Hillsborough County
PUBLIC SCHOOLS
Excellence in Education

GUIDELINES FOR ADMINISTRATION OF MEDICATION

It is recognized that medications may be essential for some students. When possible, all medications should be administered at home. If medication must be given at school, the following procedures must be followed:

1. A signed statement by the parent/guardian requesting the administration of medication must accompany all medication. The official authorization form (SB 87034) must be returned to school within two (2) days following the initial receipt of the medication. New authorization forms will be required when any changes with the orders occur.

2. Medication must be sent to school via a parent or guardian. It is not safe for children to delivery medicine to the school. This policy prevents safety concerns of lost or stolen medicines, students sharing medicines with friends, students taking medicine unsupervised.

3. Medication must be in the prescription container with the date, dosage, name of drug, and students' and physician's names clearly marked. Medication must remain in the container in which it was originally dispensed. Most pharmacies will provide an extra empty labeled bottle for parents if requested when the prescription is filled.

4. Parents should arrange for a separate supply of medication for school. Medication will not be transported between home and school on a daily or weekly basis. Exceptions by Florida statutes 1002.20(h)(i) are Asthma Inhalers and EpiPens which require special parent forms and physician forms/doctor's orders.

5. When any medications are added or discontinued, a new authorization form will be required.

6. When medication dosages or times are changed, both steps must be followed:

   a) A written note from the parent requesting the changes must be sent to the school and then a new signed authorization form with the correct information must be completed.
   b) A new label from the pharmacist or physician's order/prescription indicating the change must be sent to the school. A fax is acceptable.

7. Medication will be stored in a locked cabinet at the school at all times. Exceptions by statutes are Asthma Inhalers and EpiPens which students carry and require special parent and physician forms/doctor's orders.

8. Since there are a number of students who receive medication during school hours, a school district employee designated by the principal will administer medication.

9. Oral nonprescription (over-the-counter) or sample drugs will be dispensed only when accompanied by written orders from a physician. Medication is always to remain in the container in which it was purchased. Written parental authorization is needed for all nonprescription drugs. Cough drops will be treated as an over-the-counter medication. Students may not carry over the counter medicines at school. Possession of drugs of any kind can lead to serious disciplinary action.

GUIDELINES FOR ADMINISTRATION OF MEDICATION (cont.)

10. Substances not to be given at school are all unregulated products, such as herbs and food supplements, which are being used as treatments, dietary supplements, or folk remedies.

11. *No Prescription Narcotic analgesics* are to be dispensed at school. The side effects make it unsafe for students to attend school while medicated with narcotics.

12. Liquid medication will be given in a calibrated measuring device. The parent should supply a calibrated measuring device.

13. When medication is discontinued or, at the end of the school year, medication not taken home by the parent will be destroyed.

14. Planning and protocols for any medication or treatment which requires one time dosage for a specific intent are the responsibility of the Registered Nurse ONLY>

15. Parents of students attending after school programs, will need to make arrangements with the after-school programs when medicines or treatments are needed.

Florida Statue 1006.062 is the reference for the above guidelines.

Questions regarding these procedures should be directed to the Health Services Nurse assigned to the school your child attends or to the office of School Health Services, Department of Student Support, 273-7020.

Physician Authorization for Administration of Medication(s)

Student Name_____ DOB__/__/__ Grade/Class_____

Over the counter medication can be given at school with the consent of a parent and **physician's signature is required** for the dispensing of the following common OTC medications. Each medication will be administered as directed by the physician's order (**WITH DOSING AMOUNTS**). Please circle yes of no if your child is allowed to have the medications listed below administered at school.

Acetaminophen for pain **DOSE & Frequency:**	Yes	No	Ibuprofen for pain **DOSE and Frequency:**	Yes	No
Petroleum Jelly for chapped lips, abrasions	Yes	No	Hydrocortisone cream 1% for itching	Yes	No
Heating pad for aches and/or menstrual cramps	Yes	No	Antacid for GI upset (Tums)	Yes	No
Baking soda paste for stings and splinters	Yes	No	Hard Candy for sore throat	Yes	No

Please note If the child has an elevated temperature (≥100.0 ° F), vomiting, diarrhea, rash, green respiratory drainage, green drainage from one or both eyes &/or lice, a parent or guardian will be contacted and will need to make arrangements to pick their child up immediately. Students may not return until they have been fever/symptom free for 24 hours (without medication). If necessary, the school nurse and/or principal may ask for a written statement from a licensed physician stating it is safe for the student to return.

List all allergies, drug reactions, and health conditions:

_____

_____

_____

List all medications taken at home on a regular basis:

_____

_____

_____

We understand that under the provision of Florida Statute 232.46 school personnel cannot be held liable for reactions or side effects from the administration of the above medication(s). We also grant permission to contact myself and/or the physician if there are questions or concerns about medications. I have read the "Guidelines for Administrations of Medication".

Parent/Guardian Signature_____ **Physician Stamp:**

Daytime Contact Number_____

Physician's Signature_____

Physician's Phone Number_____

Date_____

Hillsborough County Public Schools
Tampa, Florida
School Health Services • 1202 E. Palm Ave. • Tampa, FL • 33605 • 813-273-7020

Authorization for Administration of Medication and Management of Diabetes In the School Setting

INSTRUCTIONS:
1. When the information on this form is completed and signed by the Physician and Parent, it will serve as the Physician Orders in the school setting.
2. If the Physician's Office has a comparable form it will be acceptable and can serve as the Physicians Orders.
3. The School Nurse will review the information.
4. Attach Student's Emergency Card to this form.

Date: _____

Student's Name _____ **Birth Date:** _____

*My permission is hereby granted to **School Health Services Personnel / and or to Principal's Designee** to administer and / or allow Student to self-administer the following medications and treatments.*

I. BLOOD GLUCOSE MONITORING:

To be performed at school: Yes _____ No _____

To be performed by the Student or the Principal's Designee (requires affidavit): Yes _____ No _____

Type of Meter: _____ Target Range for BG: _____ mg/dl to _____ mg/dl

Time to be performed:

_____ Before breakfast
_____ Mid-morning: before snack
_____ Before lunch
_____ Dismissal
_____ Before PE / Activity Time
_____ After PE / Activity Time
_____ Mid-afternoon
_____ PRN for signs / symptoms of ↓BS

II. INSULIN ADMINISTRATION:

To be performed by Student or Health Services Personnel: Yes _____ No _____

(If YES, complete the following section)

TYPE OF INSULIN	DOSE	TIME TO BE ADMINISTERED
_____ Humalog		
_____ Regular		
_____ NPH		
_____ Lente		
_____ Ultralente		
_____ Other _____		

_____ Insulin Delivery Method

_____ # unit(s) per _____ grams Calculate Insulin dose for Carbohydrate Intake Yes _____ No _____

SLIDING SCALE:

Blood Sugar: _____ Amount of Insulin: _____
Blood Sugar: _____ Amount of Insulin: _____
Blood Sugar: _____ Amount of Insulin: _____
Blood Sugar: _____ Amount of Insulin: _____

ADDITIONAL INSTRUCTIONS:

_____

_____

III. MEALS/SNACKS INSTRUCTIONS:

Can student determine correct portions & number of carbohydrate servings? Yes _____ No: _____

(Parents to provide snacks if necessary and will restock supplies as needed)

Meal Event	Time/ Location	Food Content & CHO Amount
____ Breakfast		
____ Mid-morning		
____ Lunch		
____ Mid-afternoon		

Meal Event	Time/ Location	Food Content & CHO Amount
____ Before PE/Activity		
____ After PE/Activity		
____ PRN for Low BG		
____ Special Snacks		
Instructions:		

IV. MANAGEMENT OF HIGH BLOOD SUGAR (>200 mg/dl)

(Follow sliding scale as indicated above; if nausea / vomiting – call parent; student to be sent home)

USUAL SIGNS / SYMPTOMS FOR THIS CHILD:

_____ Increased thirst, urination, appetite
_____ Tired / drowsy / less energy
_____ Blurred vision
_____ Warm, dry, or flushed skin
_____ Other _____

INDICATE TREATMENT CHOICES:

_____ Sugar free fluids
_____ Avoid concentrated sweets
_____ Frequent bathroom privileges
_____ May not need snack
_____ Other _____

V. MANAGEMENT OF VERY HIGH BLOOD SUGAR (>500 mg/dl)

USUAL SIGNS / SYMPTOMS FOR THIS CHILD:

_____ Nausea / vomiting
_____ Abdominal pain
_____ Rapid, shallow breathing
_____ Weakness / muscle aches
_____ Dry mucous membranes
_____ Extreme thirst
_____ Fruity breath odor _____
Other _____

INDICATE TREATMENT CHOICES:

_____ Check urine for **Ketones**
_____ Notify parents if signs/symptoms present
From previous column
_____ If unable to reach parents, call 911
_____ Sugar-free fluids if tolerated
_____ Frequent bathroom privileges
_____ Stay with student and document changes in status
_____ Other _____

VI. MANAGEMENT OF LOW BLOOD SUGAR *(range of low BS for this student)*

Less than < [ ] ***mg/dl (may vary for individual student)***

EMS will be called for Extreme Low BS

USUAL SIGNS / SYMPTOMS FOR THIS CHILD:

_____ Change in personality
_____ Weak/ shaky/ tremors
_____ Tired/ drowsy/ fatigue
_____ Dizzy/ staggering walk
_____ Headache
_____ Inattentive/ confused
_____ Nausea/ loss of appetite
_____ Clammy/ sweating
_____ Blurred vision
_____ Irritability/ crying/ aggressive
_____ Loss of consciousness
_____ Slurred speech
_____ Seizures

INDICATE TREATMENT CHOICES:

_____ Call EMS if unconscious or seizure
_____ 4-6 oz. Fruit juice or sweetened drink
_____ 4-6 Sugar cubes or hand candies
_____ 3 Glucose tablets
_____ Concentrated gel or tube frosting
_____ Honey, syrup, table sugar
_____ Retest BG 15-20 minutes post snack
_____ Repeat treatment until good response
_____ Follow treatment with snack of
Protein/ carbohydrates
_____ ***Glucagon Injection** (requires affidavit)
_____ Other _____

VII. LIST ANY OTHER MEDICATIONS TO BE GIVEN AT SCHOOL:

Medication	Dose	Time	Route	Possible side effects

I understand that treatments and procedures are being performed by the Student, School Health Staff or Principal Designee within the school or by EMS in the event of loss of consciousness or seizure. I also understand that the school is not responsible for damage, loss of equipment, or expenses utilized in these treatments and procedures. I have reviewed and agree with the indicated instructions.

_____
Name of School

_____ _____ _____
Physician's Signature / Date | Parent's Signature / Date | School Nurse Contact

_____ _____ _____
Phone Number | Phone Number | Phone Number

HILLSBOROUGH COUNTY PUBLIC SCHOOLS

HILLSBOROUGH COUNTY PUBLIC SCHOOLS
School Health Services
Diabetes Medical Management Plan Supplement For Student Wearing Insulin Pump

Reviewed 3-2017

School Year _____ - _____

Student Name: _____ **Date of Birth:** _____ **Pump Brand/Model:** _____

Pump Resource Person : _____ Phone/Beeper: _____ (See basic diabetes plan for parent phone #)

Child-Lock On? _____ Yes _____ No How long has student worn an insulin pump? _____

Blood Glucose Target Range : _____ Pump: Insulin _____ Humalog _____ Novolog _____ Regular

Insulin: Carbohydrate Ratios: _____

(Student to receive carbohydrate bolus _____ *immediately before / minutes* before eating)

Lunch/Snack Boluses Pre-programmed? _____ Yes _____ No Times _____

Insulin Correction Formula for Blood Glucose Over Target: _____

Extra pump supplies furnished by parent/guardian: ☐ infusion sets ☐ reservoirs ☐ batteries ☐ dressings/tape ☐ insulin ☐ syringes/insulin pen

	STUDENT PUMP SKILLS	NEEDS HELP?		IF YES, TO BE ASSISTED BY AND COMMENTS:
1.	Independently count carbohydrates	Yes	No	
2.	Give correct bolus for carbohydrates consumed	Yes	No	
3.	Calculate and administer correction bolus	Yes	No	
4.	Recognize signs/symptoms of site infection.	Yes	No	
5.	Calculate and set a temporary basal rate.	Yes	No	
6.	Disconnect pump if needed.	Yes	No	
7.	Reconnect pump at infusion set	Yes	No	
8.	Prepare reservoir and tubing.	Yes	No	
9.	Insert new infusion set.	Yes	No	
10.	Give injection with syringe or pen, if needed.	Yes	No	
11.	Troubleshoot alarms and malfunctions.	Yes	No	
12.	Re-program basal profiles if needed.	Yes	No	

MANAGEMENT OF HIGH BLOOD GLUCOSE ***Follow instructions in basic diabetes medical management plan, but in addition:***

If blood glucose over target range _____ hours after last bolus or carbohydrate intake, student should receive a correction bolus of insulin using formula; Blood glucose - _____ ÷ _____ = _____ units insulin

If blood glucose over 250, check urine ketones.

1. **If no ketones** give bolus by pump and recheck in 2 hours.
2. **If ketones present or,** _____ Give correction bolus as an injection immediately and contact parent / health care provider.

If two consecutive blood glucose readings over 250 (2 hours or more after first bolus given).

1. Check urine ketones.
2. Give correction bolus as an injection.
3. Change infusion set.
4. Call parent.

MANAGEMENT OF LOW BLOOD GLUCOSE Follow instructions in Basic Diabetes Care Plan, but in addition:

If low blood glucose recurs without explanation, notify parent/diabetes provider for potential instructions to suspend pump.

If seizure or unresponsiveness occurs:

1. Call 911 (or designate another individual to do so).
2. Treat with Glucagon (See basic Diabetes Medical Management Plan).
3. Stop insulin pump by:
   - _____ Placing in "suspend or stop mode (See attached copy of manufacturer's instructions).
   - _____ Disconnection at pigtail or clip (Send pump with EMS to hospital).
   - _____ Cutting tubing.
4. Notify Parent.
5. If pump was removed, send with EMS to hospital.

ADDITIONAL TIMES TO CONTACT PARENT

- _____ Soreness or redness at infusion site.
- _____ Detachment of dressing / infusion set out of place.
- _____ Leakage of insulin.
- _____ Insulin injection given.
- _____ Other: _____

Effective Date(s) of Pump Plan: _____

Parent's Signature: _____ Date: _____

School Nurse's Signature: _____ Date: _____

Diabetes Care Provider Signature: _____ Date: _____

AFFIDAVIT FOR
PARENTAL AUTHORIZATION
FOR THE ADMINISTRATION OF
DIABETIC INJECTABLES
AND / OR DIABETIC PROCEDURES

TO: Hillsborough County School Board
School Health Services
1202 E. Palm Ave.
Tampa, FL 33605
813-273-2378

We/I, the undersigned, _____ ,have enrolled
Our/my child, _____ at _____
(Child's Name) **(Name of School)**

It may be necessary for my child to have one or more of the following medical procedures performed during school hours.
(Please check off the appropriate procedures)

☐ **1. Finger Sticks for Blood Glucose Monitoring** ☐ **2. Insulin Injections** ☐ **3. Glucagon Injections**

Physician's Orders for these procedures are attached to this document.

We / I specifically request that these procedures be administered by members of the school staff. With the signing of this document, we / I affirm that the individuals listed therein have been trained to perform these procedures to my satisfaction and that the procedures used meets with my approval. We / I thereby release all claims, demands, damages, actions, causes of action or suits at law or in equity, of whatsoever nature against the School Board or any employees for following this request.

We / I also understand that if there is equipment and medication needed to perform this procedure, it will be maintained by us / me; delivered to the school in working order; and that school personnel will assume no responsibility for the proper maintenance or delivery of the equipment or medication necessary for this procedure.

The following staff members have been trained to our / my satisfaction and in accordance with a procedure established by the school under the order of _____
(Physician's Name)

1. **Finger Sticks for Blood Glucose Monitoring**

Equipment to be supplied by parent	**List Names of Staff Members / Position**
	1.Includes ALL School Health Personnel

2. **Insulin Injections**

Equipment to be supplied by parent	**List Names of Staff Members / Position**
	1.Includes ALL School Health Personnel

3. **Glucagon Injections**

Equipment to be supplied by parent	**List Names of Staff Members / Position**
	1.Includes ALL School Health Personnel

SWORN TO AND SUBSCRIBED BEFORE ME ON THIS _____ of _____, _____
Day Month Year

_____ _____ _____
Signature of Notary Date Signature of Parent / Guardian

Hillsborough County
PUBLIC SCHOOLS
Excellence in Education

Authorization For Student to Carry and Independently Self-Administer Emergency Medication(s)/Procedure(s) for Life Threatening Medical Conditions

Date: _____

Student's Name: _____ **Birth date:** _____

School: _____

Teacher's Name: _____ **Grade / Homeroom** _____

To be completed by physician:

Diagnosis: _____

The above named student is under my care. I feel that this student has a life threatening illness and that he/she is capable of and has been instructed in the proper administration of the required medication(s) and/or procedure(s). The student has been instructed in the treatment plan, self-administration of their medications / procedures and has demonstrated the skill level necessary to manage their own care.

Telephone	*Printed Physician's Name*	*Signature*	*Date*

To be completed by parent:

I request and give permission for my child to carry and self-administer the medication(s) and/or procedure(s), as indicated in the physician's order during the school day, at school-sponsored activities or while in transit to or from schools. I have observed my child demonstrate the necessary skill level to implement the care plan prescribed by his/her health care provider. I am responsible for ensuring my child has all medications, procedure equipment and supplies for their life threatening condition. Adult supervision will not be provided. This form is effective only for this school year and includes all school sponsored activities and summer school.

By signing this form, I am indemnifying and holding the district harmless against any injury or claims that arise as a result of the student's self-management of life threatening condition. Permission is also granted for school personnel to contact the physician if there are questions or concerns about the medication(s) and/or procedure(s). We/I are aware the privilege of self-administration of medication(s)/procedure(s) can be withdrawn if abused by the student. The district reserves the right to seek emergency medical treatment for the student when deemed necessary and appropriate.

Telephone	*Printed Parent/Guardian Name*	*Signature*	*Date*

To be completed by student at school:

☐ I will keep my medication, supplies & equipment with me at school ☐ I will use only as prescribed by my doctor ☐ I will not allow any other person to use my medication(s) or procedure equipment ☐ I will notify a school staff member if I am having more difficulty than usual with my health condition.

Printed Student Name	*Signature*	*Date*
Printed Registered Nurse Name	*Signature*	*Date*

Distribution: Nurse

(Updated 10-11-2010) (rev.3.2017)