Hot Topics in School Health Night Two

-Home Hospital
-Anaphylaxis and Asthma School Forms

Howard Taras, MD

UCSD Pediatrics / School Health

HOME HOSPITAL INSTRUCTION
- *common problems:*

Too often a doctor's note is accepted by District as final decision that student is eligible

- Even when doctors don't write on application what makes this condition temporary and what will change to make school attendance possible

Too often inappropriately used

- Students with long-standing mental health problems (anxiety, agoraphobia, gender dysphoria, etc) on HHI for years
- Students with chronic debilitating conditions (years of chronic fatigue syndrome; some forms of immune deficiency): HHI for years
- Often even inappropriate for students with DNR orders

HOME HOSPITAL INSTRUCTION (HHI)

OFTEN CONFUSED WITH:

1. Independent Study / Alternative Placements
   - www.cde.ca.gov/sp/ea/is/

2. Home Instruction:

Home Hospital Instruction (HHI)

- Purpose: To maintain a student at former level of performance while recovering from temporary disability, so as to not jeopardize student's future performance upon returning to regular school day (or alternative ed).

- For temporary disabilities

- Temporary disability based on physician's written description of the disabling condition (i.e., student unable to attend school).

- Schools responsible to determine appropriateness of HHI application
- Instruction occurs in: home, hospital or residential facility.

- Student receives one hour for every day of school from a California-credentialed teacher

What is “Temporary Disability”?

- A physical, mental or emotional disability incurred while student is enrolled in regular day classes (or alternative education) and after which the student can reasonably be expected to return to regular day classes or alternative education.

True Examples of HHI requests

7 yo with "significant disability, blind, spastic quadriplegia, g-tube": HHI denied

9yo girl with ulcerative colitis and associated anxiety disorder. GI specialists requests HHI. Granted for 11 months. Condition unchanged. HHI then denied.

8yo student with fatigue, autism, anxiety, "PANDA", constipation; Too symptomatic able to get to school or stay there. Student does go out of home for other events (meals at cousins' home; playground). HHI denied.

16yo with obesity, DM, cardiomyopathy, renal dysfunction; First reason given for HHI was cardiomyopathy, infections if exposed to others; disoriented, poor vision, cannot maintain blood glucose. (can manage all in school and none are temporary). HHI denied.

14yo, chronic constipation, abdominal distension, nausea, retching, daily bowel cleanouts required; feeding intolerance; After months, same symptoms. Further HHI denied.

It is not INDEPENDENT STUDY

What is Independent Study?

- Voluntary program; uses alternative instructional strategies that respond to individual student needs
- Instruction can be provided at home, school site, or virtually;
- School system is still responsible for provision of general education, special education, and related services
- Not an alternative curriculum; Pupils are expected to meet the same educational objectives as all other pupils. Must be substantially equivalent to classroom instruction.
- (A) "short term independent study contract"
- (B) iHigh or Mt Everest Academy: both are virtual academies with independent self-paced learning

It is not HOMESCHOOLING

What is Home Schooling?

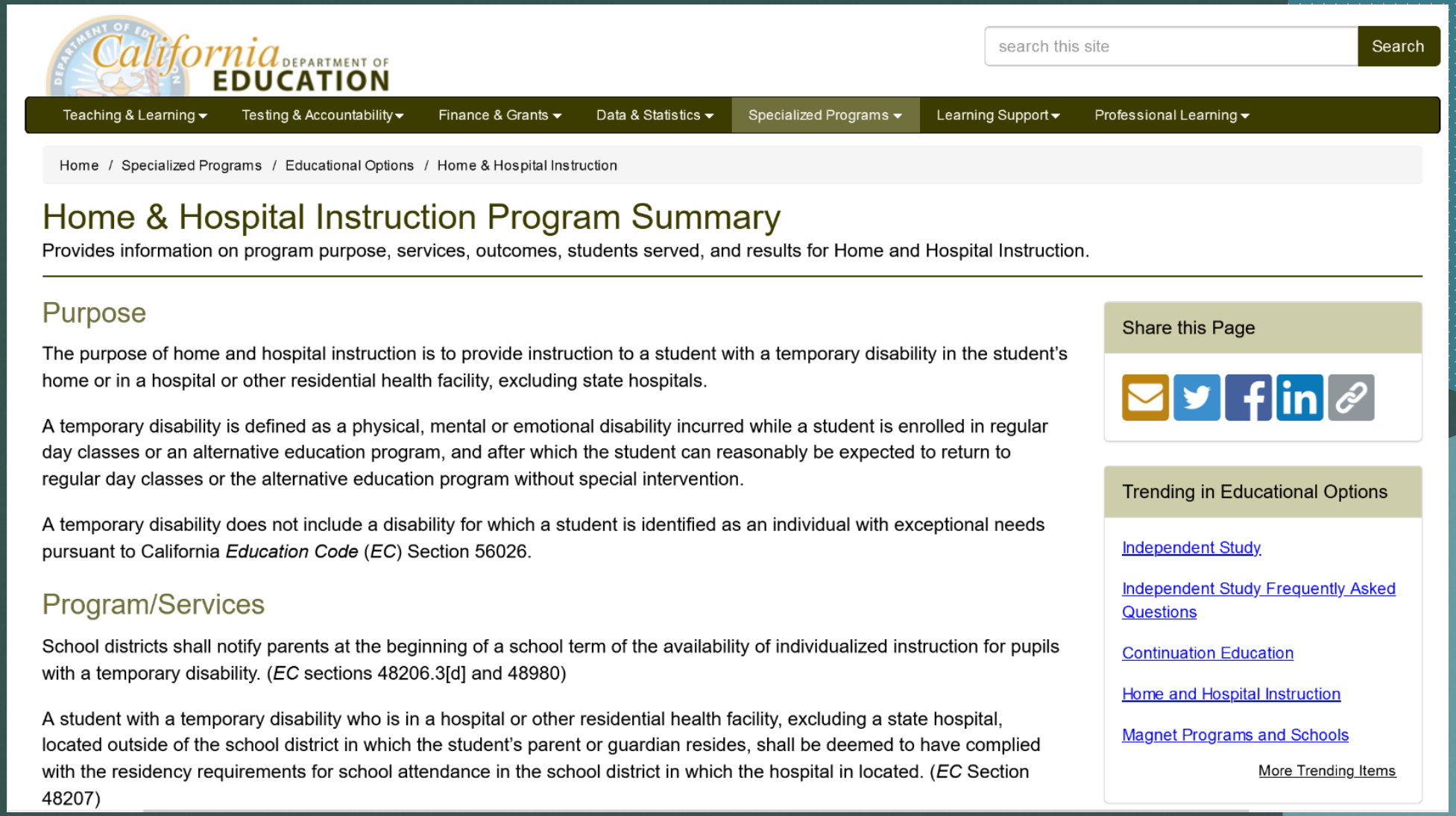
- **Home-based private school:** Parents sign an affidavit with State of California, maintain an attendance register, must instruct in English, proof that instructors are capable of teaching, teach courses taught in public school, maintain a list of courses of study, maintain a list of instructors

- **Private school satellite program:** majority of instruction is provided at home; and private school satellite program must meet same requirements as parent (above).

- **Instruction via private tutor:** 3 hours a day for 175 days/year. Instructor can be parent, if she/he has required teaching credential. No affidavit required.

Resources

- https://www.cde.ca.gov/sp/eo/hh/hhprogramsummary.asp



California DEPARTMENT OF EDUCATION

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Home / Specialized Programs / Educational Options / Home & Hospital Instruction

Home & Hospital Instruction Program Summary

Provides information on program purpose, services, outcomes, students served, and results for Home and Hospital Instruction.

Purpose

The purpose of home and hospital instruction is to provide instruction to a student with a temporary disability in the student's home or in a hospital or other residential health facility, excluding state hospitals.

A temporary disability is defined as a physical, mental or emotional disability incurred while a student is enrolled in regular day classes or an alternative education program, and after which the student can reasonably be expected to return to regular day classes or the alternative education program without special intervention.

A temporary disability does not include a disability for which a student is identified as an individual with exceptional needs pursuant to California *Education Code* (*EC*) Section 56026.

Program/Services

School districts shall notify parents at the beginning of a school term of the availability of individualized instruction for pupils with a temporary disability. (*EC* sections 48206.3[d] and 48980)

A student with a temporary disability who is in a hospital or other residential health facility, excluding a state hospital, located outside of the school district in which the student's parent or guardian resides, shall be deemed to have complied with the residency requirements for school attendance in the school district in which the hospital in located. (*EC* Section 48207)

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Trending in Educational Options

Independent Study

Independent Study Frequently Asked Questions

Continuation Education

Home and Hospital Instruction

Magnet Programs and Schools

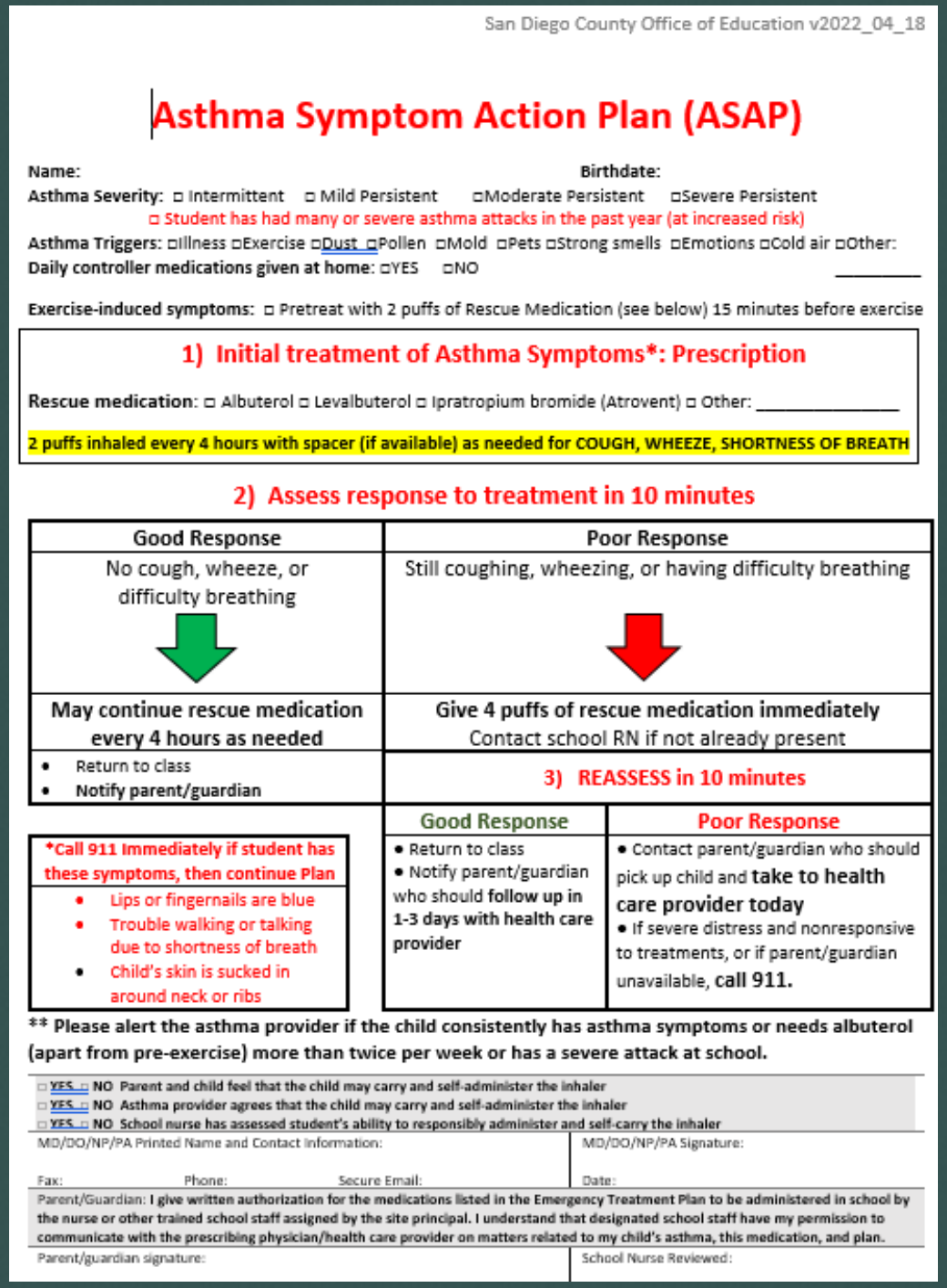
More Trending Items

Anaphylaxis and Asthma School Forms

Susan Laubach, MD

Asthma and Anaphylaxis School Forms

- NEW! Asthma Symptom Action Plan (ASAP)
- REMINDER: only 1 form needed!
  - Medication Authorization
  - Self-Carry
  - FERPA / HIPAA statements and parental consent



San Diego County Office of Education v2022_04_18

Asthma Symptom Action Plan (ASAP)

Name: **Birthdate:**

Asthma Severity: ◻ Intermittent ◻ Mild Persistent ◻Moderate Persistent ◻Severe Persistent

◻ Student has had many or severe asthma attacks in the past year (at increased risk)

Asthma Triggers: ◻Illness ◻Exercise ◻Dust ◻Pollen ◻Mold ◻Pets ◻Strong smells ◻Emotions ◻Cold air ◻Other:

Daily controller medications given at home: ◻YES ◻NO _____

Exercise-induced symptoms: ◻ Pretreat with 2 puffs of Rescue Medication (see below) 15 minutes before exercise

1) Initial treatment of Asthma Symptoms*: Prescription

Rescue medication: ◻ Albuterol ◻ Levalbuterol ◻ Ipratropium bromide (Atrovent) ◻ Other: _____

2 puffs inhaled every 4 hours with spacer (if available) as needed for COUGH, WHEEZE, SHORTNESS OF BREATH

2) Assess response to treatment in 10 minutes

Good Response	Poor Response
No cough, wheeze, or difficulty breathing	Still coughing, wheezing, or having difficulty breathing
May continue rescue medication every 4 hours as needed	**Give 4 puffs of rescue medication immediately** Contact school RN if not already present
• Return to class • **Notify parent/guardian**	**3) REASSESS in 10 minutes**

Good Response	Poor Response
• Return to class • Notify parent/guardian who should **follow up in 1-3 days with health care provider**	• Contact parent/guardian who should pick up child and **take to health care provider today** • If severe distress and nonresponsive to treatments, or if parent/guardian unavailable, **call 911.**

***Call 911 Immediately if student has these symptoms, then continue Plan**

- Lips or fingernails are blue
- Trouble walking or talking due to shortness of breath
- Child's skin is sucked in around neck or ribs

**** Please alert the asthma provider if the child consistently has asthma symptoms or needs albuterol (apart from pre-exercise) more than twice per week or has a severe attack at school.**

◻ YES ◻ NO **Parent and child feel that the child may carry and self-administer the inhaler**
◻ YES ◻ NO **Asthma provider agrees that the child may carry and self-administer the inhaler**
◻ YES ◻ NO **School nurse has assessed student's ability to responsibly administer and self-carry the inhaler**

MD/DO/NP/PA Printed Name and Contact Information: | MD/DO/NP/PA Signature:

Fax: Phone: Secure Email: | Date:

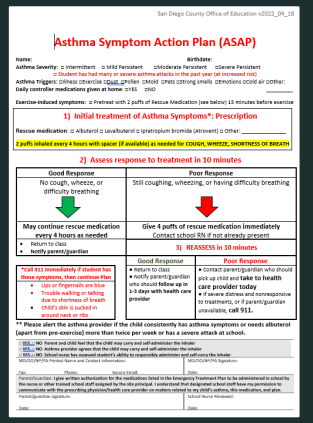
Parent/Guardian: **I give written authorization for the medications listed in the Emergency Treatment Plan to be administered in school by the nurse or other trained school staff assigned by the site principal. I understand that designated school staff have my permission to communicate with the prescribing physician/health care provider on matters related to my child's asthma, this medication, and plan.**

Parent/guardian signature: | School Nurse Reviewed:

Asthma Symptom Action Plan

("ASAP")

ASAP: Essential Components



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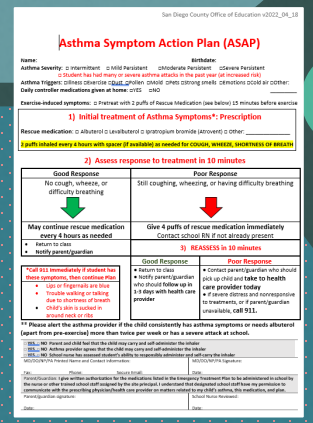
Asthma Triggers: □Illness □Exercise □Dust □Pollen □Mold □Pets □Strong smells □Emotions □Cold air □Other:

Daily controller medications given at home: □YES □NO

Exercise-induced symptoms: □ Pretreat with 2 puffs of Rescue Medication (see below) 15 minutes before exercise

ASAP: Essential Components



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2) Assess response to treatment in 10 minutes

Good Response	Poor Response
No cough, wheeze, or difficulty breathing	Still coughing, wheezing, or having difficulty breathing
May continue rescue medication every 4 hours as needed • Return to class • Notify parent/guardian	Give 4 puffs of rescue medication immediately Contact school RN if not already present

3) REASSESS in 10 minutes

	Good Response	Poor Response
*Call 911 immediately if student has these symptoms, then continue Plan. • Lips or fingernails are blue • Trouble walking or talking due to shortness of breath • Child's skin is sucked in around neck or ribs	• Return to class • Notify parent/guardian who should follow up in 1-3 days with health care provider	• Contact parent/guardian who should pick up child and take to health care provider today • If severe distress and nonresponsive to treatments, or if parent/guardian unavailable, call 911.

** Please alert the asthma provider if the child consistently has asthma symptoms or needs albuterol (apart from pre-exercise) more than twice per week or has a severe attack at school.

YES__ NO Parent and child feel that the child may carry and self-administer the inhaler
YES__ NO Asthma provider agrees that the child may carry and self-administer the inhaler
YES__ NO School nurse has assessed student's ability to responsible administer and self-carry the inhaler

MD/DO/NP/PA Printed Name and Contact Information | MD/DO/NP/PA Signature

I am _____ Phone _____ Secure Email: _____ | Date: _____

Parent/Guardian: I give written authorization for the medications listed in the Emergency Treatment Plan to be administered in school by the nurse or other trained school staff assigned by the site principal. I understand that designated school staff have my permission to communicate with the prescribing physician/health care provider on matters related to my child's asthma, this medication, and plan.

Parent/guardian signature | School Nurse Reviewed

Date: _____ | Date: _____

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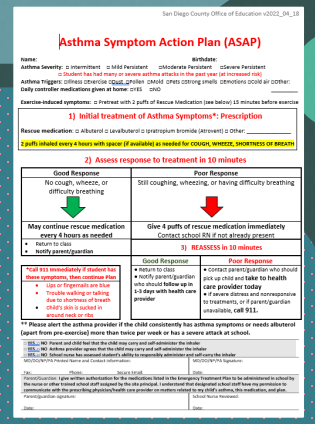
Notes

- Prescription on inhaler can say "2 puffs" and then school personnel can follow the orders on this plan.

Medication Authorization (no additional forms needed)

ASAP: Essential Components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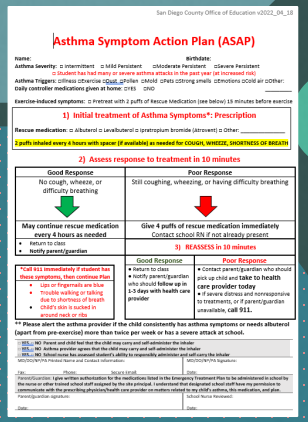
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- Return to class
- Notify parent/guardian

3) REASSESS in 10 minutes

***Call 911 Immediately if student has these symptoms, then continue Plan**

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Good Response

- Return to class
- Notify parent/guardian who should **follow up in 1-3 days with health care provider**

Poor Response

- Contact parent/guardian who should pick up child and **take to health care provider today**
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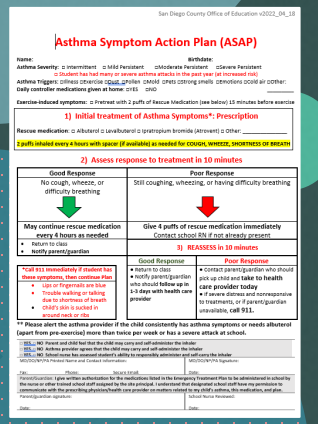
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MD/DO/NP/PA Signature:

Fax: Phone: Secure Email:

Date:

Parent/Guardian: I give written authorization for the medications listed in the Emergency Treatment Plan to be administered in school by the nurse or other trained school staff assigned by the site principal. I understand that designated school staff have my permission to communicate with the prescribing physician/health care provider on matters related to my child's asthma, this medication, and plan.

Parent/guardian signature:

School Nurse Reviewed:

Date:

Date:

Self-Carry Authorization (no additional form needed)

FERPA / HIPAA (no additional form needed)

No redundant forms needed

AUTHORIZATION FOR MEDICATION ADMINISTRATION
(EDUCATION CODE SECTION 49423)

I, the undersigned, as legal parent/guardian of _____
Student Name

_____ attending _____
Birthdate School

Request that the following medication(s) _____ for _____

be made available to my child at the time(s) prescribed _____

I understand that only personnel meeting the requirements of the California Education and Administration Codes will be performing the above mentioned health care service and will be using only the standardized procedure approved by our physician.
I will provide the medication(s) in the prescription container(s) which is labeled with the name of my child, the prescribing physician's name, and a[illegible]of medication(s) prescribe[illegible]
If any of the conditions in the Physici[illegible]tement change, a ne[illegible]must be signed by the parent/guardian and the physician.
Both prescription and nonprescription me[illegible]ns require [illegible]n statement from the physician *and* a written statement from the parent indicating desire th[illegible]district a[illegible]e student as set forth in the physician's statement.
To facilitate the foregoing, I hereby grant pe[illegible]n exchange between our physician and the Poway Unified School District of the confidential me[illegible]ation contained in my child's records necessary to accomplish this service.
I will notify the school immediately if the health[illegible]y child changes, we change physicians, or there is a change in or cancellation of the procedure.

➢ **I have read and accept the conditio[illegible]orth by Pow[illegible]ied School District for Medication Administration pursuant to Edu[illegible]ode Section 494[illegible]**

Parent/Guardian Signature _____ **Date:** _____ **Phone:** _____

This portion to be completed by a physician licensed in the State of California.

Name of Medication	Method of Administration	Dosage			Approx. Time of Day/Reason
		Puffs	mg.	ml.	
1.					
2.					
3.					

Print Name of Physician _____ **Physician Signature** _____ **Date** _____

CA Medical License _____ **Phone** _____ **Fax** _____

H-26 Rev 6/2018 102

AUTHORIZATION FOR MEDICATION ADMINISTRATION
Education Code Section 49423; 5 California Code of Regulations 603

Any pupil who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by a school nurse or other designated school district personnel if the district receives:

1. A written statement from a physician licensed in the State of California, or physician assistant, detailing the name of the medication, method, amount, and time schedules by which such medication is to be taken.

2. Written authorization from the parent/guardian of the pupil indicating the desire that school personnel assist the pupil in the matters set forth in the Physician's Statement.

This authorization is valid only for the current school year. In addition, if any of the conditions in the Physician's Statement changes during the school year, a ne[illegible]ysician's Statement[illegible]arent/guardian authorization form must be submitted.

This portion to be completed by parent/guardian.

I request that a school nurse or other designated school[illegible]onnel administer medication, or assist in the administration of medication, as directed by my child'[illegible]ician[illegible]

Pupil's Name _____ Grad[illegible] _____

I authorize the school nurse or other designated school district personnel to communicate directly with my child's physician's office, as may be necessary, regarding the Physician's Statement. I understand what school personnel will do to assist in administering medication to my child.

I understand that I have certain responsibilities to enable school personnel to assist in the administration of medication to my child. This includes ensuring that a current, authorized Physician's Statement has been delivered to the school nurse or other authorized personnel. This also includes ensuring that only medication prescribed by my child's physician and listed on the Physician's Statement will be brought to the school. I understand that medication should be in containers that are clearly marked with the name of the pupil, the name of the prescribing physician, the name of the medication, and the amount of medication. Over the counter medication must be in the original container and labeled with the student's name.

I understand that I may terminate consent for the administration of medication to my child at any time by notifying the school nurse in writing.

Signature of Parent/Guardian _____ Date _____

San Diego County v2018_09

Allergy and Anaphylaxis Emergency Plan

Name:	Date of Birth:	Weight: lbs / kg
Date of Plan:	Age:	
ALLERGIES:		

Child has asthma: yes / no (if yes, higher chance of a severe reaction)
Child has had anaphylaxis: yes / no (if yes, higher chance of a severe reaction)
Child may carry medicine: yes / no
Child may give him/herself medicine: yes / no (if child refuses, an adult must give medicine)

Attach child's photo

☐ **The "Always-Epinephrine" Option:** If checked, **give epinephrine** immediately, if the child has ANY symptom (mild or severe) after a sting or eating a food listed above. (Option advised for those schools where a nurse is not always present.)

IF IN DOUBT, GIVE EPINEPHRINE! ANAPHYLAXIS is a potentially life-threatening, severe allergic reaction

For SEVERE Allergy or Anaphylaxis **What to look for:** If child has ANY of these symptoms after eating a food or having a sting, **give epinephrine** ➢ Breathing: trouble breathing, wheeze, cough ➢ Throat: tight or hoarse throat, trouble swallowing or speaking ➢ Brain: confusion, agitation, dizziness, fainting, unresponsiveness ➢ Gut: severe stomach pain, vomiting, diarrhea ➢ Mouth: swelling of lips or tongue that affects breathing ➢ Skin: many hives or redness over body, face color is pale or blue	Give EPINEPHRINE! **What to do:** 1. **Inject epinephrine right away!** Note the time. 2. Call 911 • Ask for ambulance with epinephrine • Tell rescue squad when epinephrine was given 3. Stay with child and: • Call parents • **Give a second dose of epinephrine** if symptoms worsen or do not get better in 5 minutes • Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on their side 4. Give other medicine (e.g. antihistamine, inhaler) if prescribed. Do not use other medicine in place of epinephrine.
For MILD Allergic Reaction **What to look for:** If child has mild symptoms, or no symptoms but a sting or ingestion of the food is suspected, give antihistamine and monitor the child. Mild symptoms may include: ➢ Skin: a few hives, mild rash, mild swelling, OR ➢ Mouth/nose/eyes: itching, rubbing, sneezing, OR ➢ Gut: mild stomach pain, nausea or discomfort Note: if the child has more than one mild symptom area affected, **give epinephrine**	Give Antihistamine and **Monitor** the Child **What to do:** 1. Give antihistamine if prescribed 2. **If in doubt, give epinephrine** 3. Call parents 4. Watch child closely for 4 hours 5. **If symptoms worsen, give epinephrine** (See "For SEVERE Allergy and Anaphylaxis")

Medicine/Doses
Epinephrine (intramuscular in thigh): ☐ 0.1 mg ☐ 0.15 mg ☐ 0.30 mg
Antihistamine (by mouth): ☐ Diphenhydramine _____mg (_____ml) ☐ Other_____: _____ mg (_____ml)
Other medications: ☐ Albuterol 4 puffs ☐ other: _____

PROVIDER Signature	Date	Name (printed)	Phone	NPI#

PARENT/GUARDIAN Signature	Date	Name (printed)	Phone

I authorize the school to follow Plan and contact the Health Care Provider, and release the school district and personnel from civil liability

Reviewed by school nurse: _____ Date: _____ _____

Allergy and Anaphylaxis Emergency Plan

Name:	Date of Birth:	Weight: lbs / kg
Date of Plan:	Age:	
Allergies:		

Child has asthma: yes / no (if yes, higher chance of a severe reaction)
Child has had anaphylaxis: yes / no (if yes, higher chance of a severe reaction)
Child may carry medicine: yes / no
Child may give him/herself medicine: yes / no (if child refuses, an adult must give medicine)

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☐ **The "Always-Epinephrine" Option:** If checked, **give epinephrine** immediately, if the child has ANY symptom (mild or severe) after a sting or eating a food listed above. (Option advised for those schools where a nurse is not always present.)

- **Self-carry /self-administration Authorization**
- **Medication Authorization**
- **FERPA / HIPAA parental consent statement**

(no additional forms needed!)

Medicine/Doses
Epinephrine (intramuscular in thigh): ☐ 0.15 mg ☐ 0.30 mg
Antihistamine (by mouth): ☐ Diphenhydramine _____mg (_____ml) ☐ Other_____: _____ mg (_____ml)
Other medications: ☐ Albuterol 4 puffs ☐ other: _____

PROVIDER Signature	Date	Name (printed)	Phone	FAX

PARENT/GUARDIAN Signature	Date	Name (printed)	Phone

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