

## STUDENTS

### Student Health Services and Requirements

#### Guidelines for School Staff/Child Care Contractor (CCC) to Carry Out Health Treatment Procedure and/or Emergency Treatment Procedures in the School Setting or any Prince William County Public School (PWCS) Extended Day or Overnight Field Trip.

Medical services, except for the evaluation completed during the eligibility determination process for special education services, shall not be the responsibility of the School Division. Medical services are defined as those services delivered by or under the direction of a physician and the assignment of a one-on-one nurse. Health treatment procedures (HTP) and emergency treatment procedures are identified as health-related services which may be administered by a trained member of the family, school staff, or CCC. Any procedure associated with a child's medical condition that requires a school staff to perform at school, during any PWCS extended day or overnight field trip, or School Age Child Care (SACC) must have written HTP orders for the specified treatment. This includes the following regulations: 757-2, "Health Services – Allergic Reactions," 753-7, "Management of Students with Cancer in the School Setting," 757-5, "Administration of Asthma Medication to Students," 757-6, "Administering Insulin and Glucagon," and 757-7, "Management of Epileptic Seizures in the School Setting."

Health treatment procedures are health services that a student with a medical condition routinely requires, usually on a daily basis, in order to be maintained in the school setting/SACC, or extended day or overnight field trip; e.g., catheterization. Emergency treatment procedures are health services that a student with a medical condition may require only once in a great while, possibly never, in response to an unusual event relating to that condition; e.g., allergic reaction to certain foods. It is the parent's/guardian's responsibility to provide all supplies required to perform the student's medical procedure. If the health care provider's instruction is vague or unclear the school nurse may need to exchange information with the health care provider for clarification. (Refer to Attachment IV, if needed.)

#### I. Emergency Treatment Plan

- A. Request for an emergency treatment plan shall be made by the school/CCC upon awareness of a student having a medical condition that might require a response for which staff training is needed.
- B. The parent shall obtain the emergency treatment plan from the child's health care provider which shall specify 1) possible emergencies due to specific medical condition, 2) appropriate response, and 3) training if needed. The parent

and the health care provider must sign the emergency treatment plan (see Attachment I.)

- C. The emergency treatment plan shall be reviewed by the Supervisor of School Health Services.
- D. Three staff members shall be trained in the procedure by appropriate professionals. Trained staff members shall sign the emergency treatment plan.
- E. The emergency treatment plan shall be activated at the time of need and reviewed at least annually, before the first day of school.

## II. Health Treatment Procedure

Whenever a health treatment procedure may appropriately be administered to a child other than during the school day, SACC or extended day/overnight field trip, the School Division shall not be required to administer it.

Recommendations regarding the appropriateness of any health treatment procedures to be administered by school personnel shall be reviewed by School Health Services when necessary. No action on a treatment procedure shall be implemented until written recommendations have been thoroughly reviewed by the Supervisor of School Health Services. All HTPs shall be reviewed at least annually and upon review by the school nurse, parents, and physician, HTPs except for asthma, cancer, diabetes, allergy action, and seizure plans may remain in effect for consecutive years. A new HTP shall be requested by the school nurse if there is a change in the student's medical status during the school year. All new HTPs shall be reviewed and approved by the Supervisor of School Health Services.

Requests for the renewal of previously approved authorizations shall be submitted to School Health Services by August 1 of each school year.

The following procedures shall be adhered to whenever a health treatment procedure is required:

- A. There shall be on file a copy of the physician's authorization for a health treatment procedure and the guidelines to be followed (see Attachment II). A typed authorization signed by the health care provider shall include:

1. Name of treatment procedure in lay terms that is free from all abbreviations.
  2. Reason(s) for treatment(s) procedure.
  3. Qualifications required of the staff members administering the treatment procedure.
  4. Equipment and supplies required for the treatment procedure to be supplied by the parent.
  5. Exact procedures to be followed in the school setting/SACC, including the time intervals between applications of the treatment(s).
  6. Exact condition(s)/symptom(s) which necessitate repeating the treatment(s).
  7. Precautions/contraindications before, during, and after treatment.
  8. Problems which may arise and emergency procedures to follow.
  9. Equipment and supplies required for treatment.
  10. The source of training and ongoing consultation to be provided to staff members/CCC as authorized by the health care provider.
- B. Permission to proceed with any health treatment procedure shall be granted only upon completion of the following:
1. Parent/guardian annually makes a written request to the Supervisor of School Health Services. The physician's authorization shall be enclosed with the request.
  2. Upon receipt of the request, the Supervisor of School Health Services shall review the plan to determine if the health treatment procedure qualifies as health treatment services which PWCS/CCC would be obligated to provide. Approval or denial shall be sent to the school administrator after review.

3. Once approved, a statement shall be signed by the parent/guardian in the presence of a designee assigned by the Supervisor of School Health Services, authorizing the appropriate school staff/CCC to store the treatment supplies and to execute the treatment plan as outlined in the physician's authorization, including the training session(s).
  4. All equipment and treatment supplies shall be provided to the school/CCC by the parent. When appropriate, all supplies shall be sealed in a container appropriately dated by the licensed physician or pharmacist.
  5. Whenever equipment and treatment supplies require cleaning or sterilization, the processes shall be completed at home.
- C. When a physician authorizes the administration of a health treatment which is to be administered by school staff/CCC, the following procedures shall be followed:
1. A minimum of three persons in the building shall learn the health treatment procedure as designated in the physician's authorization. This is to ensure that at least one person is knowledgeable in completing the health treatment procedure and will be in the building during school hours. It is further recommended that person(s) working directly with any student who has cardiovascular deficiencies be CPR certified at the basic level. School bus drivers and attendants shall also be trained as appropriate.
  2. All persons administering the health treatment shall be trained as indicated by the physician(s). The training sessions for learning the authorized treatment procedure may be videotaped and kept as part of the child's confidential file if parent permission is received. A specific skills checklist shall be used to document training for each staff member trained and maintained on file at the school.
  3. A treatment/procedure log shall be used to document all health treatment/procedures done in the school setting (see Attachment III).
  4. 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, "Administering Medication."

5. 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.
  6. Should it be necessary for the health care provider to make any adjustments in health treatment procedure(s), the building administrator and Supervisor of School Health Services shall be advised in writing from the parent/guardian. The physician's new authorization shall be attached to the parent's written request. All changes shall be subject to approval and shall adhere to the procedures outlined in this regulation. Upon approval, the school personnel responsible for the health treatment procedure shall then be instructed in all changes.
  7. Whenever more than one medication and/or treatment procedure is authorized, the health care provider shall specify the order in which medication(s) and/or treatment plans shall be administered.
- D. Children with contagious and/or infectious diseases shall, according to PWCS Policy 728 and the Virginia Code §22.1-272, be excluded from school while in that condition.
- E. When a situation arises which makes the provision of a health treatment procedure temporarily inadvisable or unavailable, the student may be temporarily excluded from school.
- F. Denials for administering a treatment procedure may be appealed to the Supervisor of School Health Services.
- G. Students identified with a seizure disorder or epilepsy require only a seizure plan of care (see Regulation 757-7, "Management of Epileptic Seizures in the School Setting.")

The Associate Superintendent for Student Learning and Accountability (or designee) is responsible for implementing and monitoring this regulation.

The Associate Superintendent for Student Learning and Accountability (or designee) is responsible for reviewing this regulation in 2016.

\_\_\_\_\_  
Signature of Approval  
Supervisor of School Health Services

\_\_\_\_\_  
Date

EMERGENCY TREATMENT PLAN

STUDENT'S NAME \_\_\_\_\_

STUDENT'S SCHOOL \_\_\_\_\_

STUDENT'S GRADE \_\_\_\_\_

DIAGNOSIS/MEDICAL  
CONDITION \_\_\_\_\_

LEVEL OF CARE REQUIRED: \_\_\_\_ MINIMAL \_\_\_\_ MODERATE \_\_\_\_ COMPLEX  
OTHER: \_\_\_\_\_

LIST OF POSSIBLE EMERGENCIES THAT COULD RELATE TO SPECIFIC MEDICAL CONDITION:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

EXPLAIN EXACTLY THE PROCEDURE REQUIRED:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

LIST TRAINING NEEDED FOR ABOVE PROCEDURES TO SPECIFIC MEDICAL EMERGENCY:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

TREATMENT PROCEDURE MAY BE COMPLETED BY TRAINED SCHOOL/CCC STAFF:  
\_\_\_\_ YES \_\_\_\_ NO

OTHER: \_\_\_\_\_

Schools/CCC must obtain specific written parental/guardian authorization before any medical treatment including medication administration can be provided. When signed by the parent/guardian 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 until all signatures have been obtained. Legally appropriate school health professional-medical prescriber 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/SACC (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 be performing the above procedure on my child. I/We hereby release the Prince William County Public School Division and all of its employees of and from any and all liability in law for damages either we or our child may incur as a result of performing this procedure.

Student may not attend school until the written parental/guardian authorization has been signed and returned to the school.

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 Emergency Treatment Plan will remain in effect until annual renewal date or student's medical status requires changes.

_____ Physician's Printed Name	_____ Physician's Signature	_____ Date
_____ 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:

Printed Name	Signature	Trainer's Signature	Date of Training
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



\_\_\_\_\_  
Signature of Approval  
Supervisor of School Health Services

\_\_\_\_\_  
Date

PHYSICIAN'S AUTHORIZATION FOR HEALTH  
TREATMENT PROCEDURE(S)  
(to be typed and in lay language/no abbreviations)

STUDENT: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SCHOOL: \_\_\_\_\_ SCHOOL/SACC YEAR: \_\_\_\_\_

DATE OF AUTHORIZATION: \_\_\_\_\_ DURATION: \_\_\_\_\_

DIAGNOSIS/CONDITION: \_\_\_\_\_

LEVEL OF CARE: Minimal \_\_\_\_\_ Moderate \_\_\_\_\_ Complex \_\_\_\_\_

Other: \_\_\_\_\_

CIRCLE ONE:      INITIAL      RENEWAL      REVISED AUTHORIZATION

School/SACC Year	Physician's Signature	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

1. Name of Treatment Procedure: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Treatment Procedure may be completed by trained school/CCC staff: YES\_\_ NO \_\_

3. Reason(s) for Treatment Procedure during school day: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Exact procedure(s) to be followed in the school/SACC setting, including the time intervals between application(s) of the procedure(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Student's Name \_\_\_\_\_

5. Exact conditions which may require repeating the treatment: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Precautions/Contraindications before, during, and after treatment: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

7. Problems which may arise and emergency procedures to follow: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Equipment and supplies required for treatment: \_\_\_\_\_  
(Parent(s)/Guardian(s) must supply) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

9. Supplies: \_\_\_\_\_

Where are supplies for procedures stored: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Physician's Printed Name

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

Student's Name \_\_\_\_\_

Schools must obtain specific written parental/guardian authorization before any medical treatment including medication administration can be provided. When signed by the parent/guardian 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/SACC 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 until all signatures have been obtained. Legally appropriate school health professional-medical prescriber 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 (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).

Student may not attend school until the written parental/guardian authorization has been signed and returned to the school.

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.

I/We are aware that non-medical personnel may be performing the above procedure on my child. I/We hereby release the Prince William County Public School Division and all of its employees of and from any and all liability in law for damages either we or our child may incur as a result of performing this procedure.

Upon review and agreement by the school nurse, parent, CCC, and health care provider, this health treatment plan will remain in effect until annual review date or student's medical status requires changes.

\_\_\_\_\_  
Physician's Printed Name

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
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/CCC personnel trained in the treatment procedure:

Printed Name	Signature	Trainer's Signature	Date of Training
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## AUTHORIZATION FOR MEDICATION ADMINISTRATION

Part I - Parent or Legal Guardian to Complete - One Medication per Form				
Student Name (Last, First, Middle)			Allergies	
Date of Birth	School Name	School/SACC Year	Grade	Teacher
Has student taken this medication before? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, the first full dose must be given at home.)				
First dose was given: Date _____ Time _____				
I/We hereby request Prince William County Public School personnel/CCC to administer medication as directed by this authorization. I/We authorize school personnel/CCC to communicate with the health care provider regarding the administration of this medication as allowed by HIPPA. I/We are aware that non-medical personnel may be administering medication to our child. I/We hereby release the Prince William County Public School Division and all of its employees/CCC of and from any and all liability in law for damages either we or our child may incur as a result of this request.				
_____ Parent or Guardian Signature		_____ Daytime Telephone		_____ Date
Part II - Physician must complete this section for all prescription medication or for any nonprescription medication that is to be given for more than the recommended duration or dosage, or when age guidelines are not followed as written on the label. Nonprescription medication to be given for relief of symptoms as directed on the package label may be given with the parent or guardian's signature, and does not require a physician's authorization and signature.				
Any necessary medication that possibly can be taken before or after school/SACC should be so prescribed. Information should be written in lay language with no abbreviations.				
Student's Diagnosis:			ICD-9 Code: (when applicable)	
Name of Medication:				
Dosage of Medication:		Route:	Time(s) or interval between times to be given:	
If medication is to be given on an as-needed basis, specify the symptoms or conditions when medication is to be taken and the time at which it may be given again.				
Effective date: <input type="checkbox"/> Current School/SACC Year _____ Or <input type="checkbox"/> From _____ To _____				Medication expires on:
_____ Physician Name (Print)		_____ Physician Signature		_____ Telephone
_____ Parent or Guardian Name (Print)		_____ Parent or Guardian Signature		_____ Date
Parent Information Regarding Medication Procedures				
The parent or guardian must transport medications to and from school/SACC. All prescription medications, including physician prescription drug samples, must be in their original containers and labeled by a physician or pharmacist. Over-the-counter medication must be in the original, sealed container. No medication will be accepted by school personnel/CCC without receipt of completed and appropriate medication forms.				
Within one week after expiration of the effective date on the physician order, or on the last day of school/SACC, the parent or guardian must personally collect any unused portion of the medication. Medications not claimed within that period will be destroyed.				
A physician may use office stationery or a prescription pad in lieu of completing Part II. Faxed authorization may be acceptable as long as there is a signed parental consent. Any changes in the original medication authorization will require a new written authorization and a corresponding change in the prescription label.				



**Procedure Codes:**

- (C) Catheterization
- (D) Dressing Change (odor, drainage color, redness, warmth)
- (F) Tube Feeding (amount given, tolerated (Y/N))
- (G) Glucose Monitoring
- (N) Nebulizer (breath sounds - RN only)
- (S) Suctioning

**Signature Log:** Required for each staff member performing procedure

Initials	Signature	Date

**Comments (document any unusual changes and/or pertinent information):**

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Attachment IV  
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/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 individual 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 anytime in writing and automatically expires on June 30 at the end of the school fiscal year.

_____ Date	_____ Signature of Parent/Guardian	_____ Relationship to Child
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The school is not authorized or funded to pay for this information.