STUDENTS

Management of Students with Health Treatment Plans

This regulation and attached Health Treatment Plans (HTP) are for treatment and/or procedures that cannot be managed with HTP’s in the following regulations: 757-2, “Management of Allergic Reactions in the School Setting/School Age Child Care: Administering Epinephrine Auto-Injection”; 757-5, “Management of Asthma in the School Setting”; 757-6, “Management of Diabetes in the School Setting”; 757-7, “Management of Epileptic Seizures in the School Setting/School Age Child Care”; and 757-8, “Management of Students with Cancer in the School Setting.”

I. Health treatment procedures are identified as health-related services which may be administered by a trained member of the family, school staff, or Child Care Contractor (CCC). Any medical procedure requiring school staff to perform at school, during any Prince William County Public Schools (PWCS) extended day or overnight field trip, or School Age Child Care (SACC) must be written in an HTP (Attachment I, II, or III) completed and signed by the health care provider and parent/guardian.

II. A health treatment procedure will only be performed if necessary and ordered during the school day and as medically indicated on extended day and overnight field trips.

III. HTPs are required annually before the start of each school year. The current plan must be dated after May 1.

IV. A minimum of three staff members designated by the building principal, excluding the school nurse, shall be trained annually in the procedure by appropriate professionals.

V. All HTPs must be reviewed by the school nurse and/or supervisor or coordinator of School Health Services.

VI. All equipment and supplies shall be provided to the school/CCC by the parent/guardian. When appropriate, all supplies shall be sealed in a container appropriately dated by the health care provider or pharmacist.

VII. The parent/guardian has provided to the school/CCC all equipment and prepackaged/premeasured dosages of all medications required to be administered as part of the health treatment. All medication must be in compliance with PWCS Regulation 757-4, “Management of Medication Administration in the School Setting” (Attachment I).
VIII. The parent/guardian has assumed responsibility for the cleaning or sterilization of equipment and treatment supplies. This process shall be completed outside the school setting.

The Associate Superintendent for Special Education and Student Services (or designee) is responsible for implementing and monitoring this regulation.

This regulation and related policy shall be reviewed at least every five years and revised as needed.
Authorization to Implement Health Treatment Plans

Student: ____________________  DOB: _______________  School: _______________

Schools/Child Care Contractor (CCC) must obtain specific written parental/guardian authorization before any medical treatment including medication administration can be provided. This written informed consent gives trained school/CCC staff authorization to implement the medical order. When parents/guardians authorize a medical treatment for their child in school, such authorization includes permission for appropriate communications between the school health professional and the medical prescriber related to the specific treatment ordered. Health treatment plans not signed and dated by the parent/guardian will not be implemented.

Communications based on the medical orders generally include the following:

- The prescription of treatment itself (e.g., questions regarding dosage, method of administration, potential drug interactions);
- Implementation of the treatment in school/school age child care (e.g., questions regarding safety concerns, infection control, issues, or modifications in the treatment order related to the school setting or student’s academic schedule); and
- Student outcomes from the treatment (e.g., questions regarding observed side effects, possibly untoward reactions, observation of behavior in the classroom).

I/We are aware that non-medical personnel may perform the above procedure on my child.

In accordance with the Virginia Code § 22.1-274, I agree to the following:

I will not hold the School Board, any of its employees, or CCC liable for any negative outcome resulting from the self-administration of said emergency medication by the student.

Upon review and agreement by the school nurse, CCC, parent/guardian, and health care provider, this Health Treatment Plan will remain in effect until the annual renewal date or the student’s medical status requires changes.

Parent’s/Guardian’s Printed Name ____________________  Parent’s/Guardian’s Signature ____________________  Date _______________

School Nurse’s/CCC Printed Name ____________________  School Nurse’s/CCC Signature ____________________  Date _______________

School personnel/CCC trained in the treatment procedure:

<table>
<thead>
<tr>
<th>Printed Name</th>
<th>Signature</th>
<th>Trainer’s Signature</th>
<th>Date of Training</th>
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Prince William County Public Schools
Health Treatment Plan
Clean Intermittent Catheterization

Student Name: ________________________ Date of Birth: ________________

School: ______________________________ Grade: ______________________

This patient has a condition that he/she is unable to void on his/her own. Clean Intermittent Catheterization (CIC) is prescribed.

Catherization site: ____________________ Catheter size: __________________

Catheterize every ___________ hours or ___________ times per day.

☐ 8-ounce glass of water with every catheterization.

Other instructions: __________________________________________________________

____________________________________________________________________________

Precautions:
Contact the parent if the following signs are noted. These symptoms may indicate a urinary tract infection:

• Cloudy urine;
• Blood in urine;
• Foul smell of urine;
• Fever of 100° F or above.
• Other precautions: __________________________________________________________

It is also important to note that force should never be used to insert the catheter. If force is needed to insert the catheter, do not continue the procedure. The parent/guardian should be notified immediately.

Note: Adjustment in the treatment or discontinuation of the treatment requires a written, signed health care provider’s order. Orders must be renewed each school year. All equipment and supplies needed for the CIC will be provided by the parent/guardian.

_________________________________ __________________________
Health Care Provider’s Name Phone Number

_________________________________
Health Care Provider’s Signature Date

_________________________________
Parent’s/Guardian’s Name Date

_________________________________
Parent’s/Guardian’s Signature
Prince William County Public Schools
Health Treatment Plan
Tube Feeding

Student Name: _______________________ Date of Birth: ________ Grade: _____ SY: ___

School: _____________________________ Date Received: _______ Classroom: ____________

Type of Tube:   Method of Feeding:   Type of Nourishment:
☐ G Tube       ☐ GJ Tube       ☐ Pump       ☐ Formula: _____________
☐ NG Tube      ☐ J Tube        ☐ Gravity     ☐ Pureed Food: __________
☐ Size ________ ☐ Push         ☐ Other: ______________

Order Requirements:
• A new health care provider order is required for each school year;
• Staff will complete the Individual Feeding Log after each feeding;
• Parent/guardian will provide extra formula to be kept in case of spillage;
• If tube comes out, the parent/guardian will be called. Prince William County Public Schools staff WILL NOT reinsert tube;
• Parent/guardian is responsible for preparing food (pureeing, straining, chopping, dicing, etc.); and
• Parent/guardian will give a demonstration prior to first feeding in school.

Venting Needed: ☐ Yes  ☐ No  Frequency: ______________________________

Residual Checks: ☐ Yes  ☐ No  
☐ HOLD FEEDING if residual is more than ___________ cc.
☐ Subtract residual volume from feeding volume if residual is between _______ - _______ cc.

1st Feeding:
Time: _______ Amount: _______ Rate: _______ Flush: _______ cc water after feeding.

2nd Feeding:
Time: _______ Amount: _______ Rate: _______ Flush: _______ cc water after feeding.

PRN Feeding:
Time: _______ Amount: _______ Rate: _______ Flush: _______ cc water after feeding.

Water to be given between feedings: ☐ Yes  ☐ No
Time(s): ___________________________ Amount: ___________________________

Health Care Provider’s Name
__________________________________________ Phone Number

Health Care Provider’s Signature
__________________________________________ Date

Parent’s/Guardian’s Name
__________________________________________ Date

Parent’s/Guardian’s Signature
__________________________________________
Prince William County Public Schools
Health Treatment Plan
Authorization for Specific Medical Procedure

Student Name: ____________________________________  Date: __________________

Address: _________________________________________  Date of Birth: __________

Name of specific medical procedure: ____________________________________________

Condition for which the procedure is to be performed: ______________________________

Level of care:  ☐ Minimum  ☐ Moderate  ☐ Complex

List training needed to perform procedure: __________________________________________

Procedure can be completed by trained school staff:  ☐ Yes  ☐ No

Special orders including procedure times and/or intervals. (Attached protocol may be accepted or adapted as needed. Alternatively, a specific order may be written on the health care provider’s letterhead.):

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Precautions, possible adverse reaction, interventions:

____________________________________________________________________________
____________________________________________________________________________

Materials/equipment to perform special procedure (provided by parent/guardian):

____________________________________________________________________________
____________________________________________________________________________

Medical procedure is to be performed from __________________ to __________

___________________________________  __________________

Health Care Provider’s Name  Phone Number

________________________  __________________

Health Care Provider’s Signature  Date

Authorization of parent/guardian: I hereby request that staff perform the above procedure on my child as indicated in the Health Treatment Plan.

__________________________________________  __________________

Parent’s/Guardian’s Name  Date

________________________

Parent’s/Guardian’s Signature
School/CCC personnel trained in the treatment procedure:

<table>
<thead>
<tr>
<th>Printed Name</th>
<th>Signature</th>
<th>Trainer’s Signature</th>
<th>Date of Training</th>
</tr>
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</table>
## Authorization for Medication Administration

**Student Information: Parent/Guardian to Complete**

<table>
<thead>
<tr>
<th>Student:</th>
<th>DOB:</th>
<th>Age:</th>
<th>Grade:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>School:</th>
<th>Has the student taken this medication before?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If no, the first full dose must be given at home to decrease the risk of student having a negative reaction at school. First dose was given: Date: | Time: |

**Prescription Medication: Health Care Provider to Complete** (one form for each medication)

<table>
<thead>
<tr>
<th>Name of medication:</th>
<th>Diagnosis/condition for which medication is being administered:</th>
<th>Dosage:</th>
<th>Route:</th>
<th>Time of administration:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Length of time:</th>
<th>School year</th>
<th>Other:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Possible side effects:</th>
<th>None expected</th>
<th>Specify:</th>
</tr>
</thead>
</table>

**Health Care Provider Signature:** ___________________________ Date: ____________

**Health Care Provider Printed Name/Stamp:**

**Health Care Provider Phone Number:** ___________________________ Fax: ___________________________

**Health Care Provider Address:** ___________________________

**Over-the-Counter Medication: Parent/Guardian to Complete** (one form for each medication)

<table>
<thead>
<tr>
<th>Name of medication:</th>
<th>Reason medication is to be given:</th>
<th>Dosage:</th>
<th>Route:</th>
<th>Time of administration:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Length of time:</th>
<th>School year</th>
<th>Other:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Possible side effects:</th>
<th>None expected</th>
<th>Specify:</th>
</tr>
</thead>
</table>

**Parent/Guardian Authorization**

My signature gives permission for the principal’s designee to administer prescribed/over-the-counter medication and gives the principal’s designee permission to contact the health care provider if necessary. I also agree to pick up any unused medication at the end of the school year. I understand that medication not picked up by a parent/guardian at the end of the school year will be discarded. I have read the procedures and assume responsibility as required.

**Parent/Guardian Signature:** ___________________________ Date: ____________

**To Be Completed with Health Office Staff**

<table>
<thead>
<tr>
<th>Medication received (amount/description):</th>
<th>Medication received:</th>
<th>Health Office Staff Signature/Date</th>
<th>Parent/Guardian Signature/Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Medication picked up by:</th>
<th>Date:</th>
</tr>
</thead>
</table>

**Parent/Guardian Signature**
Attachment VI
Regulation 757-3

Prince William County Public Schools
Authorization and Consent for Exchange and Release of Medical Information

____________________________________  ________________  ________________
Student's Name                           Student I.D. #   Date of Birth

____________________________________  ________________
Parent’s/Guardian's Name                 Telephone       School

Information obtained on individual students is classified as confidential. Private information cannot be discussed with or released to anyone outside the School Division except as authorized by the parent/guardian.

The undersigned hereby authorizes: Name of Provider______________________________
Address__________________________________ Phone______________________ Fax _________________
to release to:
School Nurse: Name of School _____________________________ Address _________________
Phone __________________ Fax_____________________ information from his/her health record.

The following information is requested:

_______ Health History  
_______ Physical Exam Report  
_______ Immunization Records
_______ Other (specify) __________________

Information received on your child will be used for one or more of the following:

1. To facilitate evaluation of your child's Individualized Education Program.

2. To determine health needs of your child which may require special services during school.

3. To facilitate health counseling or school health services which you may wish for your child.

4. To provide School Division personnel with a better understanding of your child's health needs.

This authorization may be revoked by you at any time in writing and automatically expires on June 30 at the end of the school fiscal year.

____________________  __________________________  ________________
Date                Signature of Parent/Guardian       Relationship to Child

The school is not authorized or funded to pay for this information.