

Millcreek Township School District

Pre-K Program

Health Safety Plan: Policy & Procedures

2023-24

- Staff will teach and periodically review proper handwashing protocol (i.e., use soap and water for 20+ seconds).
- Staff and students wash hands upon arrival, before and after eating, after using the restroom, and between transitions from one major activity to another. When soap and water is not readily available, hand-sanitizing lotion that is at least 60% alcohol content can be used when written parent permission is on file.
 - o For the Pre-K environment, hand-sanitizers will be stored out of reach of the Pre-K students and will only be used with adult supervision.
- Staff will teach and periodically review proper respiratory etiquette (i.e., covering your mouth and nose when sneezing or coughing, washing your hands after sneezing, coughing, and/or using tissue).

Introduction

This MTSD Pre-K Early Learning Program Health Safety Plan outlines critical policies and procedures to help ensure the health safety of the MTSD Pre-K Early Learning Program students and staff.

This Pre-K Early Learning Program Health Safety Plan addresses both the MTSD Pre-K Early Learning Program's role in preventing and mitigating the spread of illness in the school environment, as well as parents' role to prevent the spread of illness in the school environment. Additionally, this plan includes information on reportable illness, the Medication Policy, the Allergy Action Plan, the Asthma Action Plan, and the Seizure Action Plan.

The content of this plan is based on guidance from the Center for Disease Control, *Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide*, 5th Edition, *Caring for Our Children*, 4th Edition and is aligned with MTSD policies and procedures.

Prevention / Mitigation of Illness in the School Environment

Handwashing and respiratory etiquette:

- Staff will teach and periodically review proper handwashing protocol (i.e., use soap and water for 20+ seconds).
- Staff and students wash hands upon arrival, before and after eating, after using the restroom, and between transitions from one major activity to another. When soap and water is not readily available, hand-sanitizing lotion that is at least 60% alcohol content can be used when written parent permission is on file.
 - For the Pre-K environment, hand-sanitizers will be stored out of reach of the Pre-K students and will only be used with adult supervision.
- Staff will teach and periodically review proper respiratory etiquette (i.e., covering your mouth and nose when sneezing or coughing, washing your hands after sneezing, coughing, and/or using a tissue).

Cleaning and sanitizing:

- Staff will clean and sanitize Pre-K classroom learning materials. (Building Custodians clean and sanitize Pre-K classrooms as they do other spaces / classrooms in the school building.)
 - Cleaning involves washing with detergent and rinsing the items to remove dirt and most germs. If possible, the items will be air dried. Items which are visibly dirty need to be cleaned as soon as possible / before another student uses them. Items that have been placed in the child's mouth or that are otherwise contaminated by body secretion or excretion are likewise to be cleaned as soon as possible / before another student uses them. Otherwise, items should be washed on a weekly basis. A recommendation is to rotate center materials through a wash cycle weekly (e.g., blocks on Monday, math/science on Tuesday, dramatic play on Friday).
 - Sanitizing involves using a solution that reduces germs on inanimate surfaces to levels considered safe by public health codes and regulations. Food areas are to be sanitized before and after each snack or meal. High touch surfaces are to be sanitized daily, or more frequently if needed.
- Items that students may have their own set of, such as a caddy or pencil bag of often used materials, will be cleaned and sanitized when needed.

Home Screening, Required Exclusions for the Program, and Returning to School

Parents are to screen their children's health every day. Children who are ill:

- Are not able to comfortably participate in program activities.
- Have a need for care that is greater than the staff can provide without compromising the health and safety of the rest of the class and their ability to maintain an instructional focus.
- Pose the risk of spreading harmful diseases to others.

If a child is showing any one of the following *within 24 hours of drop-off to school*, s/he is not to attend their Pre-K Early Learning Program. Parents are encouraged to consult with their family doctor when their children experience any of these symptoms.

- Abdominal pain that lasts for 2 hours or more.
- Development of a rash or sores.
- Diarrhea.
- Fever of 100 or greater within previous 24 hours.
- Loss of taste and/or smell.

- Shortness of breath or difficulty breathing.
- Sore throat.
- Taken fever-reducing medicine within past 24 hours.
- Unusual or significant congestion / runny nose.
- Unusual or significant cough.
- Unusual or significant headache.
- Unusual or significant irritability.
- Unusual or significant lethargy.
- Unusual or significant muscle or body aches.
- Vomiting.

Returning to school: The student is able to return to their Pre-K Early Learning Program when:

- The child is fever free for 24 hours AND has had no fever-reducing medicine for 24 hours AND all symptoms are at least improved enough to comfortably participate in the program.

Other illnesses common for young children have additional condition-specific guidelines for when the child can return to the program:

- Chickenpox (varicella) – can return after all lesions have dried or crusted (usually 6 days after the onset of the rash).
- Head lice or nits – can return the day after treatment has started.
- Impetigo – can return 24 hours after medical treatment has started.
- Pink or red conjunctiva (i.e., whites of the eyes) with white or yellow eye mucus drainage can return the day after medical treatment has started.
- Scabies – can return after treatment has been given.
- Streptococcal pharyngitis (i.e., strep throat or other streptococcal infection) – can return 24 hours after medical treatment has started.

Note: This is not an all-inclusive list. Guidance from *Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide, 5th Edition*, *Caring for Our Children, 4th Edition*, and the CDC will be used to determine the child's return to the program.

Important Notes:

- *Persistent or recurring symptoms not associated with infectious condition:* If one or more symptoms persist, excluding the fever symptom, the parent is encouraged to consult with his/her family doctor to determine if it is appropriate for the child to return to school with the lingering or recurring symptom(s). If the doctor determines it appropriate, s/he can provide a note identifying the symptom(s) that persist and state that the child is cleared to return to school. This note must be signed by the doctor and provided to the child's teacher / program staff by 3 pm the day before the child returns.

- *Child develops symptoms during the program:* If a child develops any of the above symptoms during their time in the class / program, the parent will be contacted. Depending upon the severity of the symptom, the parent may be required to pick his/her child up before the end of the class / program.
- *Minor illnesses / minor symptoms:* Children experiencing minor illnesses / minor symptoms are not required to be absent from school. Minor runny noses, slight headache, slight fatigue, occasional sneezing, and occasional coughing not associated with a fever or breathing difficulties should be monitored, but do not require absence from school *as long as the child can comfortably participate in the program*. If the program staff determine the child is not comfortably participating in the program, the parent will be notified to come pick up his/her child.

Reportable Diseases:

The parent/guardian must notify the Pre-K Early Learning Program staff person within 24 hours after their child or any member of the immediate household has developed a known or suspected infectious or vaccine-preventable disease. When a child has a disease or illness that may require exclusion, the parent/guardian should inform the staff person of the diagnosis.

The MTSD Pre-K Early Learning Program will inform parents as follows:

- The Pre-K Early Learning Program will inform parents of enrolled children when there is a suspected outbreak of a communicable disease or an outbreak of an unusual illness that represents a public health emergency in the opinion of the Department of Health.
- If a student or staff person is infected with a vaccine-preventable disease, MTSD Pre-K Early Learning Program will inform parents of children who are unvaccinated for that vaccine-preventable disease and may have been exposed to that disease.
- If there are 2 or more cases of an infectious condition in a program or class, MTSD Pre-K Early Learning Program will notify parents of children in that program or class that their child may have been exposed to that infectious condition.
- The purpose of these notifications is to make parents aware of their children's possible exposure to an infectious disease so they may monitor their children for symptoms and are encouraged to consult with their health care provider if they have any concerns.
- Confidentiality will be maintained regarding the persons who have the communicable disease.

The PA Department of Health maintains a list of reportable diseases. The MTSD Pre-K Early Learning Program is required to report when a student or staff person has any of the illnesses as indicated in the Appendix A: List of Reportable Diseases to the PA Department of Health.

Medication Policy:

The MTSD Pre-K Early Learning Program follows the MTSD Medications Policy # 210. If a child has a medication that may be needed while in the program as authorized by a medical professional, a medical plan for that child will be developed and communicated prior to the student's participation in the program. See Appendix B for MTSD Medication Policy #210, Appendix C for MTSD Medication Guidelines for Policy 210, Appendix D for the Authorization for Medication for Policy 210, and Appendix E for the Medication Log for Policy 210.

Allergy Action Plan:

If a student is being treated for an allergy, the parent completes an Allergy Action Plan form. The parent meets with the program team to review and sign the plan prior to the student's participation in the program. See Appendix F for a template Allergy Action Plan.

If there is a medication related to the student's allergy that needs to be on site while the student is in the program, the appropriate medication forms must be completed. See Appendix B for MTSD Medication Policy #210, Appendix C for MTSD Medication Guidelines for Policy 210, Appendix D for the Authorization for Medication for Policy 210, and Appendix E for the Medication Log for Policy 210.

Note: Any medication must be documented on the MTSD Authorization for Medication form, and any administration of the medication must be documented on the MTSD Medication Log, even if it is noted on the Allergy Action Plan.

Asthma Action Plan:

If a student is being treated for asthma, the parent completes an Asthma Action Plan form. The parent meets with the program team to review and sign the plan prior to the student's participation in the program. See Appendix G for a template Asthma Action Plan.

If there is a medication related to the student's asthma that needs to be on site while the student is in the program, the appropriate medication forms must be completed. See Appendix B for MTSD Medication Policy #210, Appendix C for MTSD Medication Guidelines for Policy 210, Appendix D for the Authorization for Medication for Policy 210, and Appendix E for the Medication Log for Policy 210.

Note: Any medication must be documented on the MTSD Authorization for Medication form, and any administration of the medication must be documented on the MTSD Medication Log, even if it is noted on the Asthma Action Plan.

Seizure Action Plan:

If a student is being treated for a seizure disorder, the parent completes a Seizure Action Plan form. The parent meets with the program team to review and sign the plan prior to the student's participation in the program. See Appendix H for a template Seizure Action Plan.

If there is a medication related to the student's seizure disorder that needs to be on site while the student is in the program, the appropriate medication forms must be completed. See Appendix B for MTSD Medication Policy #210, Appendix C for MTSD Medication Guidelines for Policy 210, Appendix D for the Authorization for Medication for Policy 210, and Appendix E for the Medication Log for Policy 210.

Note: Any medication must be documented on the MTSD Authorization for Medication form, and any administration of the medication must be documented on the MTSD Medication Log, even if it is noted on the Seizure Action Plan.



List of Reportable Diseases

(PA Code, Title 28, Chapter 27 | Updates 1 & 2 requiring electronic reporting.)

1. AIDS (Acquired Immune Deficiency Syndrome) \$
2. Amebiasis
3. Animal bite #
4. Anthrax #
5. An unusual cluster of isolates
6. Arboviruses (includes Colorado tick fever, Crimean-Congo hemorrhagic fever, dengue, Eastern equine encephalitis, St. Louis encephalitis, West Nile virus infection, Yellow fever, et al.) #
7. Botulism (all forms) #
8. Brucellosis
9. Campylobacteriosis
10. Cancer ^
11. CD4 T-lymphocyte test result with a count <200 cells/microliter, or a CD4 T-lymphocyte % of <14% of total lymphocytes \$
12. Chancroid
13. Chickenpox (*Varicella*)
14. *Chlamydia trachomatis* infections
15. Cholera #
16. Congenital adrenal hyperplasia (CAH) (<5y/old)
17. COVID-19 #
18. Creutzfeldt-Jakob Disease
19. Cryptosporidiosis
20. Diphtheria #
21. Encephalitis (all types)
22. Enterohemorrhagic *E. coli* (shiga toxin-producing *E. coli* or STEC) # *
23. Food poisoning outbreak #
24. Galactosemia (<5y/old)
25. Giardiasis
26. Gonococcal infections
27. Granuloma inguinale
28. Guillain-Barre syndrome
29. *Haemophilus influenzae* invasive disease # *
30. Hantavirus pulmonary syndrome #

31. Hemorrhagic fever #
32. Hepatitis, viral, acute and chronic cases
33. Histoplasmosis
34. HIV infection \$
35. Influenza (laboratory-confirmed only)
36. Lead poisoning #
37. Legionellosis #
38. Leprosy (Hansen's Disease)
39. Leptospirosis
40. Listeriosis
41. Lyme disease
42. Lymphogranuloma venereum
43. Malaria
44. Maple syrup urine disease (MSUD) (<5y/old)
45. Measles (Rubeola) #
46. Meningitis (all types--not limited to invasive *Haemophilus influenzae* or *Neisseria meningitidis*)
47. Meningococcal invasive disease # *
48. Mumps
49. Perinatal exposure of a newborn to HIV
50. Pertussis (whooping cough)
51. Phenylketonuria (PKU) (<5y/old)
52. Plague #
53. Poliomyelitis #
54. Primary congenital hypothyroidism (<5y/old)
55. Psittacosis (ornithosis)
56. Rabies #
57. Respiratory syncytial virus
58. Rickettsial diseases/infections (includes Anaplasmosis, Rocky Mountain Spotted Fever, Q fever, rickettsialpox, typhus, Ehrlichiosis)
59. Rubella (German measles) and congenital rubella syndrome
60. Salmonellosis *
61. Severe Acute Respiratory Syndrome (SARS) #
62. Shigellosis *
63. Sickle cell hemoglobinopathies (<5y/old)
64. Smallpox #
65. *Staphylococcal aureus*, Vancomycin Resistant (VRSA) or Intermediate (VISA) invasive disease
66. Streptococcal invasive disease (Group A)
67. *Streptococcus pneumoniae*, drug resistant invasive disease
68. Syphilis (all stages)
69. Tetanus

- 70. Toxic shock syndrome
- 71. Toxoplasmosis
- 72. Trichinosis
- 73. Tuberculosis, suspected or confirmed active disease (all sites) including the results of drug susceptibility testing
- 74. Tularemia
- 75. Typhoid fever #

For healthcare practitioners and healthcare facilities, all diseases are reportable within 5 work-days, unless otherwise noted.

Healthcare practitioners and healthcare facilities must report within 24 hours.

For clinical laboratories, all diseases are reportable by next work-day, unless otherwise noted.

\$ Clinical laboratories must report within 5 days of obtaining the test result.

* In addition to reporting, clinical laboratories must also submit isolates to the state Laboratory within 5 work-days of isolation.

^ Hospitals, clinical laboratories, and healthcare facilities must report within 180 days.

BLUE not currently reportable via PA-NEDSS.

Please note that certain broad categories such as #22 (Food Poisoning Outbreak) should be construed to mean all such illnesses, even if the etiology is either not otherwise listed here, or a specific etiology cannot be determined.

Further, all disease outbreaks and/or unusual occurrences of disease are reportable within the Commonwealth.

Finally, note that local jurisdictions may require reports of additional conditions not listed here within their jurisdictions.



Book	Policy Manual
Section	200 Pupils
Title	Medications
Code	210
Status	Active
Adopted	February 2, 1983
Last Revised	January 26, 2016

Purpose

The Board shall not be responsible for the diagnosis and treatment of student illness. The administration of prescribed medication to a student during school hours in accordance with the direction of a parent/guardian and licensed prescriber will be permitted only when failure to take such medicine would jeopardize the health of the student or the student would not be able to attend school if the medicine were not available during school hours.

Definitions

For purposes of this policy, **medication** shall include all medicines prescribed by a licensed prescriber and any over-the-counter medicines.

For purposes of this policy, **licensed prescribers** shall include licensed physicians (M.D. and D.O.), podiatrists, dentists, optometrists, certified registered nurse practitioners and physicians assistants.

Authority

The Board directs all district employees to comply with the Pennsylvania Department of Health's Guidelines for Pennsylvania Schools for the Administration of Medications and Emergency Care.

Before any medication may be administered to or by any student during school hours, the Board shall require the written request of the parent/guardian and licensed prescriber, giving permission for such administration.[\[1\]](#)[\[2\]](#)

Delegation of Responsibility

The Superintendent or designee, in conjunction with the Certified School Nurse (CSN), shall develop administrative regulations for the administration and self-administration of students' medications.

All medications shall be administered by the Certified School Nurse, or in the absence of the Certified School Nurse by other licensed school health staff (RN, LPN), except as otherwise noted in this policy.

In the event of an emergency, a district employee may administer medication when s/he believes, in good faith, that a student needs emergency care.[\[3\]](#)

The Certified School Nurse shall collaborate with parents/guardians, district administration, faculty and staff to develop an individualized healthcare plan as needed to best meet the needs of individual students.[4][5]

The policy and administrative regulations for administration of medications shall be reviewed, at least every two (2) years, by a committee consisting of the Certified School Nurse, school physician, school dentist and the Director of Pupil Services and revised as necessary.

Guidelines

The district shall inform all parents/guardians, students and staff about the policy and administrative regulations governing the administration of medications.

All standing medication orders and parental consents shall be renewed at the beginning of each school year.

Student health records shall be confidential and maintained in accordance with state and federal laws and regulations and the Department of Health Guidelines.[6][7]

Students may possess and use asthma inhalers and epinephrine auto-injectors when permitted in accordance with state law and Board policy.[8][9]

Delivery and Storage of Medications

All medication shall be brought to the nurse's office, or the main office if the nurse is in another building, by the parent/guardian or by another adult designated by the parent/guardian. All medication shall be stored in the original pharmacy-labeled container and kept in a locked cabinet designated for storage of medication. Medications that require refrigeration shall be stored and locked in a refrigerator designated only for medications. The district shall not store more than a thirty-day supply of an individual student's medication.

Medication should be recorded and logged in with the date, name of student, name of medication, amount of medication, and signatures of the parent/guardian or designated adult delivering the medication and the school health personnel receiving the medication.

Nonprescription medication must be delivered in its original packaging and labeled with the student's name.

Prescription medication shall be delivered in its original packaging and labeled with:

1. Name, address, telephone and federal DEA (Drug Enforcement Agency) number of the pharmacy.
2. Student's name.
3. Directions for use (dosage, frequency and time of administration, route, special instructions).
4. Name and registration number of the licensed prescriber.
5. Prescription serial number.
6. Date originally filled.
7. Name of medication and amount dispensed.
8. Controlled substance statement, if applicable.

All medication shall be accompanied by a completed Medication authorization form or other written communication from the licensed prescriber.

Disposal of Medications

Appendix B (page 3 of 4)

Procedures shall be developed for the disposal of medications consistent with the Department of Health Guidelines, which shall include:

1. Guidelines for disposal of contaminated needles or other contaminated sharp materials immediately in an appropriately labeled, puncture resistant container.
2. Processes for immediately returning to parents/guardians all discontinued and outdated medications, as well as all unused medications at the end of the school year.
3. Methods for safe and environmentally friendly disposal of medications.
4. Proper documentation of all medications returned to parents/guardians and for all medications disposed of by the Certified School Nurse or other licensed school health staff. Documentation shall include, but not be limited to, date, time, amount of medication and appropriate signatures.

Student Self-Administration of Emergency Medications

Prior to allowing a student to self-administer emergency medication, the district shall require the following:[9]

1. An order from the licensed prescriber for the medication, including a statement that it is necessary for the student to carry the medication and that the student is capable of self-administration.
2. Written parent/guardian consent.
3. An Individual Health Plan including and/or Emergency Care Plan.
4. The nurse shall conduct a baseline assessment of the student's health status.
5. The student shall demonstrate administration skills to the nurse and responsible behavior. Determination of competency for self-administration shall be based on the student's age, cognitive function, maturity and demonstration of responsible behavior.

The nurse shall provide periodic and ongoing assessments of the student's self-management skills.

The student shall notify the school nurse immediately following each occurrence of self-administration of medication.

Students shall demonstrate a cooperative attitude in all aspects of self-administration of medication. Privileges for self-administration of medication will be revoked if school policies regarding self-administration are violated.

Administration of Medication During Field Trips and Other School-Sponsored Activities

The Board directs planning for field trips and other school-sponsored activities to start early in the school year and to include collaboration between administrators, teachers, nurses, appropriate parents/guardians and other designated health officials.[10]

Considerations when planning for administration of medication during field trips and other school-sponsored programs and activities shall be based on the student's individual needs and may include the following:

1. Assigning school health staff to be available.
2. Utilizing a licensed person from the school district's substitute list.
3. Contracting with a credible agency which provides temporary nursing services.
4. Addressing with parent/guardian the possibility of obtaining from the licensed prescriber a temporary order to change the time of the dose or omit dose.

5. Asking parent/guardian to accompany the child on the field trip, with proper clearances.

6. Arranging for medications to be provided in an original labeled container with only the amount of medication needed.

Security procedures shall be established for the handling of medication during field trips and other school-sponsored activities.

Legal

1. 24 P.S. 510

2. 22 PA Code 12.41

3. 42 Pa. C.S.A. 8337.1

4. Pol. 103.1

5. Pol. 113

6. 24 P.S. 1409

7. Pol. 216

8. 24 P.S. 1414.1

9. Pol. 210.1

10. Pol. 121

24 P.S. 1401

24 P.S. 1402

Pennsylvania Department of Health "Guidelines for Pennsylvania Schools for the Administration of Medications and Emergency Care" March 2010

Pol. 000



Millcreek Township School District
3740 West 26th Street
Erie, PA 16506
(814) - 835 - 5300

Appendix C

Medication Guidelines Policy 210
for medication to be taken during school hours
Students K - 12
Version: *January 2016*

THE FOLLOWING ARE EXCERPTS FROM POLICY 210 - USE OF MEDICATIONS / ASTHMA INHALERS / EPINEPHRINE AUTOINJECTORS

Medication refers to prescribed and over the counter medications. If at all possible, medication should be administered at home. Medications will be administered during school hours only when failure to take such medicine would jeopardize the health of a student and he/she would not be able to attend school if the medication were not made available. All medications are dispensed from the health room. Students are not to carry medication with them during school hours, nor are they permitted to transport medication to and from school.

In order for medication(s) to be dispensed to students, the following requirements must be met:

For All Medications:

- ✓ MTSD must receive authorization from the physician AND parent/guardian stating what the medication is, what it is for, the dosage, and the time it is to be given.
- ✓ MTSD must receive the medication in a current, properly labeled prescription bottle. Over the counter medication must be in the original container.
- ✓ Each change in medication (dosage, time or type) throughout the year requires a new authorization form signed by both parent/guardian and physician.
- ✓ ~~Forms must be renewed annually~~
- ✓ Student must be responsible to report to the health room to receive their medication at the proper time.

Important Notice about Medications for Field Trips

If your student is going on a field trip, please make arrangements with your physician for him/her to miss that dose of medication or change the dosage time. If skipping the dose or changing the dosage time is not possible, put the dose in a properly labeled prescription bottle with the student's name, name of medication, and the time it is to be given. **This may require the acquisition of an additional prescription bottle from your pharmacy for field trip purposes. The medication must be brought to school by an adult and given to the nurse.** The nurse is unable to take a dose from your child's supply at school to send on the field trip, as this is against the scope of nursing practice. Call your school nurse if you have any questions or need assistance.

**Millcreek Township School District**3740 West 26th Street

Erie, PA 16506

(814) - 835 - 5300

Appendix D

Authorization for Medication

Policy 210

Students K -12

Version: January 2016

COMPLETED BY PARENT OR GUARDIAN (an individual form must be completed for each medication)**Section A**

I request that my child, _____ Grade _____ Homeroom: _____ be assisted in taking medications described below at school by authorized persons. I understand that I am responsible for submitting the medication in a proper and timely manner and that, if necessary, the school may request additional information from the physician regarding this medication. I agree to abide by the regulations defined in district policy and I understand that this form must be renewed annually and anytime there is a change in drug, time or dosage.

I agree to waive the School District, their officers, representatives and employees from any and all liability, claims, demands, and causes of action arising out of or in any way connected with the giving of the prescribed medication or treatment. The undersigned parent or guardian hereby assumes all risks of injury or damage to the minor child receiving prescribed medication or treatment during school activities, and specifically waives any claim for acts of negligence by employees of the School District.

Furthermore, as parent or guardian of the minor child to receive prescribed medication and/or treatment, the undersigned hereby expressly agrees to indemnify and forever hold harmless the Millcreek Township School District, officers, and their employees against any loss or any claims, demands, causes of action that might be brought by the minor or in his/her behalf to defray damages incurred by the taking of the prescribed medication and/or treatment given by the School District during regularly scheduled school hours or activities in the School District. As parent or guardian, I hereby waive all exemption rights under all state laws against any claims for reimbursements or indemnification.

COMPLETED BY PARENT OR GUARDIAN**Section A**

Name of Medication:	Parent/Guardian Daytime Phone:
Diagnosis (reason) for which medication is given:	
Dosage:	Time to be Administered:

Parent / Guardian Signature _____ Date _____

COMPLETED BY LICENSED PHYSICIAN**Section B**

Name of Medication:		
Diagnosis (reason) for which medication is given:		
Dosage:	Time to be Administered:	
Can time be adjusted to accommodate class? Yes No		
If time to be administered can be adjusted to fit schedule, by how much?		Can dose be omitted for field trips? Yes No
If medication is to be given PRN, describe indications and intervals:		
Describe any significant side effects:		
Other information:		
This authorization will be valid for one calendar year from physician's authorization date.		
Is it medically necessary for the student to carry his/her inhaler/epinephrine at all times?	Yes	No
Is this student qualified and able to self-administer his/her inhaler/epinephrine?	Yes	No

Physician's Signature _____ Date _____

Child's Name: _____ Medication: _____

☐ Prescription ☐ Non-Prescription Refrigeration Required: ☐ YES ☐ No Expiration Date: _____

If Prescription, Prescriber's Name: _____ Telephone: _____

Dosage Amount: _____ Time to Administer: _____ am _____ pm _____ times/day

Dates for Administration: From: _____ To: _____
Date Date

Special Instructions, i.e., symptoms signaling need for administration, medication indications, reasons to hold medication, contradictions:

I give permission to administer medication to my child as stated above

Parent's Signature

Date _____

[illegible]

**FARE**

Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ Yes (higher risk for a severe reaction) ☐ NoAppendix F
(page 1 of 2)**NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.****Extremely reactive to the following allergens:** _____**THEREFORE:**

Note: Any medication listed on this form must be documented on the appropriate MTSD Medication Policy 210 forms.

- ☐ If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.
- ☐ If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

**FOR ANY OF THE FOLLOWING:
SEVERE SYMPTOMS****LUNG**Shortness of
breath, wheezing,
repetitive cough**HEART**Pale or bluish
skin, faintness,
weak pulse,
dizziness**THROAT**Tight or hoarse
throat, trouble
breathing or
swallowing**MOUTH**Significant
swelling of the
tongue or lips**SKIN**Many hives over
body, widespread
redness**GUT**Repetitive
vomiting, severe
diarrhea**OTHER**Feeling
something bad is
about to happen,
anxiety, confusion**OR A
COMBINATION**
of symptoms
from different
body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
- Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
 - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
 - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
 - Alert emergency contacts.
 - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS**NOSE**Itchy or
runny nose,
sneezing**MOUTH**

Itchy mouth

**SKIN**A few hives,
mild itch**GUT**Mild
nausea or
discomfort**FOR MILD SYMPTOMS FROM MORE THAN ONE
SYSTEM AREA, GIVE EPINEPHRINE.****FOR MILD SYMPTOMS FROM A SINGLE SYSTEM
AREA, FOLLOW THE DIRECTIONS BELOW:**

- Antihistamines may be given, if ordered by a healthcare provider.
- Stay with the person; alert emergency contacts.
- Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

Note: Any medication listed on this form must be documented on the appropriate MTSD Medication Policy 210 forms.

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE

DATE

PHYSICIAN/HCP AUTHORIZATION SIGNATURE

DATE

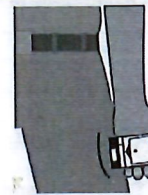
**FARE**

Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

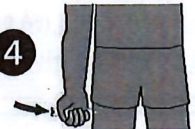
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.

3Appendix F
(page 2 of 2)

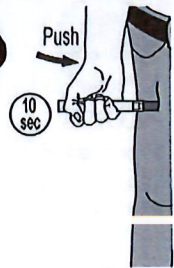
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.

3**4**

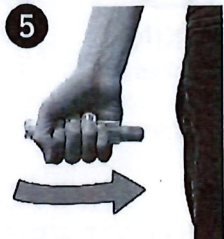
HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.

5

HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, pull off the blue safety release.
4. Place the orange tip against the middle of the outer thigh (upper leg) at a right angle (perpendicular) to the thigh.
5. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
6. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
7. Remove and massage the injection area for 10 seconds.
8. Call 911 and get emergency medical help right away.

5

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

ASTHMA MANAGEMENT PLAN & AUTHORIZATION FOR MEDICATION

Appendix G

TO BE COMPLETED BY PARENT:

Patient's Name _____ Date of Birth _____ School _____ Grade _____
 ☐ School E-mail _____ ☐ School Fax () _____
 Parent/Caregiver _____ Phone (H) _____ Phone (W) _____
 Phone (Cell) _____ E-mail _____
 Emergency Contact _____ Relationship _____ Phone _____
 Asthma Care Provider _____ ☐ Office Phone () _____
 ☐ Office E-mail _____ ☐ Office Fax () _____ (please mark best contact)

TO BE COMPLETED BY ASTHMA CARE PROVIDER

Note: Any medication listed on this form must be documented on the appropriate MTSD Medication Policy 210 forms.

RESCUE (quick-relief) MEDICATION:

	MONITORING	TREATMENT																		
RED	RED ZONE: DANGER SIGNS <ul style="list-style-type: none"> • Very short of breath, or • Rescue medicines have not helped, or • Cannot do usual activities, or • Symptoms are same or get worse after 24 hours in Yellow Zone RED ZONE: EMERGENCY SIGNS <ul style="list-style-type: none"> • Lips and fingernails are blue or gray • Trouble walking and talking due to shortness of breath • Loss of consciousness 	<p>Note: Any medication listed on this form must be documented on the appropriate MTSD Medication Policy 210 forms.</p> <ul style="list-style-type: none"> • Give rescue medication: ☐ 2 ☐ 4 ☐ 6 puffs (1 min between puffs) or 1 nebulizer treatment • Call parent and/or Asthma Care Provider • Call 911 NOW if: <ol style="list-style-type: none"> 1. Unable to reach medical care provider after arriving in the red zone 2. Child is struggling to breathe and there is no improvement after taking albuterol 3. May repeat rescue medication every 10 minutes if symptoms do not improve, until medical assistance has arrived or you are at the emergency department 																		
YELLOW	YELLOW ZONE: CAUTION <ul style="list-style-type: none"> • Cough, wheeze, chest tightness, or shortness of breath, or • Waking at night due to asthma, or • Can do some, but not all, usual activities 	<ul style="list-style-type: none"> • Continue daily controller medications • Give rescue medication: ☐ 2 ☐ 4 ☐ 6 puffs (1 min between puffs) OR 1 nebulizer treatment every 4 hours as needed • Wait 10 minutes and recheck symptoms • If not better, go to RED ZONE • If symptoms improve, may return to class or normal activity, or _____ • Parent/School Nurse: If needed, coordinate rescue medications to be given every 4 hours for ☐ 2 ☐ 3 days, if symptoms remain improved • If symptoms are not gone after ☐ 2 ☐ 3 days, move to the RED ZONE 																		
GREEN	GREEN ZONE: WELL <ul style="list-style-type: none"> • No cough, wheeze, chest tightness, or shortness of breath during the day or night • Can do usual activities 	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;">MEDICATION</th> <th style="width: 20%;">HOW MUCH</th> <th style="width: 40%;">WHEN</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td> Before Exercise ☐ Recess ☐ PE/Sports <i>(not to exceed every 4 hours)</i> </td> </tr> <tr> <td>DAILY CONTROLLER MEDICATION</td> <td>HOW MUCH</td> <td>WHEN</td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	MEDICATION	HOW MUCH	WHEN			Before Exercise ☐ Recess ☐ PE/Sports <i>(not to exceed every 4 hours)</i>	DAILY CONTROLLER MEDICATION	HOW MUCH	WHEN									
MEDICATION	HOW MUCH	WHEN																		
		Before Exercise ☐ Recess ☐ PE/Sports <i>(not to exceed every 4 hours)</i>																		
DAILY CONTROLLER MEDICATION	HOW MUCH	WHEN																		

- ☐ Administer medications as instructed above
☐ Student has been instructed in the proper use of all his/her asthma medications, and in my opinion, the student can carry and use his/her inhaler at school
☐ Student needs supervision or assistance to use his/her inhaler medication
☐ Student should **NOT** carry his/her inhaler while at school ☐ Have student use spacer with inhaler medication

ASTHMA CARE PROVIDER SIGNATURE _____

PLEASE PRINT PROVIDER NAME _____

DATE _____

I give permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact my asthma care provider if necessary and for this form to be faxed/emailed to my child's school or be shared with school staff per FERPA guidelines. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices.

PARENT SIGNATURE _____

DATE _____

Seizure Action Plan & Log

Date: _____

This student is being treated for a seizure disorder. The information below outlines important information should a seizure occur during the student's participation in the program.

Student's Name: _____

Parent's Name: _____ Phone: _____

Treating Physician: _____ Phone: _____

Relevant medical history: _____

Historical Seizure Information:

Seizure type:	Length:	Frequency:	Description:

Basic first aid / comfort & care provided in the event a seizure occurs.

- | | |
|--|---|
| <input checked="" type="checkbox"/> Stay calm and track time
<input checked="" type="checkbox"/> Keep child safe
<input checked="" type="checkbox"/> Do not restrain
<input checked="" type="checkbox"/> Do not put anything in the child's mouth
<input checked="" type="checkbox"/> Stay with the child until fully conscious
<input checked="" type="checkbox"/> Record seizure in log | <input checked="" type="checkbox"/> Protect child's head (for grand mal seizure)
<input checked="" type="checkbox"/> Watch breathing / keep airway open (for grand mal seizure)
<input checked="" type="checkbox"/> Turn child on side (for grand mal seizure)
<input type="checkbox"/> Other: _____ |
|--|---|

Emergency Response – A 'seizure emergency' is defined noted below. For each, check the appropriate box(es) for the emergency response.

☒ A convulsive seizure that lasts longer than 5 minutes

- ☐ Call 911
☐ Notify parent or emergency contact
☐ Administer emergency medication as indicated on the student's Authorization for Medication form
☐ Other: _____

☒ Student does not regain consciousness after the seizure

- ☐ Call 911
☐ Notify parent or emergency contact
☐ Administer emergency medication as indicated on the student's Authorization for Medication form
☐ Other: _____

✓ Student has more than one seizure in one day

- ☐ Call 911
- ☐ Notify parent or emergency contact
- ☐ Administer emergency medication as indicated on the student's Authorization for Medication form
- ☐ Other: _____

✓ Student is injured or has diabetes

- ☐ Call 911
- ☐ Notify parent or emergency contact
- ☐ Administer emergency medication as indicated on the student's Authorization for Medication form
- ☐ Other: _____

✓ Student has breathing difficulties

- ☐ Call 911
- ☐ Notify parent or emergency contact
- ☐ Administer emergency medication as indicated on the student's Authorization for Medication form
- ☐ Other: _____

☐ Other: _____

- ☐ Call 911
- ☐ Notify parent or emergency contact
- ☐ Administer emergency medication as indicated on the student's Authorization for Medication form
- ☐ Other: _____

Seizure triggers or warning signs: _____

Student's reaction to seizure: _____

Does the student need to leave the room after a seizure? ☐ Yes ☐ No

If yes, describe the process for returning student to the room: _____

Important considerations:

Are accommodations needed during emergency response exercises? _____

Other? _____

Seizure Plan Review Meeting Signatures:

_____	_____
Parent	Date
_____	_____
Primary CD & ELP Staff Person	Date
_____	_____
Secondary CD & ELP Staff Person	Date
_____	_____
Supervisor or Coordinator of CD & ELP	Date

Seizure Log:

Date	Time seizure started	Time seizure ended	Description: What occurred prior; Seizure activity; Student recovery; Emergency response if needed	Staff initials