name:	Last Name:
Address:	Birth Date (if known):
<p>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.)</p>	
<p>_____ Mental Health _____ Substance Abuse Treatment _____ HIV/AIDS</p>	
<p>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>)</p>	
<p>Authorization Duration (This authorization will be in force and effect until the date or event specified below. At that time, this authorization to use or disclose this protected health information expires.)</p>	
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, 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>DEPARTMENT OF HEALTH AUTHORIZATION</p> <p>Authorization to SHA/LPN by:</p> <p>_____ PHN</p> <p>DATE</p>
--

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.

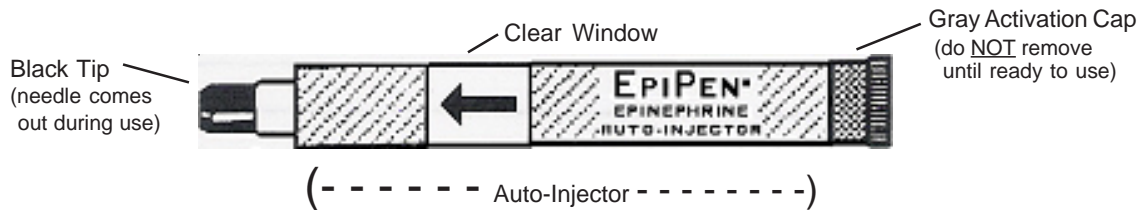
Names of School Personnel Trained:

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

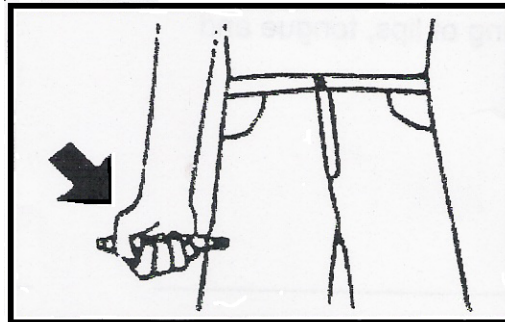
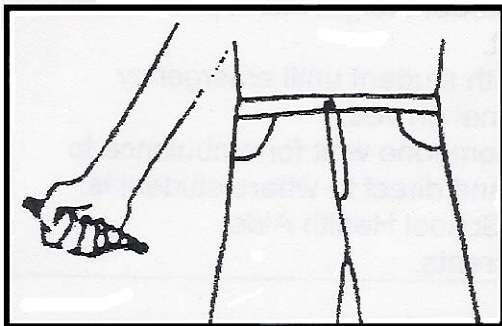


1. Form fist around auto-injector (black tip down).
2. Pull off gray activation cap.

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) and The Food Allergy & Anaphylaxis Network (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/LLEGAL GUARDIAN'S
NAME: _____
(type/print)

PARENT'S/LLEGAL 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)
Medication: * 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: _____

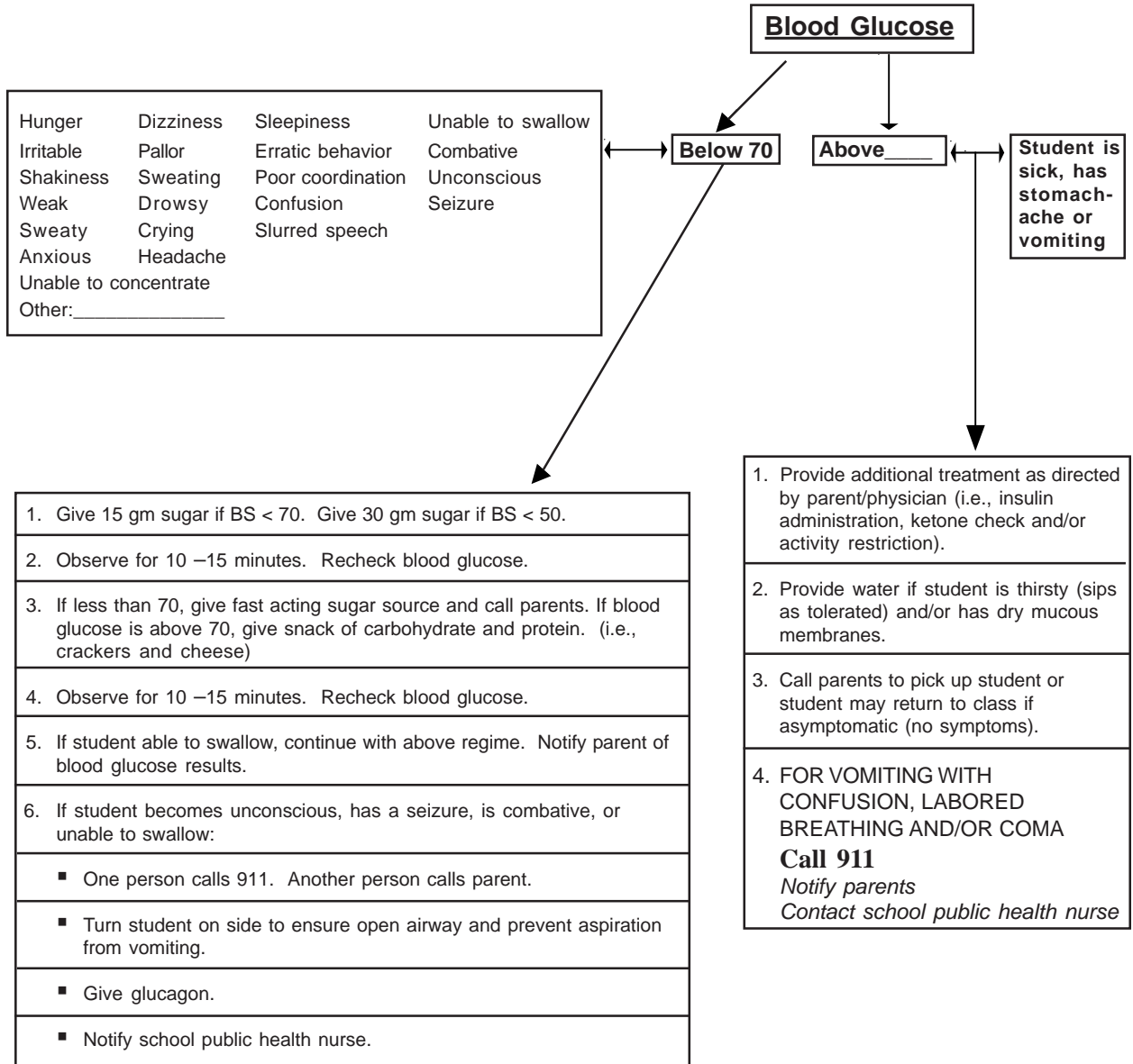
Physician's Name: _____
(type/print)

ADDRESS: _____

Telephone: _____ Fax: _____

<p>DEPARTMENT OF HEALTH AUTHORIZATION</p> <p>Authorization to SHA/LPN by:</p> <p>_____ PHN</p> <p>DATE _____</p>
--

ALGORITHMS for BLOOD GLUCOSE RESULTS Summary of Treatment Procedures



Fast Acting Sugar Sources (15 gms)	
• 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

Warning Signs and Symptoms:			
Behavioral Symptoms:		Physical Symptoms:	
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.

Warning Signs and Symptoms:		
Behavioral Symptoms:	Physical Symptoms:	
<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:

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"> 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. 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. 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. 4. Consult with primary care provider to develop a plan, if needed, to remedy the situation. Document in student's folder.
<p>Students who are fed through a G-Tube with orders to begin an oral feeding program:</p>	<ol style="list-style-type: none"> 1. Obtain a medical order/prescription from the primary care physician. 2. Collaborate/share information with private practice staff (feeding team). 3. Carry out ONLY 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). 4. Carry out written, outlined, program utilizing trained staff only. 5. Work with school nurse or educational staff to monitor child's weight on a monthly basis. 6. Obtain orders signed by a Hawaii licensed physician annually or when there are changes in the child's feeding program/status. 7. File orders in the child's school file.
<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"> 1. Contact the Medical Doctor and state concerns, and/or 2. Request consultation and an assessment by the school PHN who can further discuss issue(s) with the treating medical doctor. 3. Request a second opinion (may be at school's expense). 4. MONITOR and DOCUMENT behaviors that cause concern. 5. Work with school nurse or educational staff to monitor child's weight on a monthly basis. 6. Obtain signed orders annually or when there are changes in the child's feeding program/status. 7. File orders in the child's school file.

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).

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Special Education Services Branch
Office of Curriculum, Instruction and Student Support
Department of Education
637 18th Avenue, Room C-102
Honolulu, Hawaii 96816
(808) 733-4400

Children with Special Health Needs Branch
Family Health Services Division
Department of Health
Wilcox Annex
741 Sunset Avenue
Honolulu, Hawaii 96816
(808) 733-9070

Public Health Nursing Branch
Community Health Division
Department of Health
1250 Punchbowl Street, Room 210
Honolulu, Hawaii 96813
(808) 586-4620

Website for Department of Education
<http://doe.k12.hi.us>

Website for Public Health Nursing
<http://www.hawaii.gov/doh>
Click on "Family/Child Health", then "Public Health Nursing"

Center for Disease Control
<http://www.cdc.gov/healthyyouth>

Encyclopedia of Mental Health: describes specific disorders, treatments, and recent research
<http://www.mentalhealth.com>

Health Finder: resource from U.S. Department of Health and Human Services
<http://healthfinder.gov>

Mayo Health Clinic
<http://www.mayoclinic.com>

National Asthma Education and Prevention Program
<http://www.nhlbi.nih.gov/about/naepp>

National Institute of Health: main consumer health information
<http://health.nih.gov>

The Food Allergy & Anaphylaxis Network
<http://www.foodallergy.org>

School Health Information
<http://www.schoolnurse.com>

Guldmann Lift: for information on ceiling hoist
<http://www.guldmann.com>