☐ Elementary

☐ Secondary

■ Both

Policy 7000

Wellness

Effective: August 2006 as Policy 5145.0

Revised: July 2023

Catholic schools recognize that it is essential to educate the whole child, spiritually, academically, physically, socially, and emotionally. Similarly, wellness education must be multi-dimensional and encompass all the same areas in order to promote ultimate health, well-being, and students' ability to learn. Catholic schools aid this emphasis on total wellness by embracing the reverence for life, self-respect, and respect for others.

All schools participating in the National School Lunch Program (NSLP) and/or the School Breakfast Program (SBP) must develop their own school specific wellness policy based on the following requirements.

1 Nutrition Promotion and Education

Goal: to positively impact eating behaviors.

1. Wellness objectives concerning nutrition are supported through the Diocesan Health Course of Study (2022) grade-level indicators relating to diet, nutrition, and exercise. Additionally, similar grade-level indicators are included in the Science Course of Study (2019).
2. Nutrition guidelines, food pyramids, charts, suggestions for healthy food choices, and other messages that support wise food choices will be displayed in or near the cafeteria as well as in classrooms during the nutrition unit of instruction.
3. Snack breaks, if applicable, will be scheduled as necessary to maintain energy levels. Additionally, school policy will outline what types of healthy snacks may be eaten during this time.
4. All students are required to participate in nutrition education.
5. Nutrition education shall be provided to families via handouts, newsletters, website, presentations, and workshops.
6. Parents are encouraged to provide healthy snacks.
7. Staff and teacher are asked not to consume sugary drinks or snacks in the classroom. If they eat in the presence of the students they are asked to promote healthy eating behaviors.
8. Drinking water will be available to students via drinking fountains. Students are permitted to keep water bottles at their desks.

1. Physical Education

Goal: to promote physical fitness and to have students develop habits that will be beneficial throughout their lives.

1. Physical fitness is supported through the Diocesan Physical Education Course of Study (2019).
2. All elementary students and the designated grade levels in high school shall participate in Physical Education.
3. All appropriate grade levels will have scheduled recess times.

4. Discipline should not include loss of recess time except in rare instances.
5. Students will be encouraged to participate in school and community sports programs and to be physically active outside of school.

3 Other School-Based Activities

Goal: to be mindful of the connection between nutrition and physical education when planning the activities.

1. The Religion Course of Study (2022) supports reverence for life, self-respect, and respect for others, which are foundational concepts of wellness. All school-based activities are also rooted in these Religion Course of Study concepts.
2. The school should use food in limited ways as a reward for behavior, and minimize sugary treats for classroom celebrations.
3. Schools are encouraged to consider healthy food or non-food fundraisers.
4. Teachers will be offered professional development in nutrition as is needed, and in physical activities that might be appropriate to incorporate in the classroom.

4 Standard and Nutrition Guidelines

1. Smart Snacks
    a. Any food and beverage sold to students at schools during the school day,* other than those foods provided as part of the school meal programs.
    b. Examples include à la carte items sold in the cafeteria and foods sold in school stores, snack bars, and vending machines.
    c. Foods and beverages sold during fundraisers, unless these items are not intended for consumption at school or are otherwise exempt by your State agency. The school day is defined as the midnight before to 30 minutes after the end of the school day
    d. Smart Snacks are mandatory for the schools participating in NSLP. Other schools are highly encouraged to follow these guidelines. Smart snacks standards: https://fns-prod.azureedge.us/sites/default/files/resource-files/smartsnacks.pdf
2. All school cafeteria managers and staff will participate in the USDA Professional Standards for Child Nutrition Professionals' training upon hire and annually. Documentation of completed trainings are kept on file.
3. Lunch periods are scheduled as near the middle of the school day as possible. The complete schedule will be available provided by the individual school.
4. Schools participating in the SBP and/or NSLP will follow the current USDA Dietary guidelines: https://education.ohio.gov/getattachment/Topics/Other-Resources/Food-and-Nutrition/National-School-Lunch-Program/meal_pattern_charts_BL_NSLP.pdf.aspx
5. Nutrition information for all school meals is available from the cafeteria manager upon request.

5 Standards for all foods and beverages provided, but not sold to students

1. Celebrations and reward:
    a. At minimum they will meet Smart Snacks standards
    b. A list of healthy and non-food party ideas will be available.
    c. A list of foods and beverages that meet Smart Snacks will be available.
    d. A list of healthy and non-food rewards will be available.
2. Fundraising – only foods and beverages that meet or exceed Smart Snacks standards to be sold through fundraisers on the school campus during the school day.

6 Policies for food and beverages marketing

Marketing for foods and beverages can be seen in schools on posters, the fronts of vending machines, textbook covers, and scoreboards. Schools are encouraged to allow marketing and advertising of only those foods and beverages that meet the Smart Snacks, USDA Recommendations, and the American Heart Association's criteria for a healthy lifestyle in School nutrition standards. Schools can help students make healthy choices by marketing and promoting healthful foods and beverages. Some low-cost strategies include:

1. Collecting suggestions from students and families for meals and snack items that might be offered.
2. Conducting taste tests of new menu items and asking students to provide feedback.
3. Placing nutritious items where they are easy for students to select (placing fruits and vegetables to the front of the school meal line or near the cash register).
4. Using attractive displays for fruits and vegetables (fruit basket).
5. Pricing nutritious foods and beverages at a lower cost, while increasing the price of less nutritious foods and beverages. Using signs or verbal prompts to encourage students to try healthy foods.

All advertising in school publications and school media outlets must be approved by the principal.

7 Public involvement, public updates, policy leadership, and evaluation plan.

1. Each school will designate a person who will be in charge of the wellness policy's compliance.
2. The general public and the school community is encouraged to participate in development, implementation, and evaluation of the wellness policies.
3. Parents, students, and the school community should be updated annually regarding the content and implementation of the policy. The assessment of the policy implementation, Wellness Policy Assessment Tool, will be conducted every three years and will be also available to the public.

References

- CDC: https://www.cdc.gov/healthyschools/nutrition/wellness.htm#print
- Ohio Department of Education: https://education.ohio.gov/getattachment/Topics/Student-Supports/Food-and-Nutrition/Resources-and-Tools-for-Food-and-Nutrition/School-Meal-Programs-Trainings-and-Webinars/School-Meals-Wellness-Policies-Presentation.pdf.aspx?lang=en-US
- Ohio Department of Education: https://education.ohio.gov/getattachment/Topics/Other-Resources/Food-and-Nutrition/Resources-and-Tools-for-Food-and-Nutrition/School-Meal-Programs-Trainings-and-Webinars/Wellness_Policy_Summer_Regional_2017-1.pdf.aspx
- https://codes.ohio.gov/ohio-revised-code/section-3313.814
- https://codes.ohio.gov/assets/laws/revised-code/authenticated/33/3313/3313.816/9-24-2012/3313.816-9-24-2012.pdf

Revision History: 07/23, 07/16, 08/12, 03/12, 08/11, 08/06

☐ Elementary

☐ Secondary

■ Both

Policy 7010

Immunizations

Effective: May 2019 as Policy 5116.0

Revised: May 2025

Introduction

Ohio Law requires each student to demonstrate compliance with immunizations requirements via medical documentation. All students must provide a record of immunization compliance to their school by the 14th day from the first day of attendance. If no immunization record was provided when the student registered, a record must be submitted to the school showing compliance by the 14th day of school to avoid exclusion as required by Ohio Law.

Reporting

Annually by the 15th of October, the school shall report a summary, of the immunization records of all initial entry students in the school to the Department of Health.

Exemptions:

1. A pupil who has had natural rubeola, and presents a signed statement from the pupil's parent, guardian, or physician to that effect, is not required to be immunized against rubeola.

2. A pupil who has had natural mumps, and presents a signed statement from the pupil's parent, guardian, or physician to that effect, is not required to be immunized against mumps.

3. A pupil who has had natural chicken pox, and presents a signed statement from the pupil's parent, guardian, or physician to that effect, is not required to be immunized against chicken pox.

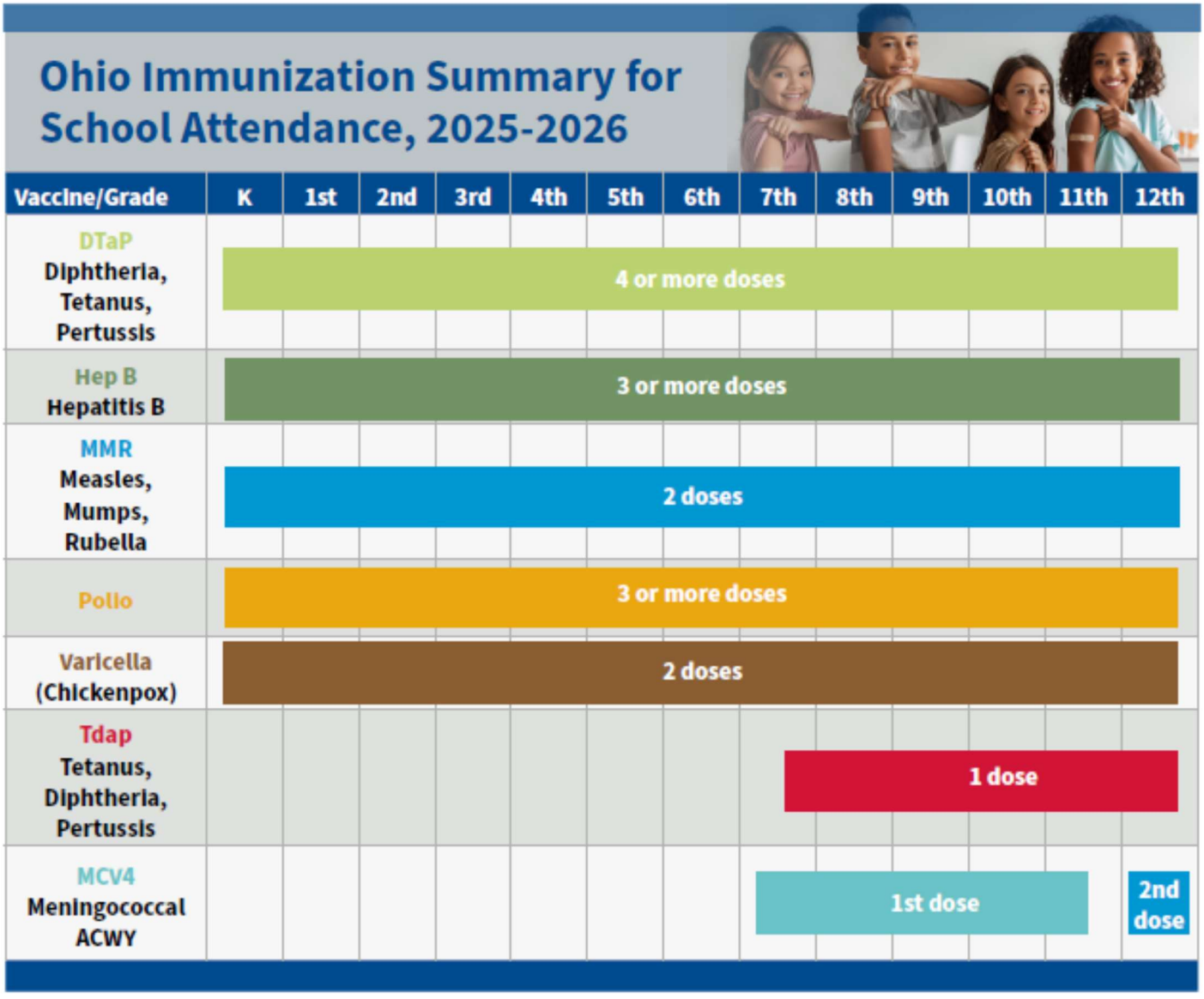
4. A pupil who presents a written statement of the pupil's parent or guardian in which the parent or guardian declines to have the pupil immunized for reasons of conscience, including religious convictions, is not required to be immunized.

5. A child whose physician certifies in writing that such immunization against any disease is medically contraindicated is not required to be immunized against that disease.

All non-medical vaccine exemptions are reviewed by the principal and approval will be made on a case by case basis for admittance to school. The state exemption form needs to be completed. Please see ORC 3313.671 for further information as to exceptions to immunization requirements.

Tuberculosis (TB) Requirements

All new students to the school who have spent more than 30 consecutive days in a TB endemic region within the past five years or who were born in a TB endemic region must also present evidence of a negative Tuberculin (TB) test before they can attend school. The TB test must have been completed within the past year in the United States. Current enrolled students who spend 30 or more consecutive days in a TB endemic region will also be required to have a negative Tuberculin (TB) test before returning to school.



Important Notes:

- Vaccine should be administered according to the most recent version of the Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger or the Catch-up immunization schedule for persons aged four months-18 years who start late or who are more than one month behind, as published by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.
- Vaccine doses administered less than or equal to four days before the minimum interval or age are valid (grace period). Doses administered greater than or equal to five days earlier than the minimum interval or age are not valid doses and should be repeated when age appropriate.
- If MMR and varicella are **not** given on the same day, the doses must be separated by at least 28 days with no grace period.
- For additional information, please refer to the Ohio Revised Code 3313.67 and 3313.671 and the Ohio Department of Health (ODH) Director's Journal Entry regarding school immunization requirements, recommended vaccines, and exemptions to immunizations.
- **Please contact the Ohio Department of Health Immunization Program at 800-282-0546 or 614-466-4643 with questions.**

Ohio School Immunization Requirement Details	
DTaP **Diphtheria, Tetanus, Pertussis**	**Grades K-12** Four or more doses of DTaP or DT vaccine, or any combination. If all four doses were given before the fourth birthday, a fifth dose is required. If the fourth dose was administered at least six months after the third dose, and on or after the fourth birthday, a fifth dose is not required. *Recommended DTaP or DT minimum intervals for kindergarten students are four weeks between the first and second doses, and the second and third doses; and six months between the third and fourth doses and the fourth and fifth doses.*
Hep B **Hepatitis B**	**Grades K-12** Three doses of hepatitis B vaccine. The second dose must be administered at least 28 days after the first dose. The third dose must be given at least 16 weeks after the first dose and at least eight weeks after the second dose. The last dose in the series (third or fourth dose) must not be administered before age 24 weeks.
MMR **Measles, Mumps, Rubella**	**Grades K-12** Two doses of MMR vaccine. The first dose must be administered on or after the first birthday. The second dose must be administered at least 28 days after the first dose.
Polio	**Grades K-12** Three or more doses of IPV vaccine. The FINAL dose must be administered on or after the fourth birthday with at least six months between the final and previous dose, regardless of the number of previous doses. *If any combination of IPV and OPV was received, four doses of either vaccine are required. Only trivalent OPV (tOPV) counts toward the U.S. vaccination requirements. Doses of OPV administered before April 1, 2016, should be counted (unless specifically noted as administered during a campaign). Doses of OPV administered on or after April 1, 2016, should **not** be counted.*
Varicella **(Chickenpox)**	**Grades K-12** Two doses of varicella vaccine must be administered prior to entry. The first dose must be administered on or after the first birthday. The second dose should be administered at least three months after the first dose; however, if the second dose is administered at least 28 days after the first dose, it is considered valid.
Tdap **Tetanus, Diphtheria, Pertussis**	**Grades 7-12** One dose of Tdap vaccine must be administered on or after the tenth birthday. Tdap can be given regardless of the interval since the last tetanus or diphtheria-toxoid containing vaccine. *Children aged seven years or older with an incomplete history of DTaP should be given Tdap as the first dose in the catch-up series. If the series began at age seven to nine years, the fourth dose must be a Tdap given at age 11-12 years. If the third dose of Tdap is given at age 10 years, no additional dose is needed at age 11-12 years.*
Meningococcal **Meningococcal ACWY**	**Grades 7-11** One dose of meningococcal (serogroup A, C, W, and Y) vaccine must be administered on or after the 10th birthday. **Grade 12** Two doses of meningococcal (serogroup A, C, W, and Y) vaccine. Second dose on or after age 16 years. If the first dose was given on or after the 16th birthday, only one dose is required.

STATE OF OHIO
LEGAL IMMUNIZATION EXEMPTION
Per OHIO STATUTE 3313.671 (Exemptions)

Religious, Good Cause, and Medical Exemption Form
Amended Substitute Senate Bill No. 282. Ohio Revised Code.
Sections 3313.671. Pat (3) and (4)

Section 3313.671, part (3): A pupil who presents a written statement of his parent or guardian in which the parent or guardian objects to the immunization for good cause, including religious convictions, is not required to be immunized.

Section 3313.671 part (4): A child whose physician certifies in writing that such immunization against my disease is medically contraindicated is not required to be immunized against that disease. This section does not limit or impair the right of a board of education of a city, exempted village, or local school district to make and enforce rules to secure immunization against poliomyelitis, rubeola, rubella, diphtheria, pertussis, and tetanus of the pupils under it jurisdiction.

I understand that the immunization Law permits me to sign a waiver on my child taking the immunization.

I hereby object and request the school to waiver the immunization of my child against the following:

D.T.P. _____	**Polio: _____**	**Rubeola: _____**	**MMR: _____**
Rubella: _____	**Mumps: _____**	**Hepatitis B: _____**	**Varicella: _____**
Tdap: _____	**MCV4: _____**	**ALL Vaccines: _____**	

Child's Name: _____

Religious: _____ **Denomination** _____

Good Cause: _____ **Please Explain** _____

Medical Reason: _____ You must have a signed statement from your physician stating the condition and attach it to this form.

I further understand that during the course of an outbreak of any of the aforementioned vaccine preventable diseases, that the student named here is subject to exclusion from school for the duration of the outbreak.

This action is necessary not only to protect this student, but the remainder of the students and faculty of the school.

Parent/Guardian Signature: _____

Address: _____ **Date:** _____

Revision History: 5/25, 07/23, 08/19

☐ Elementary

☐ Secondary

■ Both

Policy 7020

Emergency Medical Authorization

Effective: July 2023

Revised:

An Emergency Medical Authorization must be completed annually before the October 1st for each student enrolled.

The completed form should be submitted to the school and kept on file. If a parent requests a change of the form, the school may permit the parent to make changes or to submit a new form.

In the event emergency medical treatment for a student is necessary, the school will adhere to the instructions on the authorization form. If a parent refuses to grant consent for emergency medical treatment, the parent must indicate in the proper place on the Form (i.e., Part II) the procedure the parent wishes school authorities to follow in the event of a medical emergency involving his/her child.

Even if a parent grants consent for emergency medical treatment, when a student becomes ill or is injured and requires emergency medical treatment while under school authority, or while engaged in an extra-curricular activity authorized by the appropriate school authorities, the building administrator(s) shall make reasonable attempts to contact the parent before treatment is given. The school representative shall present the student's Emergency Medical Authorization Form or a copy thereof to the hospital or practitioner rendering treatment.

The Emergency Medical Authorization Form will be kept in an easily accessible file in each school building during the school year.

Any time a student or a group of students is taken out of the building to participate in a school event (i.e. field trip), the staff in charge of the event must take the Emergency Medical Authorization Forms for those students.

References

Emergency medical authorization, Ohio Rev. Code § 3313.712 | Case text Search + Citator

Revision History: 07/23

☐ Elementary

☐ Secondary

■ Both

Policy 7030

Medical Records for Transfer Students

Effective: July 2023

Revised: May 2025

The school has the responsibility to keep records for each student, including health care records.

A physical exam is required for any new student (i.e. incoming kindergarten student, transfer from a school outside the diocese and incoming high students.)

These records may be maintained in hard copy form, digitally (FACTS or other School Information System), or in a combination of the two. A health record folder is maintained separately from the pupils' academic record.

Health Records include:

1. Emergency medical authorization
2. Physician orders
3. Medication administration documentation
4. Physical examination records
5. Immunization records
6. Nursing documentation for visits to the health office
7. Screening record and follow up documentation
8. Emergency action plans
9. Health history information
10. Oral examination records
11. Immunization record
12. Record of student's ability to participate in an educational program (PhyEd, exemptions, etc.)
13. Routine screening tests such as hearing, vision, scoliosis, and any follow-up information
14. Other health information as required by law.

When a pupil transfers from one school to another, the student health summary should be sent to the receiving school only after the parent or guardian's written consent and written request of the receiving school. If the record is in the hard copy form, the green chart needs to be scanned and securely send to the receiving school.

Health records are usually not sent out of state unless there is a written request by the parents or the student is 18 years of age or older.

Revision History: 5/25, 10/24, 07/23

☐ Elementary

☐ Secondary

■ Both

Policy 7040

Health while Away from School

Effective: July 2023

Revised:

Field trips and off-campus trips, when used for teaching and learning, are integral to the curriculum and are an educationally sound and important component of the instructional program of the schools. For purposes of this policy, a field trip shall be defined as any planned journey for any number of students away from school premises, and under the supervision of a professional staff member and that is an integral part of a Course of Study.

Schools will ensure the safety and well-being of students while they are out of their assigned school building. They shall ensure:

1. Staff members in charge have Emergency Medical Authorization information, any Emergency Health Plans, any medications and medication consent forms, and have been properly trained by the school nurse; School medication and immunization policies apply.

2. Parental permission is sought and obtained before any student leaves the school on a trip; a sample Field Permission Form is attached to this policy.

3. Each trip is properly monitored and supervised. A professional staff member shall not change a planned itinerary while the trip is in progress, except where the health, safety, or welfare of the students in his/her charge is endangered or where changes or substitutions beyond his/her control have changed the purpose of the trip. In any instance in which the itinerary of a trip is altered, the professional staff member in charge shall notify the building administration immediately.

4. Any volunteer who has the possibility of working alongside, being delegated care, custody, or control of child(ren) and youth, while acting on behalf of a school and is aged 18 years of age or older, is required to comply with the Diocese's Safe Environment Policy in order to begin service.

5. All chaperones must be 21 years of age or older

6. Staff members involved in a field trip activity will not receive additional pay for their service.

7. Staff members will avoid conflict of interest and will not receive any benefits from outside agencies in relation to school sponsored trips. Neither they will act as agents or solicitors for any such agency.

8. All school trips must be approved by the principal.

9. Appropriate educational experience and proper supervision shall be supplied for any students whose parents do not wish them to participate in a field trip.

10. For overnight coeducational trips—male and female adult supervision must be provided.
    a. All coeducational contacts and activities will take place in public areas of the building or housing

accommodations under adult supervision.

b. Male and female students will have separate sleeping arrangements. This applies to minors as well as adults, unless the adults are married.

11. Male and female students should use separate bathroom and shower facilities. In the event it is not possible, different times should be designated for male and female bathroom and shower use.

12. Only licensed travel agencies/transportation firms/hotels will be contracted.

References

https://dpi.wi.gov/sites/default/files/imce/sspw/pdf/Meeting_Student_Health_Needs_While_on_Field_Trips_Tool_Kit.pdf

Revision History: 07/23

Policy 7100

☐ Elementary

☐ Secondary

■ Both

Administering Medications to Students

Effective: July 2023

Revised: January 2025

Employees of the schools of the Diocese and public school employees (e.g., school nurses) working in schools are permitted to administer prescribed and over-the-counter (OTC) medication to a student when conditions exist.

Prescription Medications

In all instances where prescription medication is to be administered under this policy, the licensed prescriber prescribing the medication has the power to direct, supervise, decide, inspect, and oversee the administration of such medication.

Before the student will be permitted to take medication during school hours, use an inhaler to self-administer asthma medication, or use an epinephrine autoinjector (epi-pen), a Medication Administration Record (MAR) General Medication form, Authorization for the Possession and Use of Asthma Inhaler/Other Emergency Medication(s), Authorization for the Possession and Use of Epinephrine Autoinjector (epi-pen) must be filed annually and as necessary for any change in medication order with the school principal and to the school nurse if one is assigned to the student's building.

No prescription medication shall be given to any student by any employee of the school unless the following have been received in the school where the medication will be administered:

- Written instructions from the licensed prescriber for the administration of the prescribed medication. Such instructions shall be signed by the licensed prescriber.
- Written instructions should include:
    - student name,
    - the name of the drug,
    - the dose,
    - the route,
    - the frequency,
    - time to be administered,
    - the diagnosis or reason the medication is needed,
    - a list of adverse effects that may be reasonably expected,
    - contraindications to administering the medication,
    - licensed prescriber contact information,
    - pharmacy contact information (for prescription medication only).

- A written statement from the licensed prescriber which identifies the specific conditions and circumstances under which contact should be made with him or her in relation to the condition or reactions of the student receiving the medications and reflects a willingness on the part of the licensed prescriber to accept direct communications from the person administering the medication.
- A written statement from the parent authorizing school personnel to give medication and authorizing school personnel to contact the licensed prescriber directly.
- Medication should be delivered to school by a responsible adult (whenever possible, a parent) in an original pharmacy labeled container or manufacturer's package.
- When medication dose changes, a new prescription container label should be requested to replace the outdated dosage label.
- Medication is counted and documented upon receipt and signed by the school staff member and adult delivering the medication.
- All school staff who administer medications shall adhere to the six rights of safe medication administration, which include:
    - The right student,
    - The right medication,
    - The right dose,
    - The right route,
    - The right time,
    - The right documentation.
- All medications should be administered by the school nurse. If the school nurse is not available to administer the medication, the building principal or school administrator and the school nurse should jointly identify an unlicensed authorized personnel (UAP) to administer medication to students.
- Any school employee may be authorized to administer emergency (prescription and/or OTC) medications who:
    - is willing to assume that responsibility,
    - is authorized in writing by the school principal or his/her designee,
    - has received approved training for the administration of emergency medications
    - has been sufficiently instructed by the school nurse:
    - in recognizing the signs and symptoms of medical emergency,
    - on the proper administration of emergency medication,
    - on proper follow up procedures following administration of emergency medication,
    - has successfully completed an annual return demonstration of administration of emergency medication,
    - has been deemed competent by the school nurse.

Over-the-counter Medications (OTC)

Administrators may choose to allow over-the-counter medications to be administered at school by designated personnel to enable students to stay in class to reduce the burden on working parents (see H.B. 70 https://www.legislature.ohio.gov/download?key=23674).

All school staff who administer OTC medications shall adhere to the six rights of safe medication administration (see above). All school staff can be authorized to administer OTC medication (see above).

In all instances where over the counter medication is to be administered under this policy, the parent must:

- have the permission to dispense OTC medications on the FACTS SIS (or other SIS used by school) over the counter medication section completed
- or the Over-the-Counter Medication Request form completed and signed by the parent/guardian.

The school designee will only administer OTC medications to a child when written permission from the parent is on file. This permission must contain the name of the medication, dosage, time to be administered, and the parent name. Non-prescription medication must be in its original container. No loose pills in baggies can be accepted. Medication will be administered according to label directions only. All medication will be kept in the school clinic. The only medication students are permitted to carry on themselves are inhalers and epinephrine auto-injectors with a self-carry authorization form signed by his/her physician. The designee may give medication with permission on file, but must document and notify the parents of administration through the school SIS or phone call.

Students shall be permitted to possess and self-administer over-the-counter topical sunscreen products while on school property or at a school-sponsored event.

No alternative remedy, or treatment requiring topical application, or that is otherwise considered "alternative," "herbal," or "botanical" may be self-administered at school.

Self-administration of over-the-counter-medication (High School only)
A student may be allowed to possess and self-administer an over-the-counter medication upon the written authorization of the parent. The parent must complete the permission to self-carry over the counter medication form.

If a student is found with a medication in his/her possession, his/her record should be checked to determine if the proper authorization is on file. If the student does not have the proper form on file, the parents should be contacted to complete and submit the form.

The medication must be in original and individual single dose packaging. No loose pills in baggies can be accepted. Students may not self-carry more than the maximum daily allotment of doses of the medication.

Rule/Procedure
School Responsibilities:

1. The building principal or school administrator will ensure that all school staff authorized to administer medications to students will have received the necessary education, training, and competency validation from the school nurse. Written documentation of the training provided for each person authorized to administer a prescribed or OTC medication or treatment will show what training was given, the trainer's name and professional status, and when the training was given.

2. The building principal or school administrator ensures there is an accurate and confidential system of record keeping for medication orders and medication administration.
    a) The medication administration record must be maintained each time a medication is administered at school and during any school-sponsored event (i.e., field trip, sports event) and should include:
        - date,
        - time,
        - dosage,
        - initials of individual dispensing medication,
        - extension or disruption of medication,
        - any changes,
        - description of reactions experienced by the student,
        - any errors made in the administration of the medication.
    b) The medication administration record should include that student's picture to assist with identification of the student while taking appropriate steps to maintain confidentiality.
    c) Side effects should be noted and reported to registered professional school nurse.
    d) Student refusal of the medication should be documented, and the parent notified.
    e) If a prescribed medication to be administered at school is taken at home or prior to school, it should be documented on the MAR.
3. The person giving the prescription medication shall be provided instruction by the licensed prescriber and approved by the school and demonstrate or provide evidence of appropriate learning. The school nurse will perform an initial evaluation of the extent to which the medication may be delegated, with such delegation appropriately accepted by unlicensed or licensed school employees.
4. Approximately two weeks prior to the end of school, parents will be notified in writing to pick up any remaining unused medication. The parent or guardian shall pick up unused portions of medications within five business days after the completion of the school year or when medications have been discontinued. Medication/treatment supplies will be destroyed if they have not been picked up after five business days after the completion of the school year.

Stock Emergency Medications:
Schools may procure and administer stock emergency medications for the management of pupils attending school who have asthma, a life-threatening allergy, and/or diabetes (see additional policies in 7000 section).

Albuterol: Authorized staff (school bus driver, employee, or volunteer) may use an albuterol inhaler to any pupil who appears to be experiencing sudden onset of cough, shortness of breath, and chest tightness that signals an asthma attack if, as soon as practicable, the school bus operator, employee or volunteer reports the sudden onset of cough, shortness of breath and chest tightness by dialing the telephone number "911" or, in an area in which the telephone number "911" is not available, the telephone number for an emergency medical service provider.

Epinephrine: Authorized staff (school bus driver, employee, or volunteer) may use an epinephrine auto−injector to administer epinephrine to any pupil who appears to be experiencing a severe allergic reaction if, as soon as practicable, the school bus operator, employee or volunteer reports the allergic reaction by dialing the telephone number "911" or, in an area in which the telephone number "911" is not available, the telephone number for an emergency medical service provider.

Glucagon: Authorized staff (school bus driver, employee, or volunteer) may administer glucagon to any pupil who they know is diabetic and who appears to be experiencing a severe low blood sugar event with altered consciousness if, as soon as practicable, the school bus operator, employee, or volunteer reports the event by dialing the telephone number "911" or, in an area in which the telephone number "911" is not available, the telephone number for an emergency medical service provider.

Field Trips

The following applies to any school sponsored activity, including field trips, athletics, student groups or clubs, and any overnight events/field trips where a student has medication that may need to be given.

Before the field trip, at least one-school personnel must have successfully completed the applicable approved training depending on the medication needs of the students. Current training documentation must be on file with the school prior to the date of event or practice.

If medication is not typically given during the school day, written instructions from the licensed prescriber for the administration of the prescribed medication should be submitted to the school nurse, administrator or his/her designee assigned to administer student prescribed medications. Such instructions shall be signed by the licensed prescriber.

Parents or legal guardians of students who allow their child to possess and self-administer *albuterol and/or epinephrine* must provide a completed Medication Administration Record Form to the school in accordance with the school's medication policies.

References

Model Policy Administering Emergency Medications to Students - https://cdn.fs.pathlms.com/66MYcRevRk2TJtBAp0Gt

Revision History: 01/25, 07/23

☐ Elementary

☐ Secondary

■ Both

Policy 7110

Bloodborne Pathogens

Effective: September 2022 as Policy 4114.30

Revised: July 2023

Occupational Safety and Health Administration (OSHA) is the federal government agency that oversees the Bloodborne Pathogen Standards (OSHA Title 29 Code 1910.1030). Bloodborne pathogens are infectious microorganisms in human blood that can cause disease in humans. These pathogens include, but are not limited to, hepatitis B (HBV), hepatitis C (HCV) and human immunodeficiency virus (HIV). Needlesticks and other sharps-related injuries may expose workers to bloodborne pathogens.

In order to reduce or eliminate the hazards of occupational exposure to bloodborne pathogens, schools must implement an exposure control plan for the building with details on employee protection measures. The plan must also describe how a school will use engineering and work practice controls, personal protective clothing and equipment, employee training, medical surveillance, hepatitis B vaccinations, and other provisions as required by OSHA's Bloodborne Pathogens Standard (29 CFR 1910.1030). Engineering controls are the primary means of eliminating or minimizing employee exposure and include the use of safer medical devices, such as needleless devices and shielded needle devices.

The required elements of an Exposure Control Plan (ECP) are:

1. Determination of employee exposure. Identify the employees who are at risk of occupational exposure. For example, school nurse, first aid providers, teachers and teacher's aide in the classroom with developmentally disabled students where biting might be expected or with students who require medical assistance (e.g. epi-pen administration), custodians, maintenance employees, cafeteria staff, science, art, technology, agri-science teachers and any other teachers or school staff that may come into contact with blood and other infectious materials must receive training.
2. Implementation of various methods of exposure control, including universal precautions, engineering and work practice controls, personal protective equipment, and housekeeping. Schools must provide the HBV vaccine to at-risk employees who request it or have been exposed to blood-borne pathogens at no cost to employees.
3. Post-exposure evaluation and follow-up
4. Communication of hazards to employees and training will include general safety and health guidelines and an understanding of work duties that may put them at risk of exposure.
5. Recordkeeping. Employee exposure records for the duration of employment plus 30 years. Training records must be retained for three years from the date on which the training occurred, although it is advisable to retain training records for the duration of employment.
6. Procedures for evaluating circumstances surrounding exposure incidents.

Mandated Bloodborne Pathogens Training for Employees Form

The Occupational Safety and Health Administration (OSHA) has promulgated a standard to reduce occupational exposure to hepatitis B (HBV), hepatitis C (HCV) and human immunodeficiency virus (HIV) and other bloodborne pathogens. With the increasing prevalence of these viruses and the possibility of undiagnosed infections, this standard requires that employees consider blood and certain other body fluids from all individuals to be infectious. Reasonable anticipated contact with blood and other potentially infectious materials is what places an individual at risk of exposure to bloodborne pathogens, not the type of facility in which one works.

The health and welfare of all employees is a joint concern of the employee and the school system. While each employee is ultimately responsible for his or her own health, the Diocese recognizes a responsibility to provide as safe a work place as possible.

In accordance with Department of Labor, Occupational Safety and Health Administration, Part 1910 of Title 29 of the Code of Federal Regulations (CFR), each employee must receive a bloodborne pathogens in-service at the time of employment and then annually thereafter.

It is the employee's responsibility to be certain that he/she reads and understands this training. Please sign the affidavit below and return it to the school nurse.

I hereby certify that I have participated in the bloodborne pathogens training and that I understand and will follow the infection control guidelines to the best of my ability for my own safety and for the safety of those with whom I work. I understand that maximum confidentiality of the medical condition and/or information of students and employees must be maintained.

Employee Signature _____

Employee Name Printed _____

School/duty assignment _____

Date of Training _____

Employee Hepatitis B Vaccination Form

This school is offering the hepatitis B vaccine, free of charge, to its employees at risk of exposure to hepatitis B virus who request it. The fact sheet information regarding Hepatitis B vaccination is available here: https://www.cdc.gov/vaccines/hcp/vis/vis-statements/hep-b.html

The vaccine is given in three doses: one dose immediately and one at the second, third, and sixth month. **It is the responsibility of the employee to present himself or herself at the assigned time for all three doses**. It is important to complete the series of injections, as full immunity to hepatitis B virus is not assured until after all three doses have been given. In case employment is terminated, this school is no longer responsible for further hepatitis B vaccinations or for completion of the series.

I have been informed of the serious nature of hepatitis B infection as well as the benefits and minimal risks of the hepatitis B vaccination and have had the opportunity to have my questions answered. Having been given this information, I have decided:

_____ **YES, I request to have the hepatitis B vaccination**. I understand that it is my responsibility to report right away to _____ for the initial dose of vaccine and as instructed for additional doses. I have read and understand the potential side effects, and I wish to have the hepatitis B vaccine given to me. I do not hold this school responsible should any adverse reaction or side effect occur.

_____ _____

(Employee sign name) (Printed Employee Name)

_____

(Date)

Revision History: 07/23, 09/22

☐ Elementary

☐ Secondary

■ Both

Policy 7120

Asthma Inhalers

Effective: July 2023

Revised:

As mandated by Sections 3313.7113, 3313.7114, 3314.144, 3326.30, 3328.30 of the Revised Code, this policy is intended to create a framework for accommodating individuals with asthma symptoms.

The school will obtain a prescriber-issued protocol specifying definitive orders for asthma inhalers with or without spacers including dosages of medication to be administered, the number of times that each inhaler may be used before disposal and method of disposal. This prescriber shall be a licensed health care professional authorized to prescribe drugs, as defined in section 4729.01 of the Revised Code.

Procurement

The school may procure asthma inhalers with or without spacers through purchase or may accept donations of them from a wholesale distributor of dangerous drugs or a manufacturer of dangerous drugs, as defined in section 4729.01 of the Revised Code. The district may accept donations of money to purchase asthma inhalers with or without spacers.

Location, Replacement and Disposal

Building level administration shall be responsible for identifying one or more locations in the school in which an inhaler must be stored. Inhalers must be stored in a safe, secure, accessible, locked location in accordance with ORC 3313.713 that will allow for rapid, life-saving administration.

Inhalers that have expired should be disposed of according to manufacturer's guidelines. Used and expired inhalers shall be replaced in a reasonable time period.

Specifications of individuals who can provide a dosage of an asthma inhaler to an individual in an emergency situation

Building level administration shall be responsible for identifying individuals employed by or under contract with the school, in addition to the school nurse licensed under section 3319.221 of the Ohio Revised Code or an athletic trainer licensed under Chapter 4755 of the Ohio Revised Code, who may access and use an asthma inhaler to provide a dose to an individual in an emergency situation.

Identified individuals specified above, other than a school nurse or athletic trainer, must complete training based on the protocol developed with the prescriber before being authorized to access and use an asthma inhaler. Only trained personnel should administer an asthma inhaler to a person believed to be having asthma symptoms.

Emergency medical services must be requested immediately after an asthma inhaler is used by an employee or contractor, other than a school nurse, athletic trainer, or another licensed health professional.

Usage

Identified and trained individuals may administer an asthma inhaler to students, school employees or contractors, school visitors and other individuals in the school building in an emergency situation when a person exhibits signs and symptoms of asthma on school premises during the school day.

Reporting

The school will report each procurement of and occurrence in which an asthma inhaler is used to the Ohio Department of Education per protocol**.** Nothing herein shall affect a student's ability to self-administer asthma inhalers.

References

Ohio Association of School Nurses and Ohio Department of Health:
School+Sample+Stock+Asthma+Inhaler+Policy.pdf (ohio.gov)

Revision History: 07/23

☐ Elementary

☐ Secondary

■ Both

Policy 7200

Student Accidents

Effective: July 2023

Revised:

If a student has an accident/injury at school:

1. First aid should be administered by trained staff
2. If medical assistance is needed, call 911
3. Notify the student's parents or legal guardian as soon as possible, if 911 is called, contact the parents by telephone
4. Notify the principal
5. Record an incident report, as soon as possible, all pertinent facts concerning the accident and submit it to the principal. An incident report should be completed when an injury leads to any of the following:
    a) The student misses ½ day or more of school.
    b) The student seeks medical attention (health care provider office, urgent care center, emergency department).
    c) EMS 9-1-1 is called.
6. All serious incidents involving injury that could result in possible liability are to be reported immediately to the superintendent using on-line reporting system. No written communication is to be released to anyone other than the superintendent unless directed by the Diocesan Insurance Officer or Diocesan legal counsel.

Incident reports are to be kept on all injuries requiring medical attention which occur while students are on school property, in school buildings, on the way to or from school, or at school-sponsored activities.

Follow Policy 1320 for details on reporting and filing student incident reports.

Revision History: 07/23

☐ Elementary

☐ Secondary

■ Both

Policy 7210

Food Allergies and Epinephrine

Effective: July 2023

Revised:

Background

Anaphylaxis is a severe allergic reaction that is rapid in onset and may cause death. Not all allergic reactions will develop into anaphylaxis. In fact, most are mild and resolve without problems. However, early signs of anaphylaxis can resemble a mild allergic reaction. Unless obvious symptoms, such as throat hoarseness or swelling, persistent wheezing, or fainting or low blood pressure, are present, it is not easy to predict whether these initial, mild symptoms will progress to become an anaphylactic reaction that can result in death. Therefore, all children with known or suspected ingestion of a food allergen and the appearance of symptoms consistent with an allergic reaction must be closely monitored and possibly treated for early signs of anaphylaxis.

Symptoms of anaphylaxis

1. Mucous Membrane Symptoms: red watery eyes or swollen lips, tongue, or eyes.
2. Skin Symptoms: itchiness, flushing, rash, or hives.
3. Gastrointestinal Symptoms: nausea, pain, cramping, vomiting, diarrhea, or acid reflux.
4. Upper Respiratory Symptoms: nasal congestion, sneezing, hoarse voice, trouble swallowing, dry staccato cough, or numbness around mouth.
5. Lower Respiratory Symptoms: deep cough, wheezing, shortness of breath or difficulty breathing, or chest tightness.
6. Cardiovascular Symptoms: pale or blue skin color, weak pulse, dizziness or fainting, confusion or shock, hypotension (decrease in blood pressure), or loss of consciousness.
7. Mental or Emotional Symptoms: sense of “impending doom,” irritability, change in alertness, mood change, or confusion.

Allergens that May Result in Anaphylaxis that Require Use of Epinephrine

1. Foods such as peanuts, tree nuts, milk, eggs, fish, or shellfish.
2. Medications such as penicillin or aspirin.
3. Bee venom or insect stings, such as from yellow jackets, wasps, hornets, or fire ants).
4. Latex, such as from gloves.

Students with Diagnosed Life-Threatening Allergies:

1. At the start of the school year or upon transfer to the school, parent/guardian of a student with known allergies that may be severe enough to cause anaphylaxis should provide the school with student-specific medical orders, a medical management plan, and their own supply of epinephrine. The Information should include:
    a) Information about the food allergen, including a confirmed written diagnosis from the child’s doctor or allergist.
    b) Information about signs and symptoms of the child’s possible reactions to known allergens.

c) Information about the possible severity of reactions, including any history of prior
d) anaphylaxis (even though anaphylaxis can occur even in children without a history of prior anaphylaxis).
e) A treatment plan for responding to a food allergy reaction or emergency, including whether an epinephrine auto-injector should be used.
f) Information about other conditions, such as asthma or exercise-induced anaphylaxis that might affect food allergy management.
g) Contact information for parents and doctors, including alternate phone numbers for notification in case of emergency.

2. Parents or legal guardians of students who allow their child to possess and self-administer an epinephrine auto-injector must provide a completed Medication Administration Record Form to the school in accordance with the school's medication policies.
3. All students who have had a prior anaphylactic reaction or have otherwise been identified as at-risk for having a severe allergic reaction should have this addressed specifically in an individualized health care plan and/or emergency care plan.
4. The parent/guardian of a student with a known serious allergy may be requested to provide an extra epinephrine auto-injector to the school for use by authorized personnel in case of emergency.
5. A school official will notify each of the student's teachers when aware that a student is in valid possession of an epinephrine auto-injector in accordance with the school's medication policies.
6. A school official will notify each of the student's teachers about the epinephrine auto-injector that was provided by the parent/guardian and where it is stored in the school for use by authorized personnel in case of emergency.

Individuals with Undiagnosed Life-threatening Allergies:

For students, staff, and any other individual on school grounds:

1. Every school building is recommended to maintain a stock of at least two epinephrine auto-injector devices at all times. The principal and the school nurse are responsible for identifying one or more locations in the school in which an epinephrine autoinjector must be securely stored.**

2. Each school should obtain a prescriber-issued protocol specifying definitive orders for epinephrine auto injector and dosages of epinephrine to be administered through school. This protocol may be used: *Epinephrine Standing Order Protocol* and *Standing Order Certification Form.*

3. It is recommended schools maintain documentation of the training course(s) successfully completed by each employee who is authorized to administer epinephrine and make such documentation available upon request.

4. Schools are encouraged to train and authorize more than the legally required minimum number of school staff to administer epinephrine. All school staff should have a basic awareness of the major signs of anaphylaxis and know whom to alert in case of an emergency and where the stock epinephrine auto-injectors are located.

5. Designated school staff shall check the expiration dates of the stock auto-injector devices at least twice per year and discard expired stock in a biohazard sharps container or locate a needle disposal facility and replace any device past its expiration date.

Procurement
The school may procure epinephrine auto-injectors through purchase or may accept donations of epinephrine auto-injectors from a wholesale distributor of dangerous drugs or a manufacturer of dangerous drugs, as defined in Section 4729.01 of the Ohio Revised Code. The school may accept donations of money to purchase epinephrine auto-injectors.

Individuals Authorized to Administer Epi-Pens in Emergency Situations
The principal and the nurse are responsible for identifying individuals employed by or under contract with the district board, in addition to the school nurse licensed under Section 3319.221 of the Ohio Revised Code or an athletic trainer licensed under Chapter 4755 of the Revised Code, who may access and use an epinephrine autoinjector to provide a dosage of epinephrine to an individual in an emergency situation.

Identified individuals specified above, other than a school nurse or athletic trainer, must complete training based on protocol developed with the prescriber before being authorized to access and use an epinephrine autoinjector. Only trained personnel should administer an epinephrine autoinjector to a person believed to be having an anaphylactic reaction. Emergency medical services must be requested immediately after an epinephrine auto-injector is used.

Usage
Identified and trained individuals may administer an epinephrine autoinjector to students, school employees or contractors, school visitors and other individuals in the school building in an emergency situation when a person exhibits signs and symptoms of anaphylaxis on school premises during the school day.

Training
1. General Training for all staff should include:
2. School policies and practices.
3. An overview of food allergies.
4. Definitions of key terms, including *food allergy, major allergens, epinephrine,* and *anaphylaxis*.
5. The difference between potentially life-threatening food allergy and other food-related problems.
6. Signs and symptoms of a food allergy reaction and anaphylaxis and information on common emergency medications.
7. General strategies for reducing and preventing exposure to allergens (in food and nonfood items).
8. Policies on bullying and harassment and how they apply to children with food allergies.
9. The school's emergency plans, including who will be contacted in the case of an emergency, how staff will communicate during a medical emergency, and what essential information they will communicate.
10. How to administer epinephrine with an auto-injector (for those formally delegated to do so).

School Responsibilities
The school will create and maintain a healthy and safe educational environment for the student with allergies. Staff should take active steps to reduce the risk of exposure in all common areas, such as classrooms and

cafeterias. Schools may consider food items for curriculum-related events, daily organized snacks, and seasonal class parties to be prepacked, labeled and meet classroom allergen restrictions. Schools may choose to designate allergen-safe zones, such as an individual classroom or eating area in the cafeteria. Consider implementation of a "no-food incentives" policy for rewards.

Schools should also provide in-depth training for the individuals authorized to administer epi-pens. They should implement specific strategies for fully integrating children with food allergies into school and class activities while reducing the risk of exposure to allergens in classrooms, during meals, during nonacademic outings, on field trips, during official activities before and after school programs, and during events sponsored by schools that are held outside of regular hours. These strategies could address (but are not limited to) the following: Special seating arrangements when age and circumstance appropriate (e.g., during meal times, birthday parties); create plans for keeping foods with allergens separated from foods provided to children with food allergies; educate staff and students on the importance of handwashing and cleaning surfaces to reduce the risk of exposure to food allergens; stress the importance of not sharing food; train staff how to read food labels to identify food allergens.

Food Allergy Preparedness Response

Schools should prepare their response plan for the food allergy emergency. The plan should include the following:

1. Easy to use communication system.
2. Quick and easy staff access to epinephrine auto-injectors.
3. Make sure that epinephrine is used when needed and someone immediately contacts emergency medical services.
4. Identify the role of each staff member in an emergency.
5. Document the response to a food allergy emergency.
    a) Time and location of the incident.
    b) Food allergen that triggered the reaction (if known).
    c) If epinephrine was used and the time it was used.
    d) Notification of parents and EMS.
    e) Staff members who responded to the emergency.

Reporting

The school official or his/her designee will report each procurement of an occurrence in which an epinephrine autoinjector is used to the department of education per protocol: https://education.ohio.gov/Topics/Other-Resources/Epinephrine-Procurement.

Exemption from Liability

Under Section 3728.03, (B) (1) The following are not liable in damages in a civil action for injury, death, or loss to person or property that allegedly arises from an act or omission associated with procuring, maintaining, accessing, or using an epinephrine autoinjector under this section, unless the act or omission constitutes willful or wanton misconduct:

1. A chartered or non-chartered nonpublic school;
2. A member of a chartered or non-chartered nonpublic school governing authority;
3. An employee or contractor of the school;
4. A licensed health professional authorized to prescribe drugs who personally furnishes or prescribes epinephrine auto-injectors, provides a consultation, or issues a protocol pursuant to this section.

Disclaimer

All schools are encouraged to implement and follow this policy; however, some schools may opt out of introducing the stock epinephrine piece due to lack of school nursing staff or not having enough individuals who are trained. In such an event, when symptoms of anaphylaxis are evident, staff members should call 911 immediately.

References

- Centers for Disease Control and Prevention. *Voluntary Guidelines for Managing Food Allergies in Schools and Early Care and Education Programs.* Washington, DC: US Department of Health and Human Services; 2013.
- State of Michigan. (2022, 10, 21). *ADDENDUM TO THE 2002 MODEL POLICY AND GUIDELINES*. Retrieved from State of Michigan: https://www.michigan.gov/-/media/Project/Websites/mde/Year/2017/01/24 Epi_Addendum_6-18-14.pdf?rev=d3c7d8b52b7c47728170d8afdf012d4e
- State of Ohio. (2022, 20, 21). *OHIO DEPARTMENT OF HEALTH-OHIO ASSOCIATION OF SCHOOL NURSES BOARD POLICY TEMPLATE FOR NON-INDIVIDUAL SPECIFIC EPINEPHRINE AUTOINJECTOR POLICY.* Retrieved from State of Ohio: https://ohio.org/wps/wcm/connect/gov/ed6aa499-638c-4d06-975a-4c8f2b37fcfc/Sample+School+Stock+Epinephrine+Autoinjector+School+Policy.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-ed6aa499-638c-4d06-975a-4c8f2b37fcfc-mqDdAxd

Revision History: 07/23

☐ Elementary

☐ Secondary

■ Both

Policy 7220

Suicide Intervention Process

Effective: July 2023

Revised: April 2025

In 2020, suicide was the third leading cause of death among young people ages 10-19. Youth suicide is preventable, and educators and schools are key to prevention.
Suicide risk exists on a continuum with various levels of risk. Staff should monitor for students who exhibits signs of unusual mental health related behavior or who threaten self harm or suicide.
If a student approaches a school employee expressing suicidal thoughts/ideation, or is concerned about a peer/friend who has been expressing such thoughts, their concern should be taken with seriousness and the following protocol should be followed.

Assess and Stabilize the situation:

1. Do not leave the student alone under any circumstance.
2. Accompany the student to a private room to discuss the concern. To increase the student's comfort, ask if there is an additional adult they would like to be present for the conversation. If the concern is about another student or person/peer outside of school, notify your school administrator that you will be contacting an administrator at the student of concern's school.
3. Ask the student if they are carrying anything they can harm themselves with (weapon, substance etc). If the student agrees, remove harmful instrument(s).
4. Assess the risk of the student harming himself/herself. A tool such as the Columbia Suicide Severity Rating Scale is recommended (Screener with Triage for Schools | The Columbia Lighthouse Project).

Take the appropriate action based on the assessment:

1. Low risk:
    a. Notify your administrator of the situation
    b. Make contact with the guardian/emergency contact before the child returns home.
    c. Provide the student and parent/guardian with printed General Resource List (See below) and assist parents in making contact with an agency or resource person.
    d. Provide the parent the Parent Notification of Mental Health Emergency Form. Ask parent to sign and return the form.
2. Moderate-High Risk (**Moderate to High Risk on the Suicide Scale):**
    a. Do not leave the student alone under any circumstance.
    b. Notify your administrator of the situation.
    c. If the student's distress is related to abuse, neglect or exploitation, contact Children's Protective Services immediately and follow their instructions.

d. Call the parent/guardian to inform them of the situation and the need for the parent/guardian to come school.
e. When the parent/guardian arrives at school, discuss the situation.
f. With parental permission, call the Nationwide Children's Hospital Psychiatric Crisis Line (614-722-1800) for a phone consult. Follow their instructions.
g. Should the parent refuse to take additional steps, call Children's Services and report the safety concern.
h. Document and summarize all communications with parents.

3. If after several attempts to contact the parent/guardian, you are unsuccessful:
   a. Consult with the administrator and determine appropriate action. Document and summarize all attempts to communicate with parents/guardians.
   b. Try contacting Emergency Contacts. Maintain confidentiality.
   c. Contact Children's Services
   d. Call emergency services or contact the Resource Officer to escort the student for a mental health evaluation.

Follow-Up

1. Assess the extent to which emergency or short term procedures were completed.
2. Confirm with the student's parent or guardian the arrangements for long-term clinical support services.
3. If no services were completed, discuss with administration the appropriate action.
4. Follow up with the student to support his or her welfare.

Re-Entry

Prior to returning to school after a mental health release related absence, a meeting will be held with the student's parent or guardian, the administrator, School Counselor and School Nurse.

1. The parent/guardian will provide the safety plan and discharge paperwork from the treatment facility.
2. During the meeting a review of the safety plan and how it will be adapted to the school setting will be completed.
3. The continued Release of Information will be discussed so that information may be shared as deemed appropriate between the school and other service providers.
4. Weekly check-ins will be set up with the school counselor and options for additional check-ins will be discussed.
5. After the meeting, the counselor will notify the teachers of the school plan and the role they will play.
6. The School Counselor will schedule a follow-up meeting with the appropriate parties within one month to update and modify the plan if necessary.

****Please remember that any information learned in this process is confidential.**

General Resource List

Emergency Risk Assessment Locations

Nationwide Children's Hospital
614-722-2000
Big Lots Behavioral Health Pavilion
444 Butterfly Gardens Dr.
Columbus, OH 43215

Ohio State University - Harding Hospital
614-293-9600
1670 Upham Dr.
Columbus, OH 43210

Sun Behavioral
614-706-2786
900 E. Dublin Granville Rd.
Columbus, OH 43229

Outpatient

Spirit of Peace Clinical Counseling
614-442-7650
https://spiritofpeaceclinicalcounseling.com

Directions for Youth
614-888-9200
1515 Indianola Ave.
Columbus, OH 43201
https://www.directionscounseling.com

Veritas Counseling & Consultation
614-398-3771
2029 Riverside Drive, Suite 201
Columbus, OH 43221
www.VeritasCounseling.org

988 Suicide and Crisis Lifeline – SB 234

Effective April 9, 2025, Ohio law requires schools serving students in any grade 9 through 12 to include the 988 Suicide and Crisis Lifeline telephone number on all of the following, if provided or used by the school:

- Student identification cards issued after April 9;
- Planners issued to students after April 9; and

Any electronic portal administered by the district or school that may be accessed by students.
The Department of Mental Health and Addiction Services provides resources that may help schools with updating materials, including the **988 Toolkit** and **Materials Generator.**

The **988 Suicide and Crisis Lifeline** provides 24/7, free, and confidential support to Ohioans in a mental health crisis. Ohioans can call or text "988" to reach a trained specialist for help and support. Contact 988ohio@mha.ohio.gov for questions about the Suicide and Crisis Lifeline. LSC Analysis: legislature.oh

Columbia Suicide Severity Rating Scale

	Past month	
Ask questions that are in bold and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** e.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** as opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?***		
6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Took pills, tried to shoot yourself, cut yourself, or hang yourself, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc. **If YES, ask:** ***Was this within the past 3 months?***	**Lifetime** **Past 3 Months**	

Parent Notification of Mental Health Emergency

Date: _____

Student: _____

DOB: _____

Form completed by (name and title): _____

Phone: _____

The parent/guardian of the student noted above has been conferenced with and advised regarding potential risk due to harm to self or others. It has been identified through direct report from the student that the following concerns are evident:

In an effort to keep the student safe, information about the following resources have been shared with the parent(s)/guardian:

__ Community mental health services

__ Current treating private provider:_____

__ Emergency room

__ Other:_____

The following additional information has been shared with the family:

__ The parent(s)/guardian has been advised of home safety and the need for supervision (student not to be left alone).

__ The parent(s)/guardian has been provided the following resources for supporting student safety:

__ Parent resource packet

If student is sent for emergency mental health services, prior to returning to school the following will occur:

__ A re-entry meeting will be held with student, parent(s)/guardian, and school support staff (including, but not limited to, School Counselor, Administrator, School Nurse)

__ Parent(s)/guardian will provide medical documentation of school absence if applicable.

__ Parent(s)/guardian are asked to provide documentation from a mental health provider stating that the student is not at imminent risk for harming his/herself or others and that it is safe for the student to return to school, and any other relevant information about the student's mental health status and needs, such as discharge summaries; recommendations from hospital, therapeutic setting, or other provider.

Additional notes:

I acknowledge that the above information was presented and reviewed.

Parent(s)/guardian: _____Date: _____

Revision History: 07/23

☐ Elementary

☐ Secondary

■ Both

Policy 7230

Communicable Diseases and Outbreaks

Effective: July 2023

Revised:

Communicable Diseases and outbreaks

Any pupil showing symptoms of a communicable disease shall be dismissed from school by the school nurse or authorized school personnel after notification of the parent(s)/guardian(s). Parents shall report all communicable diseases to the school office. In the event of an outbreak of a communicable disease, the local health department will be notified.

An outbreak is considered community-related when the number of reported cases is higher than what is expected on the basis of previous reports during a non-epidemic period for a given population in a defined time, and the outbreak is not considered to be foodborne, waterborne, zoonotic, healthcare-associated, or institutional.

School Closure

School closure is not recommended for outbreaks of infectious disease. The decision to close a school is an administrative decision and one that should be made only after consultation with public health officials and the district medical personnel.

Schools should work with local health departments to ensure that recommended control measures (e.g., exclusions, increased cleaning) are being followed. In addition, the local health department in conjunction with ODH may recommend enhanced surveillance be conducted in a school to monitor the progression and ultimate decline of an outbreak. If necessary, school closure should be utilized on a limited basis to prevent spread of infection when:

1. Infections are expected to affect large number of susceptible individuals
2. Recommended control measures are inadequate
3. The facility is unable to function due to increased illness affecting students and staff
4. The health department declares an epidemic or cause of ill health to be injurious or hazardous. The local health department has the authority to close childcare centers.

References

https://www.nj.gov/health/cd/documents/topics/outbreaks/Guidelines_Outbreaks_School.pdf

Revision History: 07/23

☐ Elementary

☐ Secondary

■ Both

Policy 7240

Menstrual Product Availability in Schools

Effective: July 2023

Revised:

Purpose

To increase student wellness and address barriers that prevent students from engaging in learning, schools that enroll girls are now required by Ohio law to provide feminine hygiene (menstrual) products for female students in grades 6 through 12.

Requirements

Each school can determine where menstrual products are stored and dispensed in the school. Schools are not required to install product dispensers, but should consider whether the location allows for discreet easy access to products where students need them.

Menstrual Products

Each school can determine the types of menstrual products offered. Menstrual products include tampons, panty liners, sanitary napkins and other products in connection with the human menstrual cycle. As best practice, each school may provide a variety of products with consideration of absorbency and size. Schools may also choose to provide age-appropriate guidance on how to use and dispose of products to avoid risks to student's health and safety.

Funding

State funding and/or reimbursement may be available to support schools in providing free menstrual products for students. Schools should contact the Ohio Department of Education for additional information on funding opportunities.

References

https://education.ohio.gov/Topics/Student-Supports/Student-Health-and-Medication-Supports/Menstrual-Products

Revision History: 07/23

☐ Elementary

☐ Secondary

■ Both

Policy 7300

Concussions

Effective: July 2023

Revised:

A concussion is a type of brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head. Concussions can also occur from a fall or blow to the body that causes the head and brain to move rapidly back and forth. Even what seems to be a mild bump to the head can be serious. Children and adolescents are among those at greatest risk for concussion. The potential for a concussion is greatest during activities in which collisions can occur, such as during physical education (PE) class, playground time, or sports activities. However, concussions can happen any time a student's head comes into contact with a hard object, such as a floor, desk, or another student's head or body. Proper recognition and response to concussion can prevent further injury and help with recovery.

A student with a concussion should be seen by a healthcare provider experienced in evaluating for concussion. A healthcare provider can make decisions about a student's readiness to return to school based on the number, type and severity of symptoms experienced by the student. The healthcare provider should also offer guidance about when it is safe for a student to return to school and appropriate levels of cognitive and physical activity. Once a healthcare provider has given permission for the student to return to the classroom, school professionals can help monitor him/her closely. Prior to receiving written clearance from a healthcare professional, students who have sustained a concussion may not participate in any school-related physical activities.

If a student has a suspected concussion, they should be removed from play, PE, sports practice until seen by a medical provider, experienced in evaluating for concussion, and cleared to return to physical exercise.

Any injury to the head should be documented as soon as possible, including all pertinent facts concerning the incident and parents or guardians shall be notified about the incident possible and given information on concussions and the need for medical attention.

(Sample here - https://www.cdc.gov/headsup/pdfs/schools/TBI_schools_checklist_508-a.pdf)

References

Ohio Department of Health Emergency Guidelines for Schools:
https://odh.ohio.gov/wps/wcm/connect/gov/5331f9a2-08b6-40dc-9717-f3ccc0ae5d72/Emergency+Guidelines+for+Schools.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_K9I401S01H7F40QBNJU3SO1F56-5331f9a2-08b6-40dc-9717-f3ccc0ae5d72-mmbJ4-G
Concussion: https://www.cdc.gov/headsup/schools/nurses.html

Revision History: 07/23

■ Elementary

☐ Secondary

☐ Both

Policy 7310

Bathroom Accidents

Effective: July 2023

Revised:

Incontinence is common among young children. Urinary incontinence, or daytime wetting, is more common than fecal incontinence, or soiling. Bladder or bowel incontinence is rarer among elementary and secondary students.

Children enrolled either in the preschool or in the kindergarten program must be fully toilet trained; able to use the bathroom by himself without assistance and without frequent accidents. Pull Ups and training diapers are not permitted.

Causes of incontinence include:

- overactive bladder
- constipation, which can result in urinary or fecal incontinence
- problems with nerves from the lower spinal cord that control bowel and bladder function problems related to other conditions, such as diabetes, inflammatory bowel disease, irritable bowel syndrome, and spina bifida

Students with incontinence may:

- need preferential seating nearest to a bathroom
- miss class time due to frequent bathroom breaks
- have pain or discomfort due to bladder or bowel issues
- need to go to the school nurse for medication or to change their clothes
- feel anxious or embarrassed by their incontinence
- be at risk for teasing or bullying due to their condition

Care Plan:

- Add regularly scheduled, frequent breaks to help reduce accidents.
- Adhere to established behavior plans
- Provide appropriate bathroom space
- Store continence supplies and clothing changes
- Support the student's privacy and dignity
- If a child has accidents frequently, she or he will be referred to the nurse for assessment and a doctor referral if indicated.

After accident assistance:

- Any child who has an accident will be removed from the classroom discreetly and escorted to the bathroom by a staff member.
- A second staff member will be present nearby but not within a sight of the child.
- The child will be encouraged to remove the soiled clothing by himself or herself.
- The staff member will assist the child in the removal of the soiled clothing only when necessary.
- The child will be placed on the toilet and encouraged to complete the action to ensure that the bladder/bowels have been completely emptied and then to wipe.
- The soiled clothing will be returned to the child's school bag in a zippered plastic bag.
- When the clothing is soiled and sent home, it will be the parents' responsibility to replace the clothing. If clothing is not provided, the parent will be asked to come to the school and provide clothing for their child.
- The staff member will check the child for sufficient cleanliness and assist as necessary.
- The staff will assist the child in getting dressed as necessary.
- Children who have accidents will never be humiliated, punished or belittled.
- The staff member will ensure that all the tasks are performed according to the standard precaution for infection and prevention control.

References

https://kidshealth.org/en/parents/incontinence-factsheet.html

Revision History: 07/23

Policy 7320

Head Lice

Effective: July 2023

Revised: November 2025

☐ Elementary

☐ Secondary

■ Both

A head lice infestation is not a communicable condition and no health risks have been associated with head lice. In accordance with the recommendation of the Centers for Disease Control and Prevention and the Ohio Department of Health, the following guidelines are approved after a student has been identified with head lice:

- Any student found to have pediculosis may remain in the classroom and go home at the end of the day to be treated. The parent or guardian will be notified by telephone.
- Verbal and/or written instructions regarding pediculosis control will be given to the parent or guardian.
- If a student is found to have active infestation (live bugs or no progress in nit removal), the parent or guardian will be notified and re-educated to ensure effective management of head lice infestations. Treatment options will be provided to the parent or guardian.
- A person with head lice shall be excluded from school until after the first treatment with an effective pediculicide. Students will be readmitted to school as soon as proof of treatment is provided to the school nurse and no active infestation is identified.
- If the parent or guardian is not compliant with treatment options and the student has missed more than one day of school, the following measures may be implemented:
    - review of attendance policy
    - conference at school with the school nurse and counselor (if indicated) with a plan developed for treatment and return.
- The Ohio High School Athletic Association (OHSAA) may have different guidelines/rules for exclusion from sports activities. See: http://ohsaa.org/medicine/sportssafety.htm

References

Head Lice Information for Schools. CDC, search “head lice”

Head Lice Management in Schools. https://www.nasn.org/nasn-resources/professional-practice-documents/position-statements/ps-head-lice

Ohio Department of Health. https://www.nocac.org/wp-content/uploads/2018/05/H-21-Head-Lice-Ohio-Dept-of-Health.pdf

Revision History: 11/25, 07/23

Policy 7330

Heimlich Maneuver

Effective: July 2023

Revised:

☐ Elementary

☐ Secondary

■ Both

Any school that operates a food service program shall require at least one employee who has received instruction in methods to prevent choking and has demonstrated an ability to perform the Heimlich maneuver to be present while students are being served food.

Any school employee is not liable in damages in a civil action for injury, death, or loss to person or property allegedly caused by an act or omission in connection with performance of Heimlich Maneuver unless such act or omission was with malicious purpose, in bad faith, or in a wanton or reckless manner.

Infants Under 1 Year

Begin the following if the infant is choking and is unable to breathe. However, if the infant is coughing or crying, do NOT do any of the following, but call EMS, try to calm the child and watch for worsening of symptoms. If cough becomes ineffective (loss of sound), begin step 1 below.

1. Position the infant, with head slightly lower than chest, face down on your arm and support the head (support jaw; do NOT compress throat).
2. Give up to 5 back slaps with the heel of hand between infant's shoulder blades.
3. If object is not coughed up, position infant face up on your forearm with head slightly lower than rest of body.
4. With 2 or 3 fingers, give up to 5 chest thrusts near center of breastbone, just below the nipple line.
5. Open mouth and look. If foreign object is seen, sweep it out with finger.
6. Tilt head back and lift chin up and out to open the airway. Try to give 2 breaths.
7. REPEAT STEPS 1-6 UNTIL OBJECT IS COUGHED UP OR INFANT STARTS TO BREATHE OR BECOMES UNCONSCIOUS.
8. Call EMS after 2 minutes (5 cycles of 30 compressions to 2 rescue breaths) if not already called.
9. If infant becomes unconscious, start infant CPR.

Children Over 1 Year of Age and Adults

Begin the following if the victim is choking and unable to breathe. Ask the victim: "Are you choking?" If the victim nods yes or can't respond, help is needed. However, if the victim is coughing, crying or speaking, do NOT do any of the following, but call EMS, try to calm him/her and watch for worsening of symptoms.

If cough becomes ineffective (loss of sound) and victim cannot speak, begin step 1 below.

1. Stand or kneel behind child with arms encircling child.
2. Place thumb side of fist against middle of abdomen just above the navel. (Do ***NOT*** place your hand over the very bottom of the breastbone. Grasp fist with other hand.)
3. Give up to 5 quick inward and upward abdominal thrusts.

4. Repeat steps 1-2 until object is coughed up, child starts to breathe or child becomes unconscious.
5. **If child becomes unconscious, place on back and go to child or adult CPR.**

For obese person or pregnant woman:
Stand behind person and place your arms under the armpits to encircle the chest. Press with quick backward thrusts.

References

- Emergency Guidelines for Schools. https://odh.ohio.gov/wps/wcm/connect/gov/5331f9a2-08b6-40dc-9717-f3ccc0ae5d72/Emergency+Guidelines+for+Schools.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_K9I401S01H7F40QBNJU3SO1F56-5331f9a2-08b6-40dc-9717-f3ccc0ae5d72-mmbJ4-G
- Ohio Laws and Administrative Rules. https://codes.ohio.gov/ohio-revised-code/section-3313.815

Revision History: 07/23

Policy 7340

☐ Elementary

☐ Secondary

■ Both

Management of Epileptic Seizures in a School Setting

Effective: July 2023

Revised: April 2025

Epilepsy is a common disorder of the brain that causes recurring seizures. Seizures result from unpredictable, abnormal electrical brain activity that causes a range of mild to severe symptoms and clinical manifestations. Failure to effectively treat and manage seizures can have serious consequences.

To care for a student with epilepsy in school, the following is required:

1. An emergency care plan must be completed yearly by a health care provider and be provided to the school by the first day of school. Sample plans:
    a. General https://www.epilepsy.com/sites/default/files/2023-08/SeizureActionPlan2023ACCE.pdf
    b. ASAP https://www.epilepsy.com/sites/default/files/2024-06/Acute-seizure-action-plan-with-EF-SFA-fillable.pdf

2. Effective April 9, 2025, **Ohio law** allows for a student to possess a drug prescribed to the student designed to prevent the onset of a seizure or to alleviate the symptoms of a seizure if both of the following conditions are satisfied:
    a. The student has the written approval of the student's physician and, if the student is a minor, the written approval of the parent, guardian, or other person having care or charge of the student. The physician's written approval shall include at least all required components of Ohio law.
    b. The school principal and, if a school nurse is assigned to the student's school building, the school nurse received copies of the written approvals.

If these conditions are satisfied, the student may possess a drug described in Ohio law at school or at any activity, event, or program sponsored by or in which the student's school is a participant. Identified school employees, contractors, and volunteers who receive a copy of the seizure action plan, have required training, and meet all other Ohio law requirements may administer the prescribed emergency seizure medication to a student if the following conditions are met:

a. The individual received a copy of the written approval issued by the student's physician which contained the information required by Ohio law; and
b. The individual has received training regarding the circumstances under which the drug is to be administered to the student and how the drug is to be administered to the student.

3. Schools and districts must designate at least one employee at each school building in addition to a school nurse to receive training on the implementation of seizure action plans every two years. The seizure training program should not exceed one hour. The training should qualify as professional development activity for the renewal of educator licenses.

   The seizure training program must include:

   a. Recognizing the signs and symptoms of a seizure;
   b. The appropriate treatment for a student who exhibits the symptoms of a seizure; and
   c. Administering drugs prescribed for seizure disorders.

In addition, each person employed as an administrator, guidance counselor, teacher or bus driver must complete a minimum of one hour of training on seizure disorders by Oct. 3, 2025. Administrators, guidance counselors, teachers and bus drivers employed after Oct. 3, 2023, must complete the training within 90 days of employment. Free education available here: Epilepsy Foundation: https://learn.epilepsy.com/courses/school-nurse-rescue-therapies-OD-v2b

References

Centers for Disease Control and Prevention: https://www.cdc.gov/school-health-conditions/chronic/epilepsy.html?CDC_AAref_Val=https://www.cdc.gov/healthyschools/npao/epilepsy.htm

Epilepsy Foundation: https://www.epilepsy.com

NASN: file:///C:/Users/srandrea/Downloads/Seizure%20&%20Epilepsy%20Guideline-2023-v5.pdf

Ohio Revised Code. Section 3313.7117. Individualized seizure action plans. **https://codes.ohio.gov/ohio-revised-code/section-3313.7117/4-9-2025**

☐ Elementary

☐ Secondary

■ Both

Policy 7350

Opioid Overdose

Effective: July 2023

Revised: May 2025

Schools that elect to obtain and maintain a supply of an overdose reversal drug for use in an emergency situation are to adopt and implement a policy regarding the supply's maintenance and the drug's use at each school building. Schools and their employees are legally permitted to purchase, store, and administer Naloxone (Narcan) in response to an opiate overdose in schools and those who do assist with such administration are immune from civil liability as well as exempt from criminal prosecution from possession, use, etc. of a prescription medication, particularly to an individual to whom it was not prescribed. The provisions of this policy outline the requirements of the law with respect to the use of Naloxone (Narcan) or similar overdose reversal drug in schools.

As a means of enhancing the health and safety of its students, staff and visitors, the school may acquire, administer, and store doses of an overdose reversal drug, specifically Naloxone (Narcan)[i], and administration devices or kits for emergency use to assist a student, staff member, or other individual believed or suspected to be experiencing an opioid overdose on school district property during the school day or at school district activities. Schools are permitted to accept monetary donations from any person to purchase overdose reversal drugs.

The school may obtain and possess opioid overdose reversal medication, such as Naloxone to be maintained and administered to a student or other individual by trained school staff if the staff member determines in good faith that the person to whom the medication is administered is experiencing an opioid overdose. Authorization for obtaining, possessing and administering Naloxone or similar permissible medications under this policy are contingent upon:

1. the continued validity of state and federal law that permit a person who is not a healthcare professional to dispense an overdose reversal drugs to the school district and its employees by law;
2. that the school and its staff are immune from criminal prosecution and not otherwise liable for civil damages for administering the opiate antagonist to another person who the staff member believes in good faith to be suffering from a drug overdose;
3. the availability of funding either from outside sources or as approved by the school to obtain and administer opioid overdose reversal medication.

To the extent Naloxone is obtained for use consistent with this policy, the school principal will designate at least two (2) individuals who may access and use Narcan to provide a dose in an emergency situation.

The school will obtain a protocol or Standing Order from a licensed medical prescriber for the use of Naloxone or other Opiate Antagonist by the school staff in all school facilities and activities and will update or renew the protocol or Standing Order annually or as otherwise required. A copy of the protocol or Standing Order will be maintained in the school office or nurse's office.

School staff should attend annual training will be responsible for attending all required training pertaining to the policy, procedures and guidelines for the storage and use of Naloxone and performing any assigned responsibilities pursuant to the guidelines and procedures.

Requirements After Administration

When Naloxone is administered, school employees must activate the community emergency response system (911) to ensure additional medical support due to the limited temporary effect of Naloxone and the continued need of recipients of additional medical care;

- School employees should contact the parent or guardian as soon as possible after administration of the Naloxone.
- School staff should inform the principal of the administration of Naloxone after taking necessary immediate emergency steps.
- The school will maintain the privacy of students and staff related to the administration of Naloxone as required by law.
- The principal, as soon as practicable after using an overdose reversal drug in an emergency situation, must report its use to the Department of Education and Workforce.

Naloxone Storage

The principal will select a storage location within the school site and the identity of the storage location(s) will be shared only with the school staff members**.** Stock Naloxone or similar overdose reversal drug must:

1. be in its original manufacturer's packaging;
2. have packaging that contains the manufacturer's instructions to use;
3. be stored in accordance with the manufacturer's or distributor's insturctions
4. be monitored for expiration dates;
5. be stored in a secured location that is accessible by trained staff.

References

School Toolkit - MN Dept. of Health (state.mn.us)

Ohio Legislative Service Commission. Bill analysis. H.B. 57. Retrieved from https://www.legislature.ohio.gov/download?key=25209

Revision History: 5/25, 07/23

Policy 7360

Cardiac Emergency

Effective: July 2023

Revised: July 2024

☐ Elementary

☐ Secondary

■ Both

A cardiac emergency requires immediate action. Cardiac emergencies may arise as a result of a Sudden Cardiac Arrest (SCA) or a heart attack, but can have other causes. SCA occurs when the electrical impulses of the heart malfunction resulting in sudden death. Signs of Sudden Cardiac Arrest can include one or more of the following:

- Not moving, unresponsive or unconscious, or
- Not breathing normally (i.e., may have irregular breathing, gasping or gurgling or may not be breathing at all), or
- Seizure or convulsion-like activity.

State Law (HB 47, 2024)

Following the passage of HB 47 in July 2024, all schools, including chartered nonpublic schools, are required to have and maintain AEDs. The law also requires that staff be trained on the use of AEDs and that each school has an emergency action plan for their use. This training shall be provided to teachers, principals, administrative employees, coaches, athletic trainers, other people who supervise athletics, and anyone else required to participate in trainings of any kind. Schools are also required, before the start of each athletic season, to hold informational meetings regarding the symptoms and warning signs of sudden cardiac arrest for all ages of students.

The Cardiac Emergency Response Plan

1. Developing a Cardiac Emergency Response Team. The Cardiac Emergency Response Team shall be comprised of those individuals who have current CPR/AED certification. It will include the school nurse, coaches, and others within the school. It should also include an administrator and office staff who can call 9-1-1 and direct EMS to the location of the SCA.
2. Members of the Cardiac Emergency Response Team are identified in the "Cardiac Emergency Response Team" attachment, to be updated yearly and as needed to remain current. One of the members shall be designated as the Cardiac Emergency Response Team Coordinator.
3. All members of the Cardiac Emergency Response Team shall receive and maintain nationally recognized training, which includes a certification card with an expiration date of not more than 2 years.
4. As many other staff members as reasonably practicable shall receive training.

Activation of Cardiac Emergency Response Team During an Identified Cardiac Emergency

1. The members of the Cardiac Emergency Response Team shall be notified immediately when a cardiac emergency is suspected.
2. The Protocol for responding to a cardiac emergency is described below and in the "Protocol for Posting" attachment.

Automated external defibrillators (AEDs) – Placement and Maintenance

1. Minimum recommended number of AEDs for school:
    - Inside school building – The number of AEDs shall be sufficient to enable the school staff or another person to retrieve an AED and deliver it to any location within the school building, ideally within 2 minutes of being notified of a possible cardiac emergency.
    - Outside the school building on school grounds / athletic fields – The number of AEDs, either stationary or in the possession of an on-site athletic trainer, coach, or other qualified person, shall be sufficient to enable the delivery of an AED to any location outside of the school (on school grounds) including any athletic field, ideally within 2 minutes of being notified.
    - Back-up AEDs – One or more AEDs shall be held in reserve for use as a replacement for any AED which may be out-of-service for maintenance or other issues. The back-up AED(s) should also be available for use by the school's athletic teams or other groups traveling to off-site locations.

2. Schools will regularly check and maintain each school-owned AED in accordance with the AED's operating manual and maintain a log of the maintenance activity. The school shall designate a person who will be responsible for verifying equipment readiness and for maintaining maintenance activity.

3. Additional Resuscitation Equipment: A resuscitation kit shall be connected to the AED carry case. The kit shall contain latex-free gloves, razor, scissors, towel antiseptic wipes and a CPR barrier mask.

4. AEDs shall not be locked in an office or stored in a location that is not easily and quickly accessible at all times.

5. AEDs shall be readily accessible for use in responding to a cardiac emergency, during both school-day activities and after-school activities, in accordance with this Plan. Each AED shall have one set of defibrillator electrodes connected to the device and one spare set. All AEDs should have clear AED signage so as to be easily identified. Locations of the AEDs are to be listed in the "Cardiac Emergency Response Team" attachment and in the "Protocol for Posting" attachment.

Communication of this Plan

1. The Cardiac Emergency Response Protocol shall be posted as follows:
    - In each classroom, cafeteria, restroom, health room, faculty break room and in all school offices.
    - Adjacent to each AED.
    - Adjacent to each school telephone.
    - In the gym, near the swimming pool, and in all other indoor locations where athletic activities take place.
    - At other strategic school campus locations, including outdoor physical education and athletic areas.
    - Attached to all portable AEDs.

2. The Cardiac Emergency Response Protocol shall be distributed to:
    - All staff and administrators at the start of each school year, with updates distributed as made.
    - All Health Services staff including the school nurse, health room assistants and self-care assistants.
    - All athletic directors, coaches, and applicable advisors at the start of each school year and as applicable at the start of the season for each activity, with updates distributed as made.

3. Results and recommendations from Cardiac Emergency Response Drills performed during the school year shall be communicated to all staff and administrative personnel. See below.

4. A copy of this Cardiac Emergency Response Plan shall be provided to any organization using the school. A signed acknowledgment of the receipt of this Plan and the Protocol by any outside organization using the school shall be kept in the school office. School administration and any outside organization using the school shall agree upon a modified Cardiac Emergency Response Plan. The modified Plan shall take into consideration the nature and extent of the use and shall meet the spirit and intent of this Plan which is to ensure that preparations are made to enable a quick and effective response to a cardiac emergency on school property.

Training in Cardiopulmonary Resuscitation (CPR) and AED Use

1. Staff Training:
    - In addition to the school nurse, a sufficient number of the staff shall be trained in cardiopulmonary resuscitation (CPR) and in the use of an AED to enable school to carry out this Plan. (It is recommended that at a minimum, at least 10% of staff, 50% of coaches, and 50% of physical education staff should have current CPR/AED certification.) Training shall be renewed at least every two years. The school shall designate the person responsible for coordinating staff training as well as the medical contact for school-based AEDs, if available.
    - Training shall be provided by an instructor, who may be a school staff member, currently certified by a nationally-recognized organization to conform to current American Heart Association guidelines for teaching CPR and/or Emergency Cardiac Care (ECC).
    - Training may be traditional classroom, on-line or blended instruction but should include cognitive learning, hands-on practice and testing.

2. Cardiac Emergency Response Drills:
    - Cardiac Emergency Response Drills are an essential component of this Plan. School shall perform a minimum of 4
    - successful Cardiac Emergency Response Drills each school year with the participation of athletic trainers, athletic training students, team and consulting physicians, school nurses, coaches, campus safety officials and other targeted responders. A successful Cardiac Emergency Response Drill is defined as full and successful completion of the Drill in 5 minutes or less. School shall prepare and maintain a Cardiac Emergency Response Drill Report for each Drill. (See “Conducting Drills” attachment.) These reports shall be maintained for a minimum of 5 years with other safety documents. The reports shall include an evaluation of the Drill and shall

include recommendations for the modification of the CERP if needed. (It is suggested that the school / school district consider incorporating the use of students in the Drills.)

3. Informational meeting – before each athletic season, schools and youth sports organizations will hold an informational meeting regarding the symptoms and warning sings of sudden cardiac arrest for student and youth athletes.

Local Emergency Medical Services (EMS) Integration with the School's Plan

1. School shall provide a copy of this Plan to local emergency response and dispatch agencies (e.g., the 9-1-1 response system), which may include local police and fire departments and local Emergency Medical Services (EMS).
2. The development and implementation of the Cardiac Emergency Response Plan shall be coordinated with the local EMS Agency, campus safety officials, on-site first responders, administrators, athletic trainers, school nurses and other members of the school and/or community medical team.
3. School shall work with local emergency response agencies to coordinate this Plan with the local emergency response system and to inform local emergency response system of the number and location of on-site AEDs.

Annual review and evaluation of the Plan

Schools shall conduct an annual internal review of the school/school district's Plan. The annual review should focus on ways to improve the response process, to include:

1. Post-event review following an event. This includes review of existing school-based documentation for any identified cardiac emergency that occurred on the school campus or at any off-campus school-sanctioned function. The school shall designate the person who will be responsible for establishing the documentation process. Post-event documentation and action shall include the following:
    - A contact list of individuals to be notified in case of a cardiac emergency.
    - Determine the procedures for the release of information regarding the cardiac emergency.
    - Date, time and location of the cardiac emergency and the steps taken to respond to the cardiac emergency.
    - The identification of the person(s) who responded to the emergency.
    - The outcome of the cardiac emergency. This shall include but not be limited to a summary of the presumed medical condition of the person who experienced the cardiac emergency to the extent that the information is publicly available. Personal identifiers should not be collected unless the information is publicly available.
    - An evaluation of whether the Plan was sufficient to enable an appropriate response to the specific cardiac emergency. The review shall include recommendations for improvements in the Plan and in its implementation if the Plan was not optimally suited for the specific incident. The post-event review may include discussions with medical personnel (ideally through the school's medical counsel) to help in the debriefing process and to address any concerns regarding on-site medical management and coordination.
    - An evaluation of the debriefing process for responders and post-event support. This shall include the identification of aftercare services including aftercare services and crisis counselors.

2. A review of the documentation for all Cardiac Emergency Response Drills performed during the school year. Consider pre-established Drill report forms to be completed by all responders.
3. A determination, at least annually, as to whether or not additions, changes or modifications to the Plan are needed. Reasons for a change in the Plan may result from a change in the established guidelines.

Protocol for School Cardiac Emergency Responders

Sudden cardiac arrest events can vary greatly. Faculty, staff and Cardiac Emergency Response Team (CERT) members must be prepared to perform the duties outlined below. Immediate action is crucial in order to successfully respond to a cardiac emergency. Consideration should be given to obtaining on-site ambulance coverage for high-risk athletic events. The school should also identify the closest appropriate medical facility that is equipped in advanced cardiac care.

1. Each student and youth athlete, before participating in an athletic activity, must submit a signed form indicating review of sudden cardiac arrest guidelines.
2. A student or youth athlete must be evaluated and cleared by specified health professionals before participation if (a) certain family members have experienced sudden cardiac arrest, or (b) the student or athlete is known to have exhibited syncope or fainting at any time before or following an athletic activity.
3. A coach must remove a student or youth athlete from participation if the student or athlete exhibits syncope or fainting, and the student or athlete cannot return to participation until evaluated and cleared by a specified health professional.
4. A coach or his or her assistant may not coach an athletic activity unless the individual has completed an annual sudden cardiac arrest training course approved by the Department of Health.
5. Schools with grades 9-12 must provide instruction in CPR and the use of an AED to students.

Steps in responding to a suspected cardiac emergency:

1. Recognize the following signs of sudden cardiac arrest and act in the event of one or more of the following:
    - The person is not moving, or is unresponsive, or appears to be unconscious.
    - The person is not breathing normally (has irregular breaths, gasping or gurgling, or is not breathing at all).
    - The person appears to be having a seizure or is experiencing convulsion-like activity. (Cardiac arrest victims commonly appear to be having convulsions).
    - Note: If the person received a blunt blow to the chest, this can cause cardiac arrest, a condition called commotio cordis. The person may have the signs of cardiac arrest described above and is treated the same.

2. Facilitate immediate access to professional medical help:
    - Call 9-1-1 as soon as you suspect a sudden cardiac arrest. Provide the school address, cross streets, and patient condition. Remain on the phone with 9-1-1. (Bring your mobile phone to the patient's side, if possible.) Give the exact location and provide the recommended route for ambulances to enter and exit. Facilitate access to the victim for arriving Emergency Medical Service (EMS) personnel.
    - Immediately contact the members of the Cardiac Emergency Response Team. Give the exact

location of the emergency. ("Mr. /Ms. ___ Classroom, Room # ___, gym, football field, cafeteria, etc."). Be sure to let EMS know which door to enter. Assign someone to go to that door to wait for and flag down EMS responders and escort them to the exact location of the patient.

3. If you are a CERT member, proceed immediately to the scene of the cardiac emergency.
   - The closest team member should retrieve the automated external defibrillator (AED) in route to the scene and leave the AED cabinet door open; the alarm typically signals the AED was taken for use.
   - Acquire AED supplies such as scissors, a razor and a towel and consider an extra set of AED pads.

4. Start CPR:
   - Begin continuous chest compressions and have someone retrieve the AED.

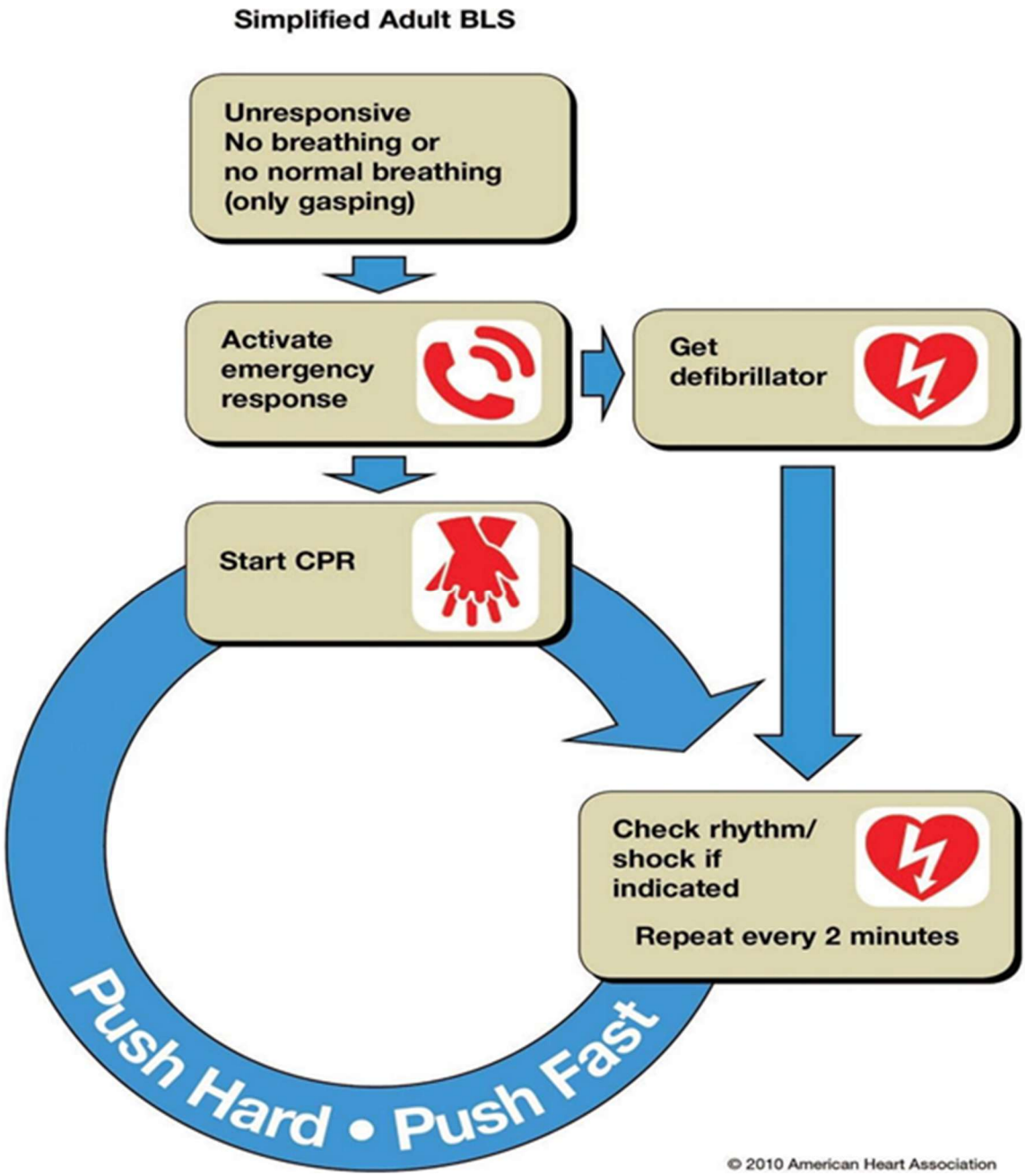
5. Use the nearest AED:
   - When the AED is brought to the patient's side, press the power-on button, and attach the pads to the patient as shown in the diagram on the pads. Then follow the AED's audio and visual instructions. If the person needs to be shocked to restore a normal heart rhythm, the AED will deliver one or more shocks.
     Note: The AED will only deliver shocks if needed; if no shock is needed, no shock will be delivered.
   - Continue CPR until the patient is responsive or a professional responder arrives and takes over.

6. Transition care to EMS.

7. Action to be taken by Office / Administrative Staff:
   - Confirm the exact location and the condition of the patient.
   - Activate the Cardiac Emergency Response Team and give the exact location if not already done.
   - Confirm that the Cardiac Emergency Response Team has responded.
   - Confirm that 9-1-1 was called. If not, call 9-1-1 immediately.
   - Assign a staff member to direct EMS to the scene.
   - Perform "Crowd Control" – directing others away from the scene.
   - Notify other staff: school nurse, athletic trainer, athletic director, etc.
   - Ensure that medical coverage continues to be provided at the athletic event if on-site medical staff accompanies the victim to the hospital.
   - Consider delaying class dismissal, recess, or other changes to facilitate CPR and EMS functions.
   - Designate people to cover the duties of the CPR responders.
   - Copy the patient's emergency information for EMS.
   - Notify the patient's emergency contact (parent/guardian, spouse, etc.).
   - Notify staff and students when to return to the normal schedule.
   - Contact superintendent.

References

Project ADAM National Affiliates, Updated November 2016 for an up-to-date version, please visit www.projectadam.com



Revision History: 07/23

☐ Elementary

☐ Secondary

■ Both

Policy 7370

Diabetic Care

Effective: July 2023

Revised:

Overview

Diabetes is a serious disease in which the body does not properly breakdown food for energy. Most of the food that we eat is broken down into sugar/glucose, for the body to use as energy. When a person has diabetes, the body either doesn't make insulin or cannot use insulin as well as it should. Since insulin is produced in the pancreas and helps get sugar/glucose into the cells of the body, when it is not working properly a buildup of sugar/glucose occurs in the blood, causing high blood glucose.

When diabetes is not managed properly, it can cause complications such as blindness, kidney failure, heart disease, nerve damage, and loss of toes, feet and even legs. Diabetes can be controlled by working with a physician to keep blood sugar/glucose levels within a normal range, eating well and being physically active. It is when steps are taken to control diabetes that the risk of developing complications may become lower.

1. According to ORC 3313.7118, schools shall provide informational materials (released by ODEW) on type 1 diabetes for parents, guardians, educators, and other persons having care or charge of children on the student's enrollment in elementary school.
2. Schools shall ensure that each student who has diabetes receives appropriate and needed diabetes care in accordance with an order signed by the student's treating practitioner. The diabetes care to be provided includes any of the following:
    - Checking and recording blood glucose levels and ketone levels or assisting the student with checking and recording these levels;
    - Responding to blood glucose levels that are outside of the student's target range;
    - In the case of severe hypoglycemia, administering glucagon and other emergency treatments as prescribed;
    - Administering insulin or assisting the student in self-administering insulin through the insulin delivery system the student uses;
    - Providing oral diabetes medications;
    - Understanding recommended schedules and food intake for meals and snacks in order to calculate medication dosages pursuant to the order of the student's treating practitioner;
    - Following the treating practitioner's instructions regarding meals, snacks, and physical activity;
    - Administering diabetes medication, as long as the conditions prescribed in division (C) of this section are satisfied.

2. Diabetes medication may be administered by a school nurse or, in the absence of a school nurse or a school employee who is trained in diabetes care.

3. Recognizing the symptoms of hypoglycemia and hyperglycemia.

Hypoglycemia

Hypoglycemia occurs when blood glucose level falls too low, below the target range specified by the student's healthcare provider. Although low blood glucose may occur in people without diabetes, it can become an emergency for individuals with type 1 diabetes (T1D) taking insulin.

What Causes Hypoglycemia?

In individuals with T1D, low blood glucose typically occurs as a result of taking too much insulin, not eating enough food, or exercising too vigorously.

Symptoms of Hypoglycemia:

Although each person is unique, there are some common signs and symptoms of hypoglycemia. Signs of hypoglycemia may initially go unnoticed; but, as hypoglycemia progresses, symptoms may worsen. Symptoms may include the following:

Mild to Moderate Symptoms	Severe Symptoms
Sweating or clammy skin	Confusion
Paleness or flushed face	Difficulty speaking
Anxiety	Difficulty swallowing
Hunger pangs	Seizures
Racing heartbeat	Lightheadedness and fainting
Shaking	Coma
Headache	Unresponsiveness
Nausea	Slurred speech

Hypoglycemia Treatment

Mild to moderate low blood glucose is treated with fast-acting glucose, such as glucose tablets, or regular sweetened juice or soda. Severe hypoglycemia is treated with emergency glucagon. It is important to defer to the Diabetes Medical Management Plan for treatment

Hyperglycemia

Hyperglycemia occurs when there is an excess of glucose in the blood resulting in blood glucose levels above the target range specified by the student's healthcare provider.

What causes Hyperglycemia?

In individuals with type 1 diabetes (T1D), hyperglycemia typically occurs because of insufficient insulin dosage or insulin pump failure. Hyperglycemia may also occur as a response to stress or illness.

Symptoms of hyperglycemia

Although each person is unique, there are some common signs and symptoms of hypoglycemia. Signs of hypoglycemia may initially go unnoticed; but, as hypoglycemia progresses, symptoms may worsen. Symptoms may include the following:

Mild to Moderate Symptoms	Severe Symptoms
Increased thirst	Vomiting
Blurred vision	Severe abdominal pain
Frequent urination	Ketones in urine
Headache	Dehydration
Fatigue	Rapid heartbeat
Weakness	Confusion and disorientation
	Change in level of consciousness
	Fruity smelling breath
	Hyperventilation

Hyperglycemia Treatment

Treatment for hyperglycemia is highly dependent on the severity of the blood glucose level. Often hyperglycemia can be treated with activity, insulin, and fluid replacement. But in severe cases hospitalization may be needed. Always defer to the Diabetes Medical Management Plan for treatment.

Sustained hyperglycemia leads to a medical emergency called diabetic ketoacidosis. A breakdown of fat, along with hyperglycemia, causes a buildup of ketones in the blood which can lead to coma and death.

4. Training. The training shall be coordinated by a school nurse or, if the school does not employ a school nurse, a licensed health care professional with expertise in diabetes who is approved by the school to provide the training. It shall take place prior to the beginning of each school year or, as needed, not later than fourteen days after receipt by the school an order signed by the treating practitioner of a student with diabetes. On completion of the training, school officials, in a manner it determines, shall determine whether each employee trained is competent to provide diabetes care. The school nurse or approved licensed health care professional with expertise in diabetes care shall promptly provide all necessary follow-up training and supervision to an employee who receives training. The school may provide training in the recognition of hypoglycemia and hyperglycemia and actions to take in response to emergency situations involving these conditions to both of the following:
    - A school employee who has primary responsibility for supervising a student with diabetes during some portion of the school day;

- A bus driver employed by a school district or chartered nonpublic school responsible for the transportation of a student with diabetes.

5. The principal or his/her designee of a school attended by a student with diabetes may distribute a written notice to each employee containing all of the following:
   - A statement that the school is required to provide diabetes care to a student with diabetes and is seeking employees who are willing to be trained to provide that care;
   - A description of the tasks to be performed;
   - A statement that participation is voluntary and that the school district or governing authority will not act against an employee who does not agree to provide diabetes care;
   - A statement that training will be provided by a licensed health care professional to an employee who agrees to provide care;
   - A statement that a trained employee is immune from liability;
   - The name of the individual who should be contacted if an employee is interested in providing diabetes care.

6. No school employee shall be subject to a penalty or disciplinary action under school or district policies for refusing to volunteer to be trained in diabetes care.

7. No school official shall discourage employees from agreeing to provide diabetes care under this section.

8. A school shall not restrict a student who has diabetes from attending the school or from school-sponsored activities on the basis that the student has diabetes, that the school does not have a full-time school nurse, or that the school does not have an employee trained in diabetes care. The school shall not require a parent, guardian, or other person having care or charge of a student to provide diabetes care for the student with diabetes at school or school-related activities.

9. On written request of the parent, guardian, or other person having care or charge of a student and authorization by the student's treating practitioner, a student with diabetes shall be permitted during regular school hours and school-sponsored activities to attend to the care and management of the student's diabetes in accordance with the order issued by the student's treating practitioner if the student's treating practitioner determines that the student is capable of performing diabetes care tasks. The student shall be permitted to perform diabetes care tasks in a classroom, in any area of the school or school grounds, and at any school-related activity, and to possess on the student's self at all times all necessary supplies and equipment to perform these tasks. If the student or the parent, guardian, or other person having care or charge of the student so requests, the student shall have access to a private area for performing diabetes care tasks.

10. If the student performs any diabetes care tasks or uses medical equipment for purposes other than the student's own care, the school official may revoke the student's permission to attend to the care and management of the student's diabetes.

11. Not later than December 31st of each year, a board of education or governing authority shall report to the department of education both of the following:
    - The number of students with diabetes enrolled in the school district or chartered nonpublic school during the previous school year;
    - The number of errors associated with the administration of diabetes medication to students with diabetes during the previous school year.

12. Glucagon Donation. A school may accept donations of injectable or nasally administered glucagon from a wholesale distributor of dangerous drugs or manufacturer of dangerous drugs, and may accept donations of money from any person to purchase the drug.

References

- Section 3313.7112. Diabetes Care. https://codes.ohio.gov/ohio-revised-code/section-3313.7112 Ohio Department of Health. What is Diabetes. https://odh.ohio.gov/know-our-programs/Diabetes/resources/what-is-diabetes_2
- Diabetes Medical Management Plan. https://diabetes.org/sites/default/files/2022-04/dmmp-4-14-22.pdf

Revision History: 07/23

☐ Elementary

☐ Secondary

■ Both

Policy 7370.1

Continuous Blood Glucose Monitoring

Effective: May 2025

Revised:

Continuous Glucose Monitoring (CGM) is a system used for Diabetic students that automatically monitors glucose levels every 2-5 minutes, providing a constant picture of the glucose values—a pattern, as opposed to a "moment-in-time" snapshot that comes from intermittent finger prick readings.

In order to keep diabetic students who use CGM devices at school safe, recommendations are:

1. Schools
    a) cannot prohibit the use of a CGM if ordered by the health care provider.
    b) should exempt students from cell phone/smart device bans who require to manage diabetes.
    c) provide students with access to the school's wireless network if using a smart device for their CGM and/or engaging in remote monitoring.
    d) should remove barriers to remote monitoring by school nurses or trained school staff.
2. The school nurse and/or trained staff will
    a) use the CGM in accordance with the health care provider's orders.
    b) promptly respond to CGM alarms.
    c) should be provided basic training on CGMs and diabetic care – see policy # 7370.
    d) can follow multiple students on one device using respective applications associated with each device
    e) not be expected to use their personal device to follow students.
    f) follow the health care provider's orders to use the CGM for routine/periodic and emergent blood glucose monitoring and ensure a timely response to all CGM alarms.
    g) should confirm appropriate diabetes care supplies are available at school and schedule routine inventory of the supplies and maintain inventory to ensure supplies (e.g., test strips) have not expired.
3. Parents
    a) Will ensure their child is equipped with a device showing CGM data and and/or that communicates alarms to school staff, such as a receiver, smart device, or insulin pump.
    b) should work with the school to set up a communication system with the school nurse to provide actionable updates on trends throughout the school day, if needed, and to establish expectations regarding the frequency of such communication.
    c) must agree to be available for insulin dosing questions via phone or text message.

4. Students
    a) who have been approved to self-manage their diabetes at school should be permitted to insert a new sensor while at school. The student's health care provider's orders should be referenced to confirm this is appropriate for the student.
5. Monitoring
    a) The health care provider's orders should indicate if remote monitoring by school staff may be medically necessary for the safety of the student. It will be individualized for each student based on their age and unique circumstances.
    b) The school nurse and parent should discuss each student's circumstances and plan for remote monitoring if needed. Different factors may influence the school's capacity to provide remote monitoring.
    c) The school and parent should discuss expectations for CGM remote monitoring during the school day. Specifically, what alarms will be set on the school device, who will be remotely monitoring the student, the response to alarms, timing of remote monitoring, and delineating actions/communication to be taken in response to alerts and/or blood glucose trends. This may be included in the individualized care plan.
    d) Frequent alarms or interventions related to the CGM sensor readings can be disruptive to class time for students. The goal should be to manage diabetes needs while also promoting student wellbeing and minimizing unnecessary interruptions in the school day.
    e) Where a school nurse and trained school staff member is remotely monitoring the CGM, this should not supersede other strategies to identify and manage hypoglycemia as outlined in the student's DMMP/provider's orders.
6. Malfunctioning of CGM
    a) If a CGM sensor falls off at school, the school nurse should help the student place all pieces into a sealable plastic bag to be sent home with the student. No portion of the CGM should be discarded while at school unless instructed by the parent.
    b) Until the sensor is replaced, the student should be monitored with a BGM. It is recommended that the sensor be replaced by the student's family if the student is unable to insert a new sensor themselves.

References

https://diabetes.org/sites/default/files/2024-06/CGMguidane-6-20-24.pdf

Diabetes Management at School Agreement

Student Name: _____ School Year: _____-_____

School: _____ Birth date: _____ Grade: _____

PARENT/GUARDIAN TO COMPLETE:

I request that the specialized health care service prescribed by the student's healthcare provider be provided for the student. I authorize the school to appoint qualified designated trained staff to ensure the prescribed treatment is provided in the absence of the school nurse. I agree to immediately notify school personnel of any change in either the student's treatment regimen or the authorizing healthcare provider.

THE FOLLOWING INFORMATION IS NECESSARY FOR STUDENTS REQUIRING

PRESCRIBED MEDICATION IN SCHOOL:

PARENT must sign this form and ensure the school has the Medical Management orders from the Healthcare Provider.

I request permission for the above student to use medication according to the healthcare provider's medication order as part of the Diabetes Medical Management Plan for school.

I assume responsibility for the safe delivery of the medication AND SUPPLIES to school, either by myself or by the student.

1. I will notify the school immediately if there is any change in the student's Medical Management Plan.
2. I authorize school personnel to communicate with the student's healthcare providers as necessary concerning the medical management of the student at school.
3. I agree to be available for insulin dosing questions via phone or text message.
4. I release and agree to hold the Diocese of Columbus, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

If Remote Monitoring is utilized

1. I request that the school nurse and/or trained clinic personnel monitor my student's blood glucose during the school day via a continuous glucose monitor (CGM) (i.e. Dexcom) remotely on a school device located within the school health office or with designated school personnel.
2. I agree to work with the school nurse to determine a communication plan to provide actionable updates on trends throughout the school day, if needed, and to establish expectations regarding the frequency of such communications.

3. I understand school staff, including the school nurse and trained delegated school personnel, will respond to low and high blood glucose alarms rather than the constantly fluctuating trends and numbers. Alarm settings on the Monitoring Ipad and guidelines will be set in accordance with the provider orders and as specified in the student's individualized health care plan. Health care providers may include trend arrows in treatment orders and parents/guardians may include arrows to guide treatment in the student's individualized health care plan developed with the school nurse.

4. I understand parents/guardians are responsible for setting the CGM alarms and notifying the school nurse of the parameters. Alarms should be set for low blood glucose and high blood glucose when treatment/action is needed. This will help the student avoid alarm fatigue and enhance learning and participation. Frequent alarms or interventions related to the CGM sensor readings can be disruptive to class time for students.

5. I acknowledge that my student is aware of the CGM alarms, alarms will remain set, and understands to notify their teacher, school nurse, or other school staff when an alarm sounds.

6. I understand school nurses and clinic staff will make best efforts to remotely monitor CGM readings. However, school staff are responsible for keeping all students safe in the school setting. The school does not guarantee the availability of continuous remote monitoring as a result of clinic caseload, related responsibilities, or in the event of a school-related emergency. I acknowledge that no school employee is responsible for and/or will constantly monitor my student's glucose on the App/Program.

My signature below indicates that I acknowledge, understand, and agree to all terms outlined above. This agreement is active for one school year and may be terminated at any time by a parent/guardian.

Parent/Guardian Name: _____

Parent/Guardian Signature:_____ Date: _____

School Nurse Name:_____

School Nurse Signature:_____ Date: _____

☐ Elementary

☐ Secondary

■ Both

Policy 7380

Seizure Action Plans

Effective: July 2023

Revised:

This policy comports with Ohio HB 33 (2023) and is also known as "Sarah's Law for Seizure Safe Schools."

Schools must create an individualized seizure action plan for each enrolled student who has an active seizure disorder diagnosis. It must be created by the school nurse, or another district or school employee if a school district or school does not have a school nurse, in collaboration with the student's parent or guardian.

Each plan must include:

1. A written request signed by a parent, guardian, or other person having care or charge of the student to have drugs prescribed for a seizure disorder administered to the student;
2. A written statement from the student's treating practitioner providing the drug information for each drug prescribed for the student for a seizure disorder; and
3. Any other component required by the State Board. The plan is effective only for the school year in which a written request is submitted and must be renewed at the beginning of each school year. Plans must be maintained in the school nurse's office, or school administrator's office if the school does not employ a full-time school nurse.

For each student who has a seizure action plan in force, a school nurse or school administrator must notify each school employee, contractor, and volunteer who:

1. Regularly interacts with the student;
2. Has legitimate educational interest in the student; or
3. Is responsible for the direct supervision or transportation of the student in writing regarding the existence and content of the student's plan.

Further, each school nurse or school administrator must identify each individual who has received training under the seizure action plan in the administration of drugs prescribed for seizure disorders (see below).

A school nurse or another district employee also must coordinate seizure disorder care at each school and ensure that all required staff are trained in the care of students with seizure disorders.

Finally, a drug prescribed for a student with a seizure disorder must be provided to the school nurse or another person at the school who is authorized to administer it to the student. The drug also must be provided in the container in which it was dispensed by the prescriber or licensed pharmacist.

Training on Seizure Action Plans
HB 33 requires districts and schools once every two years to train or arrange training for at least one employee at each school, aside from a school nurse, on the implementation of seizure action plans.

Training must be consistent with guidelines and best practices established by a nonprofit organization that supports the welfare of individuals with epilepsy and seizure disorders, such as the Epilepsy Alliance Ohio, Epilepsy Foundation of Ohio, or other similar organizations as determined by the Department.

Training must address the following:

1. Recognizing the signs and symptoms of a seizure;
2. Appropriate treatment for a student exhibiting the symptoms of a seizure; and
3. Administering seizure disorder drugs prescribed for the student.

HB 33 limits a seizure training program to one hour and qualifies the required seizure disorder training as a professional development activity for educator license renewal. If the training is provided to a district or school on portable media by a nonprofit entity, the training must be provided free of charge.

Districts and schools also must require each person employed as an administrator, guidance counselor, teacher, or bus driver to complete a minimum of one hour of self-study or in-person training on seizure disorders within 12 months after the bill's effective date. Any such individual employed after that date must complete a training within 90 days of employment.

Qualified immunity
HB 33 provides a qualified immunity in a civil action for money damages for a school, school district, members of a school district board or school governing authority, and a district's or school's employees for injury, death, or other loss allegedly arising from providing care or performing duties under the bill. The immunity does not apply if any act or omission constitutes willful or wanton misconduct.

Revision History: 07/23