ADMINISTRATIVE REGULATION

CENTENNIAL SCHOOL DISTRICT

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

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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:					