Regulation 757-3
STUDENTS
June 12, 2019

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.

Attachment I
Regulation 757-3

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:

Printed Name	Signature	Trainer's Signature	Date of Training

Attachment II
Regulation 757-3

Prince William County Public Schools
Health Treatment Plan
Clean Intermittent Catherization

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 Catherization (CIC) is prescribed.

Catherization site: _____ Catheter size: _____

Catheterize every _____ hours or _____ times per day.

☐ 8-ounce glass of water with every catherization.

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

Attachment III
Regulation 757-3

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

Attachment IV
Regulation 757-3

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:

Printed Name	Signature	Trainer's Signature	Date of Training

Attachment V
Regulation 757-3

PRINCE WILLIAM COUNTY PUBLIC SCHOOLS
AUTHORIZATION FOR MEDICATION ADMINISTRATION

Medication Expiration Date:

Student Information: Parent/Guardian to Complete

Student: _____ DOB: _____ Age: _____ Grade: _____

School: _____ Has the student taken this medication before? ☐ Yes ☐ No

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)

Name of medication: _____

Diagnosis/condition for which medication is being administered:_____

Dosage: _____Route: _____Time of administration: _____

Length of time: ☐ School year ☐ Other: _____

Possible side effects: ☐ None expected ☐ Specify: _____

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)

Name of medication: _____

Reason medication is to be given: _____

Dosage: _____ Route: _____ Time of administration: _____

Length of time: ☐ School year ☐ Other: _____

Possible side effects: ☐ None expected ☐ Specify: _____

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

Medication received (amount/description): _____

Medication received: _____/_____
Health Office Staff Signature/Date Parent/Guardian Signature/Date

Medication picked up by: _____ Date: _____
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.