BALTIMORE CITY HEALTH DEPARTMENT

Bureau of School Health

Allergy/Anaphylaxis Action Plan

This order is valid for School Year: _____ (including the summer session) School #: _____ Grade: _____

Student Name: _____ Birth Date: _____ Weight: _____ lbs.

Allergy to: _____

Asthma: ❒ Yes (higher risk for a anaphylaxis in students with asthma and history of allergy) ❒ No

1) Any SEVERE SYMPTOMS after suspected or known ingestion: One or more of the following: LUNG: Short of breath, wheeze, repetitive cough HEART: Pale, blue, faint, weak pulse, dizzy, loss of consciousness THROAT: Tight, hoarse, trouble breathing or swallowing MOUTH: Obstructive swelling (tongue and/or lips) Or combination of symptoms from different body areas: SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips), generalized flushing GI: Vomiting, diarrhea, cramping MENTAL: Uneasiness, agitation, panic 2) KNOWN INGESTION and PREVIOUS HISTORY OF ANAPHYLAXIS to the allergen (no symptoms need to be present) 3) Other: _____	1. INJECT EPINEPHRINE IMMEDIATELY 2. Call 911 3. Begin monitoring (see box below) 4. Give additional medications if prescribed:* - Antihistamine - Inhaler (bronchodilator) if Asthma symptoms present * Antihistamines & inhalers or bronchodilators are not to be depended upon to treat or prevent a severe reaction (anaphylaxis).
1) MILD SYMPTOMS ONLY AND NO PREVIOUS HISTORY OF ANAPHYLAXIS: MOUTH: Itchy mouth SKIN: A few hives mild itching GI Mild nausea/discomfort 2) Other: _____	1. GIVE ANTIHISTAMINE 2. Stay with student; alert healthcare provider and parent 3. If symptoms progress (see above), USE EPINEPHRINE 4. Begin monitoring (see box below)

HEALTHCARE PROVIDER'S AUTHORIZATION

Order 1: Medication Name: **Epinephrine Auto-Injector** Strength: ☐ **0.15 mg** or ☐ **0.3 mg**? Dose: 1 injection Route: IM

PRN & Frequency: ☐ May give 2nd injection if needed; for what symptoms?: _____

Relevant side effects: ☐ None expected ☐ Specify: Tachycardia, palpitations, sweating, nausea, vomiting, difficulty breathing, paleness, dizziness, weakness, anxiety

❒ Student may self-carry EpiPen®/epinephrine auto-injector ❒ Student may self-administer EpiPen®/epinephrine auto-injector

Order 2: Medication Name: **Benadryl** (Diphenhydramine) Strength: _____ Dose: _____ Route: _____ PRN: _____

Frequency: _____ for what symptoms?: _____

Relevant side effects: ☐ None expected ☐ Specify: _____

Healthcare Provider's Name/title: _____
(Type or print)

Office #: _____ FAX #: _____

Address: _____

Healthcare Provider's Signature: _____ Date: _____
Original (signature or signature stamp ONLY)

(Healthcare Provider's Office Stamp)

PARENT / GUARDIAN AUTHORIZATION

I understand that designated school health services staff or their designee will administer the medication as prescribed by the above healthcare provider. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication school. I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I acknowledge that the Registered Nurse (RN) can communicate with the healthcare provider as allowed by HIPAA. I authorize the RN to share this information with school staff that have a legitimate educational interest in my child.

Parent/Guardian Signature: _____ Date: _____ Emergency Phone #: _____

Date received in health suite: _____ by _____

Reviewed by Registered Nurse (Print): _____ Signature: _____ Date: _____

RN approval for self-carry/self- administration of emergency medication: _____ Date: _____

Order Review (Print) _____ Date: _____ Order Review (Print) _____ Date: _____

BALTIMORE CITY HEALTH DEPARTMENT

BALTIMORE CITY PUBLIC SCHOOLS

SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for the (current) school year _____, including the summer session.

This form must be entirely completed in order for school health services staff or their designee to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by a pharmacist or healthcare provider.
- Non-prescription medication must be in the original unopened/sealed container with the label intact.
- An adult must bring in the medication to the school.
- The registered nurse (RN) will call the healthcare provider, as allowed by HIPAA, if a question arises about the student and/or the student's medication.
- **Expired and discontinued medication not picked up by the last day of school will be destroyed.**

HEALTHCARE PROVIDER'S AUTHORIZATION

Student Name: _____ Birth Date: _____ Grade: _____ School #: _____

Condition for which medication is being administered: _____

Medication Name: _____ Strength: _____

Dose: _____ Route: _____ ☐ Time(s) In School: _____

☐ PRN & Frequency: _____ for what symptoms? _____

Relevant side effects: ☐ None expected ☐ Specify: _____

Medication shall be administered from: _____ to _____
Month/Day/Year Month/Day/Year

Healthcare Provider's Name/Title: _____
(Type or print)

Office #: _____ FAX #: _____

Address: _____

_____

Healthcare Provider's Signature: _____ **Date:** _____
(Original signature or signature stamp ONLY)

(Healthcare Provider's Office Stamp)

Discontinue Medication (HCP Signature): _____ **Date:** _____

PARENT/GUARDIAN AUTHORIZATION

I understand that designated school health services staff or their designee will administer the medication as prescribed by the above healthcare provider. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication school. I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I acknowledge that the Registered Nurse (RN) can communicate with the healthcare provider as allowed by HIPAA. I authorize the RN to share this information with school staff that have a legitimate educational interest in my child.

Parent / Guardian Signature: _____ **Date:** _____

Home Phone #: _____ **Cell #:** _____ **Work #:** _____

FOR ALTERED SCHOOL SCHEDULES, THE FOLLOWING MEDICATION GUIDELINE WILL APPLY UNLESS OTHERWISE INDICATED IN WRITING:

- Medication can be administered one hour before and one hour after the prescribed time of administration

SELF CARRY/ SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self-carry/self-administration of **emergency** medication may be authorized by the healthcare provider and must be approved by the registered nurse according to the School Medication Administration Policy.

Healthcare Provider's authorization for self-carry/self-administration of emergency medication: _____
Signature Date

Registered Nurse approval for self-carry/self-administration of emergency medication: _____
Signature Date

Date received in health suite: _____ by: _____

Order reviewed by Registered Nurse (Print): _____ Signature: _____ Date: _____

Order Review (Print)_____ Date: _____ Order Review (Print)_____ Date: _____

Order Review (Print)_____ Date: _____ Order Review (Print)_____ Date: _____

Asthma Medication Administration Sc[illegible]l Authorization Form

ASTHMA ACTION PLAN for School Year _____ (including summer school) School#: _____ Grade: _____

Student Name: _____ Birth Date: _____ Peak Flow Personal Best: _____

Parent/Guardian's Name: _____ Home #: _____ Work #: _____ Cell #: _____

ASTHMA SEVERITY: ☐ Exercise Induced ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

CHECK SYMPTOMS/INDICATIONS FOR MEDICATION USE

GREEN ZONE

☐ Breathing is good
☐ No cough or wheeze
☐ Can work, exercise, play
☐ Other: _____
☐ Peak flow greater than_____ (80% personal best)

CONTROLLER MEDICATIONS – TO BE USED DAILY AT HOME UNLESS OTHERWISE INDICATED

Medication	Dose	Route	Frequency/Time
			☐ School
			☐ School
			☐ School

EXERCISE ZONE

☐ **Prior to exercise/sports/physical education (PE)**

Medication (Rescue Medication)	Dose	Route	Frequency/Time
		Inhaled ☐ w/spacer	

If using more than twice per week for exercise/ sports/PE notify healthcare provider and parent/guardian

YELLOW ZONE

☐ Cough or cold symptoms
☐ Wheezing
☐ Tight chest or shortness of breath
☐ Cough at night
☐ Other: _____
☐ Peak flow between_____ and _____ (50% - 79% personal best)

RESCUE MEDICATIONS – TO BE ADDED TO GREEN ZONE MEDICATIONS FOR SYMPTOMS

Medication	Dose	Route	Frequency/Time
		Inhaled ☐ w/spacer	PRN
		Inhaled ☐ w/spacer	PRN

If symptoms do not improve in _____ minutes, notify healthcare provider and parent/guardian.
If using more than twice per week, notify healthcare provider and parent/guardian.

RED ZONE

☐ Medication is not helping within 15-20 minutes
☐ Breathing is hard and fast
☐ Nasal flaring or intercostal retractions
☐ Lips or fingernails blue
☐ Trouble walking or talking
☐ Other: _____
☐ Peak flow greater than_____ (50% personal best)

EMERGENCY MEDICATIONS – TAKE THESE MEDICATIONS AND CALL 911

Medication	Dose	Route	Frequency/Time
		Inhaled ☐ w/spacer	
		Inhaled ☐ w/spacer	

CONTACT THE PARENT/GUARDIAN AFTER CALLING 911

ggers

☐ Chalk dust
☐ Cigarette smoke
☐ Colds/Flu
☐ Dust/Dust mites
☐ Stuffed animals
☐ Carpet
☐ Exercise
☐ Mold
☐ Ozone alert days
☐ Pests
☐ Pets
☐ Plants
☐ Flowers
☐ Cut grass
☐ Pollen
☐ Strong odors
☐ Perfume
☐ Cleaning products
☐ Sudden change in temperature
☐ Wood smoke
☐ Foods
☐ Other
_____
_____
_____
_____

HEALTHCARE PROVIDER AUTHORIZATION

I authorize the administration of the medications as ordered above.

Student may self-carry medications: ☐ Yes ☐ No

Healthcare Provider Name: _____

Signature: _____

Office #: _____

Date: _____

(Healthcare Provider's Office Stamp)

PARENT/GUARDIAN AUTHORIZATION

I authorize the administration of the medications as ordered above.

I acknowledge that my child: ☐ is ☐ is not authorized to self-carry his/her medication(s).

Signature: _____

Date: _____

RECEIVED IN HEALTH SUITE BY_____ DATE_____

REVIEWED BY REGISTERED NURSE

Name (Print): _____

Signature: _____

Date: _____

Authorized to self-carry medications: ☐ Yes ☐ No

Order Review

(Print)_____Date: _____

(Print)_____Date: _____

Orders 6 Rev. 1/19

MARYLAND STATE DEPARTMENT OF EDUCATION
EQUITY AND EXCELLENCE

Maryland Diabetes Medical Management Plan/ Health Care Provider Order Form

Valid from: Start ___/___/___to End____/___/___or for School Year _____

MARYLAND Department of Health

Demographics

Student Name:	DOB:	Grade:	Diagnosis:
Parent/Guardian:	Home Phone:	Work Phone:	Cell Phone:

Insulin Orders

Insulin Dosing:

□ Carbohydrate coverage □ Correction dose only □ Correction dose plus CHO coverage □ Fixed dose □ Fixed dose with correction scale □ See attached dosing scale

Insulin(s):

□ **Rapid Acting:** □ Apidra □ Humalog □ Novolog □ Admelog □ Other (specify): _____

□ Any of the **rapid acting** insulins may be substituted for the others

□ **Long Acting** (if given at school): _____ Give_____ unit(s) of insulin Sub-Q at_____(time)

Insulin Delivery: □ Pen □ Syringe □ Pump (make/model):

Carbohydrate (CHO) Coverage per meal: □ _____unit(s) of insulin Sub-Q per_____grams of CHO at breakfast

□_____unit(s) of insulin Sub-Q per_____grams of CHO at lunch □ ____unit(s) of insulin Sub-Q per_____grams of CHO at dinner

Carbohydrate Dose Adjustment Prior To Strenuous Exercise Within_____Minutes:

□ Use exercise/PE CHO ratio of _____unit(s) of insulin per_____grams of CHO at breakfast

□ Use exercise/PE CHO ratio of_____ unit(s) of insulin per_____grams of CHO at lunch

□ Use exercise/PE CHO ratio of_____unit(s) of insulin per_____grams of CHO at dinner

Correction Dose: □ Give_____unit(s) of insulin Sub-Q for every_____mg/dl greater than BG of_____mg/dl

□ If pre-breakfast BG less than_____mg/dl, subtract_____unit(s) of insulin dose

□ If pre-lunch BG less than_____mg/dl, subtract_____unit(s) of insulin dose

□ If pre-dinner BG less than_____mg/dl, subtract_____unit(s) of insulin dose

□ **Fixed Dose Insulin:** ____unit(s) of insulin Sub-Q given before school meals

□ **Split Insulin Dose:**

Give_____unit(s) or_____% of meal insulin dose Sub-Q before meal and_____unit(s) or _____% of meal insulin dose Sub-Q after meal

Snack Insulin Coverage: □ No snack coverage □ Snack coverage if BG >_____mg/dl

□_____unit(s) of insulin Sub-Q per_____grams of CHO

Insulin Dose Administration Principles

*See page 2 for Hyperglycemia management

Insulin should be given:

□ Before meals □ Before snacks □ Other times (please specify):

□ For correction if BG >_____mg/dl and_____hours since last dose/bolus

□ If CHO intake cannot be predetermined, insulin should be given no more than _____minutes after start of meal/snack

□ If parent/guardian requests, insulin should be given no more than_____minutes after start of meal/snack

□ Use pump or bolus device calculations per programmed settings, once settings have been verified

□ Parent/Guardian has permission to increase/decrease insulin correction dose by +/- one (1) unit to three (3) units

Independent Insulin Administration Skills & Supervision Needs*

*Skills to be verified by school nurse

□ Insulin dose calculations □ Independent □ With Supervision	□ Carbohydrate counting □ Independent □ With Supervision	□ Measuring insulin □ Independent □ With Supervision	□ Insulin administration □ Independent □ With Supervision

Other Diabetes Medication

Name of Medication	Time	Dosage	Route	Possible Side Effects

Authorizations

HEALTH CARE PROVIDER AUTHORIZATION

I authorize the administration of the medications and student diabetes self-management as ordered above.

Provider Name (PRINT):

Phone: **Fax:**

Provider Signature: **Date:**

PARENT/GUARDIAN AUTHORIZATION

By signing below, I authorize:

- The designated school personnel to administer the medication and treatment orders as prescribed above.

By signing below, I agree to:

- Provide the necessary diabetes management supplies and equipment; and
- Notify the nurse of any changes in my child's care or condition.

Parent/Guardian Signature: **Date:**

Acknowledged and received by: **School Nurse:** **Date:**

Maryland Diabetes Medical Management Plan/ Health Care Provider Order Form
Valid from: Start___/___/___to End___/___/___or for School Year _____

Student Name: **DOB:**

Blood Glucose Monitoring*

*Self-management skills to be verified by school nurse

Blood Glucose (BG) Monitoring:

□ Before meals □ Before PE/Activity □ After PE/Activity □ Prior to dismissal □ Additional monitoring per parent/guardian request

□ For symptoms of hypo/hyperglycemia & anytime the student does not feel well □ **Student may independently check BG***

Continuous Glucose Monitoring

□ Uses CGM Make/Model:

Alarms set for: **Low_____mg/dl** **High_____mg/dl** □ **If sensor falls out at school, notify parent/guardian**

Hypoglycemia Management*

*Self-management skills to be verified by school nurse

Mild or Moderate Hypoglycemia (BG below_____mg/dl)

□ **Provide quick-acting glucose product equal to 15 grams of carbohydrate (or glucose gel), if conscious & able to swallow.**

□ Suspend pump for BG <_____mg/dl and restart pump when BG > _____mg/dl

□ Student should consume a meal or snack within _____minutes after treating hypoglycemia

□ Other: _____

Always treat hypoglycemia before the administration of meal/snack insulin

Repeat BG check 15 minutes after use of quick-acting glucose

- If BG still low, re-treat with 15 grams quick-acting CHO as stated above
- If BG in acceptable range and it is lunch or snack time, have student eat and cover meal CHO per orders
- If CGM in use and BG ≥70 mg/dL and arrow going up, no need to recheck

Student may self-manage mild or moderate hypoglycemia and notify the school nurse*: □ **Yes** □ **No**

Severe Hypoglycemia (includes any of the following symptoms):

- Unconsciousness
- Semi-consciousness
- Inability to control airway
- Inability to swallow
- Seizing
- Worsening of symptoms despite treatment/retreatment as above

GLUCAGON injection: □ 1 mg □ 0.5 mg IM or Sub-Q

- Place student in the recovery position
- Suspend pump, if applicable, and restart pump at BG >_____mg/dl
- Call 911 and state glucagon was given for hypoglycemia; notify parent/guardian

□ **If glucagon is not available or there is no response to glucagon, administer glucose gel inside cheek, even if unconscious or seizing. If glucose gel is administered, place student in recovery position.**

Hyperglycemia Management*

*Self-management skills to be verified by school nurse

If BG greater than_____mg/dl, or when child complains of nausea, vomiting, and/or abdominal pain, check urine/blood for ketones.

If urine ketones are **trace to small** or blood ketones _____mmol/L:

- Give_____ounces of sugar-free fluid or water per hour as tolerated
- Give insulin as listed in insulin orders **no more than every_____ hour(s)**

If urine ketones are **moderate to large** or blood ketones greater than _____mmol/L

- Give_____ounces of sugar-free fluid or water per hour as tolerated
- If student uses pump, disconnect pump
- Give insulin as listed in insulin orders **no more than every_____ hour(s) by injection**

If large ketones and vomiting or large ketones and other signs of ketoacidosis, call 911. Notify parent/guardian.

Recheck BG and ketones_____hours after administering insulin

Contact parent/guardian for: □ BG >_____mg/dl □ Ketones_____mmol/L

Student may self-manage hyperglycemia with trace/small ketones and notify the school nurse:* □ **Yes** □ **No**

Ketone Coverage

For ketones trace to small (urine)/<_____mmol/L (blood)
□ Correction dose plus_____unit(s) of insulin
□_____unit(s) of insulin

For ketones moderate to large (urine)/>_____mmol/L (blood)
□ Correction dose plus_____unit(s) of insulin
□_____unit(s) of insulin

Parent/Guardian Name:	**Signature:**	**Date:**
Provider Name:	**Signature:**	**Date:**

Acknowledged and received by:	**School Nurse:**	**Date:**

Maryland Diabetes Medical Management Plan/Health Care Provider Order Form
Valid from: Start ___/___/___ to End___/___/___ or for School Year _____

Student Name: **DOB:**

Physical Education, Physical Activity, and Sports

*Self-management skills to be verified by school nurse

Avoid physical education/physical activity/sports if:

- □ BG <_____mg/dl
- □ BG >_____mg/dl
- □ Trace/small ketones present
- □ Moderate/large ketones present

□ If BG is <_____mg/dl, give 15 grams of CHO and return to physical education/physical activity/sports
□ May disconnect pump for physical education/physical activity/ sports
□ Student may set temporary basal rate for physical education/physical activity/sports*
□ Other:

Transportation

*Self-management skills to be verified by school nurse

□ Check BG prior to dismissal
- □ If BG is not >_____mg/dl, give_____grams carbohydrate snack
- □ BG must be >_____mg/dl for bus ride/walk home

□ Only check BG if symptomatic prior to bus ride/walk home
□ Allow student to carry quick-acting glucose for consumption on bus, as needed for hypoglycemia*
□ Student must be transported home with parent/guardian if (specify): _____
□ Other:

Disaster Plan (if needed for lockdown, 72 hr shelter in place)

□ Continue to follow orders contained in this medical management plan
□ Additional insulin orders as follows:
□ Other:

Pump Management

Type of Pump: Pump start date: Child Lock: □ On □ Off

Basal rates:	___unit(s)/hour	___AM/PM	___unit(s)/hour	___AM/PM
	___unit(s)/hour	___AM/PM	___unit(s)/hour	___AM/PM
	___unit(s)/hour	___AM/PM	___ unit(s)/hour	___AM/PM

dditional Hyperglycemia Management:

□ If BG >_____mg/dl and has not decreased over_____hours after bolus, consider infusion site change. Notify parent/guardian
□ For infusion site failure: □ Give insulin via syringe or pen □ Change infusion site
□ For suspected pump failure, suspend or remove pump and give insulin via syringe or pen
□ If BG >____mg/dl and moderate to large ketones, student should change infusion site and give correction dose by pen or syringe
□ Comments:

Independent Pump Management Skills and Supervision Needs*

*Skills to be verified by school nurse. Supervision will be provided if not fully independent when appropriate

Student is independent in the pump skills indicated below:

□ Carbohydrate counting	□ Bolus an insulin dose	□ Set a basal rate/temporary basal rate
□ Reconnect pump at infusion set	□ Prepare and insert infusion set	□ Troubleshoot alarms and malfunctions
□ Give self-injection if needed	□ Disconnect pump	□ Other:

Additional Orders

□ Please FAX copies of BG/insulin diabetes management records every_____weeks (FAX number:)
□ Other orders:

Parent/Guardian Consent for Self-Management

- I acknowledge that my child ☐ **is** ☐ **is not** authorized to self-manage as indicated by my child's health care provider.
- I understand the school nurse will work with my child to learn self-management skills he/she is not currently capable of or authorized to perform independently.

My child has my permission to independently perform the diabetes tasks listed below as indicated by my child's health care provider:

□ Blood glucose monitoring	□ Insulin administration	□ Pump management
□ Carbohydrate counting	□ Insulin dose calculation	□ Other:

rent/Guardian Name:	**Signature:**	**Date:**
rovider Name:	**Signature:**	**Date:**

Acknowledged and received by:	**School Nurse:**	**Date:**