

Measures have been taken, by the Utah Department of Health, Bureau of Health Promotions, to ensure no conflict of interest in this activity

# Developing Individualized Healthcare and Emergency Care Plans

BettySue Hinkson MSN RN NCSN

# IHPs vs ECPs/EHPs/EAPs

- Individualized Healthcare Plans (IHPs) or
- Emergency Classroom Plans (ECPs) / Emergency Healthcare Plans (EHPs) / Emergency Action Plan (EAP)

What is the difference?



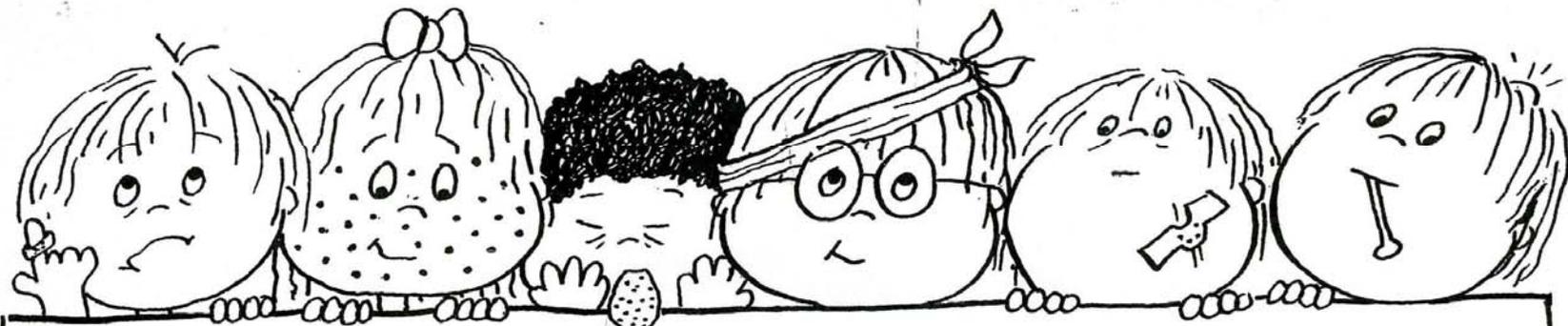
# IHPs versus ECPs

- Individualized Healthcare Plans
  - Include nursing language
  - Are written for nurses, not staff
- Emergency Classroom Plans
  - Are written for lay-staff
  - “if you see this – do this”



# Should Utah have Standardized Plans?

- Yes, and No
  - Yes, it would simplify things
  - No, not all districts have same requirements
  - No, many nurses like to be able to modify their own forms



# Who Needs a Plan?

Everyone with a medical condition?

Everyone with medication at school?

Everyone with diabetes?

May depend on district policy, but usually every student with life-saving medication during school hours

- Epinephrine
- Inhalers
- Insulin/glucagon



© Simbus Technology, Inc.  
HETUES.COM

And those students with complicated medical needs including those students needing medical accommodations at school

- Spina bifida
- Severe seizures

# What NOT to Include

- Depends on who it is written for (nurse or teacher)
  - Do not expect a teacher, UAP, or other staff to understand nursing language
  - Do not expect a teacher, UAP, or other staff to read more than 1-2 pages
  - Do not expect a teacher, UAP, or other staff to care about nursing goals, nursing diagnoses, etc.



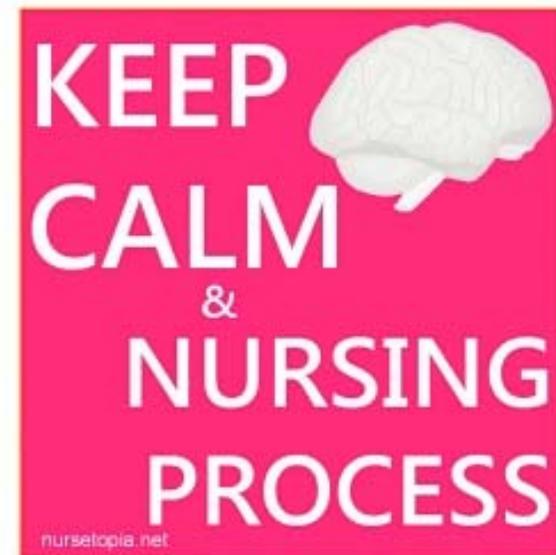
# So Which Should We Write?



- Depends on the setting in which we practice
  - Special education school where nurse is on-site?
    - May have more IHPs for case management and some ECP for teacher information
  - Regular school nurse that travels to several schools?
    - Probably has more ECPs
  - Some cases may have both IHPs and ECPs

# What to Include

- In an IHP
  - Demographics including DOB
  - Many formats available, many are copy written, can be tailored to meet individual student's needs
  - Written in nursing language
  - Address all aspects of Nursing Process
    - Assessment
    - Nursing Diagnosis
    - Goals and Outcomes
    - Planning/Nursing Interventions
    - Implementation
    - Evaluation
- Parent and physician signature



# Sample IHP

## Respiratory Dysfunction Individualized Healthcare Plan

Date	Nursing Diagnosis (ND)	Nursing Interventions	Goals/Outcomes	Date Achieved:
	<ol style="list-style-type: none"> <li>1. Potential for infection related to excessive pooling of secretions.</li> <li>2. Potential for effective airway clearance related to increase secretions</li> <li>3. Ineffective airway clearance related to perceptual and cognitive impairment</li> <li>4. Ineffective breathing pattern related to neurologic or musculoskeletal impairment</li> <li>5. Potential ineffective airway clearance related to increased secretions secondary to tracheostomy, obstruction of inner cannula or displacement of tracheostomy tube.</li> <li>6. Impaired verbal communication related to inability to produce speech secondary to tracheostomy.</li> </ol>	<ol style="list-style-type: none"> <li>1. Suction secretions from airway as needed to clear airway and stimulate cough reflex (ND1-5)</li> <li>2. Position to prevent aspiration of secretions, provide for comfort and maximize lung expansion. (ND 2-5)</li> <li>3. Assist student to expectorate sputum. (ND1-5)</li> <li>4. Perform percussion, vibrations, and postural drainage if prescribed. (ND 1,2,5)</li> <li>5. Maintain adequate hydration to thin secretions. (ND 1-5)</li> <li>6. Maintain adequate humidity of hair to promote thinning of secretions. (ND 1-5)</li> <li>7. Provide nebulization with appropriate solution and equipment as prescribed. ND 2-4)</li> <li>8. Instruct proper method of controlled coughing. (ND 1-5)</li> <li>9. Administer medications as ordered. (ND 1,2,5)</li> <li>10. Refer and follow up for medical care if needed. (ND 1-5)</li> <li>11. Obtain current medication orders or procedures that are needed in the school setting. (ND 1-5)</li> <li>12. Maintain current medical records for documentation. (ND 1-5)</li> <li>13. Utilize method of communication by which student can make his or her needs known. (ND 6)</li> <li>14. Identify and utilize factors that promote communication. (ND 6)</li> <li>15. Refer to speech pathologist to assess and facilitate methods of communication. (ND 6)</li> <li>16. Nurse will have base line vital signs, BP P R and temp.</li> </ol>	<ol style="list-style-type: none"> <li>1. Student will have decreased pooling of secretions and will remain free of infection. (ND1)</li> <li>2. Student's airway will remain clear. (ND 1-5)</li> <li>3. Student will breathe easily. (ND 3-5)</li> <li>4. Respirations are within normal limits and are not labored. (ND 2-5)</li> <li>5. Student will not experience aspiration. (ND 2-5)</li> <li>6. Student will communicate needs. (ND 6)</li> </ol>	

\_\_\_\_\_  
Parent signature

\_\_\_\_\_  
RN signature

# What to Include

- In an ECP should always include:
  - Demographic information with DOB
  - Medical diagnosis
  - Contact information for parent/guardian
  - Signs/symptoms to watch for
  - Interventions (medication, treatment, etc.)
  - Where is medication (if ordered) kept (office, backpack?)
  - Student-specific information
  - Picture if possible
  - Parent and possibly Doctor signature

Here are some sample forms. These are suggestions only, **they are NOT State Required forms.**



# Sample Anaphylaxis ECP

## Anaphylaxis Emergency Action Plan Effective Date: \_\_\_\_\_

Allergy to: \_\_\_\_\_ Asthmatic? Yes No

Name \_\_\_\_\_ DOB \_\_\_\_\_ Parent email \_\_\_\_\_  
 Parent/Guardian \_\_\_\_\_ Phone \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Severity Classification	Triggers
<input type="checkbox"/> Mild	<input type="checkbox"/> Peanuts <input type="checkbox"/> eggs <input type="checkbox"/> Insect Stings (list) _____
<input type="checkbox"/> Moderate	<input type="checkbox"/> Tree nuts <input type="checkbox"/> milk <input type="checkbox"/> all dairy _____
<input type="checkbox"/> Severe	<input type="checkbox"/> Shellfish <input type="checkbox"/> soy <input type="checkbox"/> fish _____
	<input type="checkbox"/> Latex <input type="checkbox"/> animals <input type="checkbox"/> other _____

Mild to Moderate Allergic Reaction	Action
<input type="checkbox"/> NOSE (itchy/runny nose, sneezing)	-Stay with child and call for help -Give medication (antihistamines, if ordered by physician) -Contact emergency contacts -If symptoms worsen, <b>give epinephrine</b>
<input type="checkbox"/> SKIN (a few hives, mild itch)	
<input type="checkbox"/> MOUTH (itchy mouth)	
<input type="checkbox"/> GUT (mild nausea/discomfort)	
<input type="checkbox"/> other _____	

Anaphylaxis (Severe allergic reaction)	Action
<input type="checkbox"/> LUNG (short of breath, wheezing, repetitive cough) <input type="checkbox"/> HEART (pale, blue, faint, weak pulse dizzy) <input type="checkbox"/> THROAT (tight, hoarse, trouble breathing/swallowing) <input type="checkbox"/> MOUTH (significant swelling of the tongue and/or lips) <input type="checkbox"/> SKIN (many hives over body, widespread redness) <input type="checkbox"/> GUT (repetitive vomiting or severe diarrhea) <input type="checkbox"/> OTHER (feeling something bad is about to happen, anxiety, confusion) OR A COMBINATION of mild or severe symptoms from different body areas	- <b>Give epinephrine IMMEDIATELY.</b> -Call 911. Request ambulance with epinephrine -Contact emergency contacts -Transport student to ER even if symptoms resolve. Student should remain in ER for 4+ hours because symptoms may return.  - <b>Do not depend on antihistamines or inhalers to treat a severe reaction. Use epinephrine.</b>

Medications/Doses	Weight: _____ Age: _____
Epinephrine Brand: _____	Dose: _____ 0.15 mg IM _____ 0.3 mg IM
Antihistamine Brand or Generic: _____	
Antihistamine Dose: _____	
Other (e.g., inhaler-bronchodilator if asthmatic): _____	

Location of medication: \_\_\_\_\_ Office\* \_\_\_\_\_ With teacher\* \_\_\_\_\_ With student\*

\*A completed Medication Authorization Form must be signed by both parent and physician and on file in the office before any medication can be given or carried at school (by State law).

### STATEMENT OF ACKNOWLEDGEMENT/RELEASE OF INFORMATION

As parent/guardian of the above named student, I give my permission to the school nurse and other designated staff to perform and carry out the tasks as outlined in this Emergency Action Plan (EAP) and for my child's healthcare provider to share information with the school nurse for the completion of this plan. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the school nurse whenever there is any change in the student's health status or care. Parents/Guardian and student are responsible for maintaining necessary supplies, medications and equipment.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

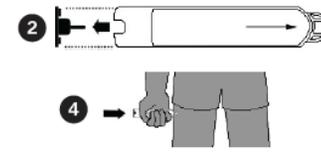
Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

School Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*If epinephrine is administered, student should ALWAYS be transported to the hospital by ambulance.**

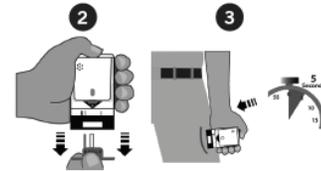
### EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



### AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



### ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



# Sample Asthma ECP

Utah Department of Health/Utah State Office of Education  
**Asthma Action Plan, Medication Authorization  
 & Self-Administration Form**  
 In accordance with Utah Code 53A-11-602

\_\_\_\_\_  
 Student Name      \_\_\_\_\_      \_\_\_\_\_      20\_\_\_\_ - 20\_\_\_\_  
 Date of Birth      School      School Year

**PHYSICIAN TO COMPLETE:**

**Green Zone: Doing Great!**

You have ALL of these:

- Breathing is easy
- No cough or wheeze
- Can sleep all night
- Able to work and play normally

Controller (preventive) medications taken at home:

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ When: \_\_\_\_\_  
 Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ When: \_\_\_\_\_  
 Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ When: \_\_\_\_\_

Avoid these asthma triggers:  Dust  Pet dander  Colds  Tobacco smoke  Mold  
 Exercise  Strong odors  Pollen  Invasions  Other: \_\_\_\_\_

Take quick-relief medication (see medication order in Yellow Zone):

Before exercise/exposure to a trigger      When: \_\_\_\_\_  
 Other: \_\_\_\_\_      When: \_\_\_\_\_

**Yellow Zone: Caution!**

You have ANY of these:

- Coughing or wheezing
- Tight chest
- Shortness of breath
- Waking up at night

Quick-relief medication with spacer (if available):	Dose:	Time interval to repeat dose:
Inhaler: _____	_____	_____
Nebulizer: _____	_____	_____

Possible side effects: \_\_\_\_\_

Parent should contact Healthcare Provider below if 1) quick-relief medication is needed more often than every 4 hours, or needed every 4 hours for more than a day or 2) there is no improvement after taking medication

**Red Zone: Emergency!**

You have ANY of these:

- Can't eat or talk well
- Breathing hard and fast
- Medicine isn't helping
- Rib or neck muscles show when breathing in

**Call 911 for an ambulance or go directly to the emergency department**

Repeat quick-relief medication every 20 minutes until medical help arrives.  
 Other: \_\_\_\_\_

Parent should contact Healthcare Provider below while providing treatment.

The above reflects my plan of care for the above named student.  
 (Please check)  It is /  It is not medically appropriate for the student to self-administer asthma medication and be in possession of asthma medication at all times. The medication(s) prescribed for this student is/are identified above.

\_\_\_\_\_  
 Healthcare Provider (print)      \_\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_  
 Signature      Date      Office Phone      Office Fax

**PARENT TO COMPLETE:**

(Please check)  Yes /  No : I authorize my child \_\_\_\_\_ to carry and self-administer the medications identified above consistent with Utah Code 53A-11-602. My child and I understand there are serious consequences for sharing any medications with others.

As parent/guardian of the above named student, I give my permission to the school nurse and other designated staff to administer medication and follow protocol as identified in the asthma action plan. I agree to release, indemnify, and hold harmless the above from lawsuits, claim expense, demand or action, etc., against them for helping this student with asthma treatment, provided the personnel are following physician instruction as written in the asthma action plan above. Parents/Guardians and students are responsible for maintaining necessary supplies, medication and equipment. I give permission for communication between the prescribing health care provider, the school nurse, the school medical advisor and school-based clinic providers necessary for asthma management and administration of medication. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis and that it is the responsibility of the parent/guardian to notify school staff whenever there is any change in the student's health status or care.

\_\_\_\_\_  
 Parent Name (print)      \_\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_  
 Signature      Home Number      Cell Number

\_\_\_\_\_  
 Emergency Contact      \_\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_  
 Relation      Home Number      Cell Number

**SCHOOL NURSE/PRINCIPAL DESIGNEE TO COMPLETE:**

Signed by physician and parent (both parts 1 and 2)  
 Medication is appropriately labeled  
 Medication log generated  
 Inhaler is kept:  Student Carries  Backpack  In Classroom  Health Office  Front Office  Other: \_\_\_\_\_  
 Asthma Action Plan distributed to need to know staff:  
 Teacher(s)  
 PE teacher(s)  
 Transportation  
 \_\_\_\_\_  
 Signature      Date

# Sample Asthma ECP



## Asthma Emergency Action Plan

Effective Date \_\_\_\_\_ Grade: \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Parent email \_\_\_\_\_  
Parent \_\_\_\_\_ Phone \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_  
Physician \_\_\_\_\_ Phone \_\_\_\_\_

### Severity Classification

Mild Intermittent  
 Mild Persistent  
 Moderate Persistent  
 Severe Persistent

### Triggers

illness  weather  pests  
 exercise  animals  odors/perfumes  
 dust  food  plants  
 smoke  ozone/pollution  mold  
 other \_\_\_\_\_

### Symptoms of an asthma episode may include any/all of these:

- Changes in breathing: coughing, wheezing, breathing through mouth, shortness of breath
- Verbal reports of: chest tightness, chest pain, cannot catch breath, dry mouth "neck feels funny", doesn't feel well, speaks quietly.
- Appears: anxious, sweating, nauseous, fatigued, stands with shoulders hunched over and cannot straighten up easily.

### Signs of an asthma emergency:

- Breathing with chest and/or neck pulled in, sits hunched over, nose opens wide when inhaling. Difficulty in walking and talking.
- Blue-gray discoloration of lips and/or fingernails.
- Failure of medication to reduce worsening symptoms with no improvement 15-20 minutes after initial treatment.
- Respirations greater than 30 per minute
- Pulse greater than 120 per minute

### TREATMENT:

- Stop activity immediately
- Help student assume a comfortable position. Sitting up is usually more comfortable.
- Encourage purse-lipped breathing.
- Encourage fluids to decrease thickness of lung secretions.
- Give medication as ordered: \_\_\_\_\_  
(A signed Medication Authorization form must be on file before medication can be carried or stored at school)
- Observe for relief symptoms. If no relief noted in 15-20 minutes, follow steps below for an asthma emergency.

Location of medication:  Office\*  Classroom\*  With student\*

\*A completed Medication Authorization Form must be signed by both parent and physician and on file in the office before any medication can be given or carried at school (by State law).

### In an ASTHMA EMERGENCY:

#### Call 911 NOW if the following danger signs are present:

- Trouble walking/talking due to shortness of breath
- Lips or fingernails blue

### STATEMENT OF ACKNOWLEDGEMENT/RELEASE OF INFORMATION

As parent/guardian of the above named student, I give my permission to the school nurse and other designated staff to perform and carry out the tasks as outlined in this Asthma Action Plan and for my child's healthcare provider to share information with the school nurse for the completion of this plan. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the school nurse whenever there is any change in the student's health status or care. Parents/Guardian and student are responsible for maintaining necessary supplies, medications and equipment.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_  
Physician Signature \_\_\_\_\_ Date \_\_\_\_\_  
School Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_

# Sample Diabetes ECP

## Diabetes Individualized Health Care Plan

Effective Date: \_\_\_\_\_

\_\_\_\_\_ 504 Plan \_\_\_\_\_ Special Education Plan  
 Type I Diabetes \_\_\_\_\_ Type II Diabetes

STUDENT INFORMATION		Age at diagnosis:	
Student:	School Year:	School:	Grade:
Date of birth:	Relationship: _____	Both Parents: _____	Other: _____
Parent/Guardian:	Phone(s): _____	Email: _____	
Parent/Guardian:	Phone(s): _____	Email: _____	
Other contact (name): _____	Phone: _____		
Physician:	Phone: _____	FAX: _____	
Physician:	Phone: _____	FAX: _____	
School Nurse:	School Phone: _____	FAX: _____	

### Blood Glucose Testing

\_\_\_\_ Student is independent \_\_\_\_ Student needs assistance with testing \_\_\_\_ Student needs supervision

Times to test:  
 \_\_\_\_ before lunch \_\_\_\_ before PE \_\_\_\_ before going home \_\_\_\_ As needed \_\_\_\_ other \_\_\_\_\_

Call parent if blood glucose is below \_\_\_\_\_ mg/dl or above \_\_\_\_\_ mg/dl

Always test if showing signs/symptoms of low or high blood glucose

### Insulin Delivery

Insulin needed during school hours? \_\_\_\_ Yes \_\_\_\_ No

Type of insulin: \_\_\_\_\_

Method of insulin delivery if needed at school: \_\_\_\_ Syringe \_\_\_\_ Insulin pen \_\_\_\_ Insulin pump

Where is insulin kept? \_\_\_\_\_

Location of medication:\*\*\* \_\_\_\_ Office \_\_\_\_ With teacher \_\_\_\_ With student

\*\*\*A completed Medication Authorization Form must be signed by both parent and physician and on file in the office before any medication can be given or carried at school

Blood Glucose Correction Dose (bolus): \_\_\_\_\_ unit(s) of insulin per \_\_\_\_\_ mg/dl over \_\_\_\_\_ mg/dl

Meal bolus: insulin-carbohydrate ratio \_\_\_\_\_ unit(s) of insulin for every \_\_\_\_\_ grams of carbohydrate (CHO)

Blood Glucose Level (mg/dl)	Units of Insulin	CHO eaten (not to be eaten)	Units of Insulin
Less than 100			
101 - 150			
151 - 200			
201 - 250			
251 - 300			
301 - 350			
351 - 400			
401 - 450			
451 - 500			

Note: Insulin dose is a total of meal bolus and correction bolus

If using insulin pump, enter blood glucose level and carbohydrates eaten or to be eaten. The pump will calculate the prescribed amount of insulin.

### Snack

Are snacks needed during school? \_\_\_\_ No \_\_\_\_ Yes (Provided by parent) – if yes what time? \_\_\_\_\_

### Exercise and Sports

Is a snack needed before PE? \_\_\_\_ No \_\_\_\_ Yes (Provided by parent)

Student should not exercise if blood glucose level is below \_\_\_\_\_ mg/dl or above \_\_\_\_\_ mg/dl.

### Low Blood Glucose (Hypoglycemia)

Emergency situations may occur with low blood sugar!

Symptoms: shaky, feels low, feels hungry, confused, other \_\_\_\_\_

- Student needs treatment when blood glucose is below \_\_\_\_\_ mg/dl or if symptomatic
- If treated outside the classroom, a responsible person MUST accompany student to the office
- If blood glucose is below \_\_\_\_\_ mg/dl give \_\_\_\_\_
- After 15 minutes recheck blood sugar
- Repeat until blood glucose is over \_\_\_\_\_ mg/dl

GLUCAGON: Student has glucagon at school (signed authorization must be submitted): Yes \_\_\_\_ No \_\_\_\_

Only trained staff can administer. Give when student is unconscious, unresponsive or having a seizure. 911 MUST always be called if glucagon is administered.

### High Blood Glucose (Hyperglycemia)

Symptoms: Increased thirst, increase need for urination, other \_\_\_\_\_

- Student needs treatment when blood glucose is over \_\_\_\_\_ mg/dl
- If blood sugar is over \_\_\_\_\_ mg/dl contact parent
- Allow unrestricted bathroom privileges
- Encourage student to drink water or sugar-free drinks
- If vomiting call parent immediately!

Wait 911 for the following	Additional Information
<ul style="list-style-type: none"> <li>If Glucagon is administered</li> <li>Student is unable to cooperate to eat or drink anything</li> <li>Decreasing alertness or loss of consciousness</li> <li>Seizure</li> </ul>	<ul style="list-style-type: none"> <li>Student must always be allowed access to fast-acting sugar.</li> <li>Student is allowed to carry a water bottle and have unrestricted bathroom privileges.</li> <li>Student is allowed to test his/her blood glucose when/where needed</li> <li>Substitute teachers must be aware of the student's health situation, but still respecting privacy</li> <li>Notify parent(s)/guardian when blood sugar is below _____ mg/dl or above _____ mg/dl and for emergencies.</li> </ul>

As parent/guardian of the above named student, I give my permission to the school nurse and other designated staff to perform and carry out the diabetes tasks as outlined in this Individualized Health Plan (IHP) and for my child's healthcare provider to share information with the school nurse for the completion of this plan. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the school nurse whenever there is any change in the student's health status or care. Parents/Guardian and student are responsible for maintaining necessary supplies, snack, blood glucose monitor, medications and equipment.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

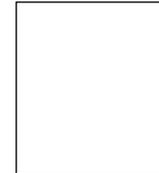
Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

School Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_

# Sample Diabetes ECP

## DIABETES EMERGENCY ACTION PLAN

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Parent/Guardian: \_\_\_\_\_ Phone(s): \_\_\_\_\_



### CHECK BLOOD GLUCOSE

<b>Below 70 (or _____) (Hypoglycemia)</b>		<b>70 – 90</b>	<b>91 – 125</b>	<b>126 – 250</b>	<b>Above 250 (or _____) (Hyperglycemia)</b>	
ONSET: Sudden		or _____	or _____	or _____	ONSET: Over time – several hours or days	
<b>*SEVERE HYPOGLYCEMIA</b> Combative Inability to swallow Loss of consciousness Seizure	<b>MODERATE HYPOGLYCEMIA</b> Blurry Vision    Confusion Weakness    Headache Sleepiness Behavior change Poor coordination Slurred speech	<b>MILD HYPOGLYCEMIA</b> Hunger    Weakness Paleness    Irritability Dizziness    Sweating Crying    Anxiety Shakiness    Headache Poor concentration Personality change Drowsiness	If exercise is planned before a snack or meal (including recess) the student must have a snack before participating.	Student is fine.	<b>MILD/MODERATE HYPERGLYCEMIA</b> Thirst Frequent Urination Stomach pains Fatigue/sleepiness Flushing of skin Increased hunger Blurred vision Lack of concentration Sweet, fruity breath Dry mouth	<b>*SEVERE HYPERGLYCEMIA</b> <u>Mild and moderate symptoms plus:</u> Labored breathing Confused Very weak Unconscious
<b>ACTIONS FOR SEVERE HYPOGLYCEMIA</b> 1. Don't attempt to give anything by mouth. 2. Position on side, if possible. 3. Contact trained diabetes personnel. 4. Administer glucagon, if prescribed. 5. <b>Call 911.</b> 6. Contact parents/guardian. 7. Stay with student.	<b>ACTIONS FOR MODERATE HYPOGLYCEMIA</b> 1. Give student fast-acting sugar source 2. Wait 10 to 15 minutes. 3. Recheck blood glucose. 4. Repeat food if symptoms persist OR blood glucose is less than 70. 5. Follow with a snack of carbohydrate and protein (e.g., cheese and crackers).	<b>ACTIONS FOR MILD HYPOGLYCEMIA</b> If student's blood sugar result is immediately following strenuous activity, give an additional fast-acting sugar.			<b>ACTIONS FOR MILD/MODERATE HYPERGLYCEMIA</b> 1. Allow liberal bathroom privileges. 2. Encourage student to drink water or sugar-free drinks. 3. Check blood glucose & administer insulin per physician orders 4. Contact parent if blood sugar is over 300 mg/dl.	<b>ACTIONS FOR SEVERE HYPERGLYCEMIA</b> 1. If student vomits or is lethargic call parent. 2. If parent is unavailable contact 911.
<b>Causes of Hypoglycemia:</b> Too much insulin, missed food, delayed food, or exercise					<b>Causes of Hyperglycemia:</b> Too much food, too little insulin, illness, stress, or decreased activity	
<b>FAST ACTING SUGAR SOURCES:</b> 3-4 glucose tablets <b>OR</b> 4 ounces juice <b>OR</b> 6 ounces regular soda <b>OR</b> 3 teaspoons glucose gel <b>OR</b> 3 teaspoons sugar in water						

**Never send a child with suspected low blood glucose anywhere alone!!!**

**\*Severe symptoms are a life-threatening emergency**

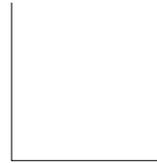
Adapted with permission from National Association of School Nurses H.A.N.D.S. <sup>SM</sup> 2008

# Sample Seizure ECP

## Seizure Individualized Healthcare Plan

Effective Date \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Parent email: \_\_\_\_\_  
 Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Treating Physician: \_\_\_\_\_ Phone: \_\_\_\_\_



### SEIZURE INFORMATION:

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs: \_\_\_\_\_  
 Student's reaction to seizure: \_\_\_\_\_

### SIGNS OF SEIZURES: PLEASE CHECK BEHAVIORS THAT APPLY TO YOUR CHILD.

PARTIAL SEIZURES	GENERALIZED SEIZURES	DANGER SIGNS- CALL 911	BEHAVIORS EXPECTED AFTER SEIZURE
<input type="checkbox"/> Lip smacking <input type="checkbox"/> Behavioral outbursts <input type="checkbox"/> Staring <input type="checkbox"/> Twitching <input type="checkbox"/> Other: _____ _____ _____	<input type="checkbox"/> Sudden cry or squeal <input type="checkbox"/> Falling down <input type="checkbox"/> Rigidity/Stiffness <input type="checkbox"/> Thrashing/Jerking <input type="checkbox"/> Loss of bowel/bladder control <input type="checkbox"/> Shallow breathing <input type="checkbox"/> Stops breathing <input type="checkbox"/> Blue color to lips <input type="checkbox"/> Froth from mouth <input type="checkbox"/> Gurgling or grunting noises <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Staring <input type="checkbox"/> Other: _____	<ul style="list-style-type: none"> <li>• Seizure lasts more than 5 minutes</li> <li>• Another seizure starts right after the 1<sup>st</sup> seizure</li> <li>• Loss of consciousness</li> <li>• Stops breathing</li> <li>• If student has diabetes</li> <li>• If seizure is the result of an injury or child is injured during seizure</li> <li>• If student is pregnant</li> <li>• If student has never had a seizure before</li> </ul>	<ul style="list-style-type: none"> <li>• Tiredness</li> <li>• Weakness</li> <li>• Sleeping, difficult to arouse</li> <li>• Somewhat confused</li> <li>• Regular breathing</li> <li>• Other: _____</li> </ul> <p><b>ALL OF ABOVE CAN LAST A FEW MINUTES TO A FEW HOURS.</b></p>
<b>IF YOU SEE THIS</b>		<b>DO THIS</b>	
SEIZURE ACTIVITY	Stay calm. Move surrounding objects to avoid injury. Do <u>not</u> hold the student down or put anything in the mouth. Loosen clothing as able. After seizure stops, roll student on his/her side. <b>Document seizure activity on log.</b> If applicable, administer medications as ordered. Notify the parent/guardian.		
STOPS BREATHING	Begin CPR/Rescue breathing. Call 911		
LOSS OF BOWEL OR BLADDER CONTROL	Cover with blanket or jacket. If necessary: discreetly assist with changing of clothes after seizure.		
DANGER SIGNS-SEE ABOVE	Call 911. Then call parent/guardian.		
FALLS DOWN, LOSS OF CONSCIOUSNESS	Help student to the floor for observation and safety		
VOMITING	Turn on side		

Emergency/Rescue Medication \*(Only oral medication can be given at school) \_\_\_\_\_  
 Location of medication: \_\_\_\_\_ Office \_\_\_\_\_ With teacher \_\_\_\_\_ With student

**\*\*\*A completed Medication Authorization Form must be signed by both parent and physician and on file in the office before any medication can be given or carried at school.**

Does student have a **Vagus Nerve Stimulator (VNS)**? YES NO  
 If YES, Describe magnet use \_\_\_\_\_

**SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS** (regarding school activities, sports, trips, etc.)  
 \_\_\_\_\_  
 \_\_\_\_\_

### STATEMENT OF ACKNOWLEDGEMENT/RELEASE OF INFORMATION

As parent/guardian of the above named student, I give my permission to the school nurse and other designated staff to perform and carry out the tasks as outlined in this Individualized Healthcare Plan and for my child's healthcare provider to share information with the school nurse for the completion of this plan. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the school nurse whenever there is any change in the student's health status or care. Parents/Guardian and student are responsible for maintaining necessary supplies, medications and equipment.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 School Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Sample Generic ECP

Alpine School District Health Services

## INDIVIDUALIZED HEALTHCARE PLAN

\_\_\_ 504 Plan \_\_\_ Special Education Plan

STUDENT INFORMATION				
Student:	School Year:	School:	Grade:	
Date of Birth:	Lives with: <input type="checkbox"/> Both Parents <input checked="" type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other			
Father:	Phone:	Email:		
Mother:	Phone:	Email:		
Other contact (name):	Phone:			
Physician:	Phone:	FAX:		
Physician:	Phone:	FAX:		
School Nurse:	School Phone:	FAX:		
MEDICAL CONDITION				
MEDICATIONS				
<small>Any and all medication (oral, nasal, topical, injection, etc.) to be given at school, must first be created by the school nurse, accompanied by the completed and signed "Authorization for Student Medication" form, and any other State required forms (as need for inhalers, epinephrine and diabetes medication). These forms must be updated and signed by the physician each school year and/or whenever there is a medication change - NO EXCEPTIONS.</small>				
MEDICATION	DOSE	ROUTE	TIME	SIDE-EFFECTS
HEALTH CARE & EMERGENCY ACTION PLAN				
TRANSPORTATION CARE PLAN				
Special care required? <input type="checkbox"/> yes <input type="checkbox"/> no. Please specify: _____				
SIGNATURES				
<small>As parent/guardian of the above named student, I give my permission to the school nurse and other designated staff to perform and carry out the tasks as outlined in this Individualized Health Plan (IHP) and for my child's healthcare provider to share information with the school nurse for the completion of this plan. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the school nurse whenever there is any change in the student's health status or care. Parents/Guardian and student are responsible for maintaining necessary supplies, medications and equipment.</small>				
<b>Parent:</b> _____	<b>DATE:</b> _____			
<b>Physician:</b> _____	<b>DATE:</b> _____			
<b>School Nurse:</b> _____	<b>DATE:</b> _____			

# Remember...

- You will probably need separate paperwork for medication authorization (depending on State and District requirements).



# Questions?

BettySue Hinkson MSN RN NCSN  
bhinksonrn@alpinedistrict.org



# Resources

American Nurses Association (2011). *Scope and Standards of Practice: School Nursing*. Silver Spring; MD.

Selekman, J. (2006). *School Nursing: A comprehensive text*. Philadelphia, PA: F.A. Davis Co.