CENTENNIAL
SCHOOL DISTRICT

ADMINISTRATIVE REGULATION

APPROVED: December 13, 2016

REVISED:

210.1-AR-0 PHYSICIAN AND PARENT AUTHORIZATION FOR STUDENT SELF-ADMINISTRATION OF DIABETES TREATMENT

____________________________________ ____________________________
Student/Patient Name Date Form Completed

Section 1. *To be completed by the Physician.*

The above student is a patient under my care for diabetes mellitus type __ .

This student is competent to self-administer the following medication or monitoring equipment and is able to practice proper safety precautions for the handling and disposal of such medication and monitoring equipment:

☐ This student is authorized to self-monitor his or her blood glucose levels to ensure maintenance of levels within the range of ____ mg/dL and ____ mg/dL, using the following equipment at the following times or under the following conditions:

Equipment authorized: ____

Times of day or conditions when self-monitoring is required: ___________________________
____
____

☐ This student is authorized to self-administer the following medications:

☐ Insulin type(s): ____

Device used for administration: ____________________________________

For correction of hyperglycemia: ____ unit(s) for every ____ mg/dL over ____ mg/dL

For coverage of carbohydrate intake: ____ unit(s) for every ____ g. of carbohydrate

Other: ____

Potential serious reactions: ____

Necessary emergency response: ______________________________________
____
____

☐ Other Medication: ___________________________ For: ____________________________

When: __________________________________ Dosage: __________________________

Potential serious reactions: ____

Necessary emergency response: ____
____
____

This authorization to self-administer the foregoing medication(s) or monitoring equipment and to practice proper safety precautions for the handling and disposal of such medication and monitoring equipment shall remain in full force and effect, unless revoked in writing by me, through _____________________.

____
Signature of Physician Printed Name License Number

Section 2. *To be completed by the Parent or Guardian.*

I(we) am(are) the parent(s) or guardian(s) of the above student and hereby authorize the CENTENNIAL School District to comply with the self-administration instructions of my(our) child's health care practitioner outlined herein. I(we) release the District and any of its employees or agents from any responsibility or liability for the use, possession, or distribution of the prescribed medication or monitoring equipment and acknowledge that the school entity bears no responsibility for ensuring that the medication is taken by the student or that the monitoring equipment is used. I(we) have read the authorization of the health care practitioner contained herein and understand fully the authorizations, releases, and acknowledgements I(we) am(are) providing by signing this document.

____
Signature of Parent or Guardian Printed Name Date

____
Signature of Parent or Guardian Printed Name Date

Section 3. *To be completed by the Student.*

I have received instruction from my health care practitioner on the use of, and the proper safety precautions for the handling and disposal of, the medications and monitoring equipment described above. I will not allow other students to have access to the medication and monitoring equipment, and I understand the safeguards about which I have received instruction.

____
Signature of Student Printed Name Date

ADMINISTRATIVE REGULATION

CENTENNIAL SCHOOL DISTRICT

APPROVED: December 13, 2016

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210.1-AR-1 MEDICATION SELF-ADMINISTRATION COMPETENCY ASSESSMENT FORM

Name of Student	Date of Assessment	Student Age
Name of Treating Physician	Date of Current Orders From Physician	
Diagnosis	Medication/Treatment to be Self-Administered	

Answer *all* of the following questions by circling "yes" or "no." If you cannot conclusively respond to a question by answering "yes," you must answer that question "no." The student can be approved for self-administration *only* if *all* questions, other than the last, are answered "yes" and the last is answered "no."

Yes No Can the student accurately explain the chronic condition for which he or she requires medication?

Yes No Can the student accurately explain the time of day or the exact conditions under which he or she must administer his or her medication?

Yes No Can the student identify the exact dose of medication that he or she must administer, and, if that dosage varies based on conditions (e.g., high or low blood sugars or carbohydrate intake for a diabetic), can he or she explain exactly how to calibrate the correct dosage?

Yes No Does the student understand the importance of regular, consistent administration of medication in accordance with the orders of his or her treating physician?

Yes No Can the student explain the safe and secure containment of medications and equipment that he or she will use or self-administer, including the safe disposal or containment of treatment waste and adherence to universal precautions in doing so (e.g., sharps used to draw blood for blood glucose monitoring)?

Yes No Has the student demonstrated to you the cognitive and motor necessary to administer the medication or treatment regimen in question?

Yes No Do you have written orders or other written confirmation from the treating physician or nurse practitioner that the student can self-administer the medication or treatment in question?

Yes No Has the student expressed any opinions or demonstrated any behaviors to you or others that raise concerns about his or her maturity, attitude toward his or her condition, or willingness to respond truthfully to your questions or ability to adhere consistently to his or her treatment in accordance with the orders of his or her treating physician? If yes, explain the source of your concern: ____________
____
____
____

Check one:

______ This student is competent to self-administer the medication or treatment described above.

______ This student is not competent at this time to self-administer the medication or treatment described above.

____
Signature of School Nurse Printed Name of School Nurse Date

ALLERGY/ANAPHYLAXIS ACTION PLAN

Student Photo

Student Name_______________________________ D.O.B. ______________ Grade _____
Address ____________________________________ Phone Number ____________________
Name of Doctor _______________________________ Preferred Hospital _________________

ALLERGY: (check appropriate) To be completed by Doctor

☐ Foods (list):

☐ Medications (list):

☐ Latex: Circle: Type I (anaphylaxis) Type IV (contact dermatitis)

☐ Stinging Insects (list):

RECOGNITION AND TREATMENT

Chart to be completed by Physician ONLY		**Give CHECKED Medication**	
If food ingested or contact with allergen occurs:		EpiPen®	Antihistamine
No symptoms noted	I ☐ Observe for other symptoms		
Minor symptoms - Such as itchy mouth, few hives, mild itch, mild nausea/discomfort			
Mouth	Itching, tingling, or swelling of lips, tongue, mouth		
Skin	Hives, itchy rash, swelling of the face or extremities		
Gut+	Nausea, abdominal cramps, vomiting, diarrhea		
Throat+	Tightening of throat, hoarseness, hacking cough		
Lung+	Shortness of breath, repetitive coughing, wheezing		
Heart+	Thready pulse, low BP, fainting, pale, blueness		
Neuro+	Disorientation, dizziness, loss of conscience		
If reaction is progressing (several of the above areas affected), **The severity of symptoms can quickly change. +Potentially life-threatening.**			

DOSAGE:

Epinephrine: Inject into outer thigh ☐ **EpiPen® 0.3 mg** OR ☐ **EpiPen® Jr. 0.15 mg** (see reverse for instructions)

Antihistamine: Benadryl ________________________.mg To be given by mouth *only if able to swallow.*

☐ This child has received instruction in the proper use of the EpiPen®. It is my professional opinion that this student **SHOULD** be allowed to carry and use the EpiPen® independently. The child knows when to request antihistamine and has been advised to inform a responsible adult if the EpiPen® is self-administered.

☐ It is my professional opinion that this student **SHOULD NOT** carry the EpiPen®.

EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call parents/guardian to notify of reaction, treatment and student's health status.
3. Treat for shock. Prepare to do CPR.
4. Accompany student to ER if no parent/guardians are available.

PHYSICIAN'S SIGNATURE. _________________________________**DATE**______________

Side 2: To Be Completed by Parent/Guardian, Student and School

Allergy/Anaphylaxis Action Plan (continued) Student Name ___________________________

Parent/Guardian AUTHORIZATIONS

☐ I want this allergy plan implemented for my child; I want my child to carry the EpiPen® and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of EpiPen®.
☐ I want this plan implemented for my child and I do not want my child to self-administer EpiPen®.
☐ It is recommended that backup medication be stored with the school nurse in case a student forgets or loses the EpiPen® and/or antihistamine. The school district is not responsible or liable if backup medication is not provided to the school nurse and the student is without working medication when medication is needed.

Your signature gives permission for the nurse to contact and receive additional information from your health care provider regarding the allergic condition(s) and the prescribed medication.

Parent/Guardian Signature:____________________________________Date:______________

Student Agreement:
☐ I have been trained in the use of my EpiPen® and allergy medication and understand the signs and symptoms for which they are given;
☐ I agree to carry my EpiPen® with me at all times;
☐ I will notify a responsible adult (teacher, nurse, coach, noon duty, etc.) 1MMEDIATELY when auto-injector EpiPen® (epinephrine) is used;
☐ I will not share my medication with other students or leave my EpiPen® unattended;
☐ I will not use my allergy medications for any other use than what it is prescribed for.

Student Signature ____

☐ Back-up medication is stored at school ☐ Yes ☐ No

DIRECTIONS FOR EPIPEN® USE

1. Pull off gray activation cap.
2. Hold black tip to outer thigh (apply to thigh only).
3. Press hard into outer thigh until auto-injector mechanism functions. Hold in place for 10 seconds.
4. Massage the injection site for 10 seconds.
   Other:____________________________
5. Once Epipen® is used, call 911/EMS. Take the used EpiPen® to the emergency room with you.

STAFF MEMBERS TRAINED

NAME	TITLE	ROOM	TRAINED BY

EMERGENCY CONTACTS

		NAME	HOME #	WORK #	CELL #
Parent/Guardian					
Parent/Guardian					
Other:					

ADMINISTRATIVE REGULATION

APPROVED: January 8, 2019

REVISED:

CENTENNIAL SCHOOL DISTRICT

210.1–AR-3. INFORMATION ABOUT EMERGENCY EPINEPHRINE ADMINISTRATION

Dear Parents/Guardians:

In accordance with the Pennsylvania Public School Code provisions on "School Access to Emergency Epinephrine" and Board Policy 210.1, the Centennial School District maintains a stock supply of epinephrine auto-injectors in each school building (stock epinephrine auto-injectors). An auto-injector prefilled with epinephrine is the drug of choice used for the emergency treatment of severe allergic reactions (anaphylaxis) to insect stings or bites, foods, drugs, and other allergens. If your child has been diagnosed with an allergy or health condition that requires use of epinephrine, it is still your responsibility to provide your child's prescribed medication to the school nurse.

The law and Board Policy 210.1 give trained school employees the authority to administer epinephrine to any student whom they believe in good faith is experiencing anaphylaxis. In the event that a student who does not have epinephrine is experiencing an anaphylactic reaction, a trained school employee may use the stock epinephrine auto-injector in accordance with the standing order issued by the school physician or provide the student with a stock epinephrine auto-injector for self-administration.

By law, the Centennial School District is required to notify parents/guardians of their ability to exempt their children from emergency administration of stock epinephrine auto-injectors.

Please complete the attached form (Refusal to Permit Administration of Stock Epinephrine for Emergency First Aid) and return it to your child's school, if you **DO NOT** want a trained school employee to:

- Administer a stock epinephrine auto-injector to your child if s/he is believed to be experiencing a life-threatening allergic reaction (anaphylaxis); or
- Provide a stock epinephrine auto-injector for self-administration if your child is authorized to self-administer.

The refusal is valid for the ___________________ school year. If you change your mind after submitting the attached form, you must submit a written request notifying the school nurse that your prior refusal to permit administration of stock epinephrine for emergency first aid is revoked.

If you have questions or concerns, please contact __________________________________.

Refusal to Permit Administration of Stock Epinephrine for Emergency First Aid

I, ________________________, acknowledge that I have received a copy of Policy 210.1 on Epinephrine Auto-Injectors and this informational document; I have read and fully understand their content; and by signing this form, I refuse to permit a trained school employee to: administer a stock epinephrine auto-injector to my child in the event that s/he is believed to be experiencing a life-threatening allergic reaction (anaphylaxis); or to provide a stock epinephrine auto-injector for self-administration if my child is authorized to self-administer.

________________________	__________	____________________________
Child's Name	Grade	School/Teacher

________________________	____________	______________________
Parent/Guardian Signature	Date	Phone Number

The refusal is valid for the ___________________ school year. If you change your mind after submitting the attached form, you must submit a written request notifying the school nurse that your prior refusal to permit administration of stock epinephrine for emergency first aid is revoked.

Please return the completed form to your child's school nurse. The school nurse shall maintain the completed form in the student's health records file.

Verification

This signed exemption form has been verified by contacting the above named parent/guardian by phone:

____	__________________
School Nurse Signature	Date