INFORMATION FOR SCHOOL MANAGEMENT OF DIABETES MELLITUS

School Year: _____

Student's Name: _____ Date of Birth: _____ Effective Date: _____

School Name: _____ Grade: _____ Homeroom: _____

CONTACT INFORMATION:

Parent/Guardian #1: _____ Phone #: Home: _____ Work: _____ Cell/Pager: _____

Parent/Guardian #1: _____ Phone #: Home: _____ Work: _____ Cell/Pager: _____

Diabetes Care Provider: Phone #:

Other emergency contact: _____ Relationship: _____

Phone Numbers: Home: _____ Cellular/Pager: _____

Insurance Carrier: _____ Preferred Hospital: _____

EMERGENCY NOTIFICATION: Notify parents of the following conditions:

a. Loss of consciousness or seizure (convulsion) immediately after calling 911 and administering Glucagon.
b. Blood sugars in excess of 300 mg/dl. With ketones present
c. Positive urine ketones.
d. Abdominal pain, nausea/vomiting, fever, diarrhea, altered breathing, altered level of consciousness

STUDENT'S COMPETENCE WITH PROCEDURES: (Must be verified by parent and school nurse)

- ❑ Blood glucose monitoring
- ❑ Determining insulin dose
- ❑ Measuring insulin
- ❑ Injecting insulin
- ❑ Independently operates insulin pump
- ❑ Carry supplies for BG monitoring
- ❑ Carry supplies for insulin administration
- ❑ Monitor BG in classroom
- ❑ Self treatment for mild low blood sugar
- ❑ Determine own snack/meal content

MEAL PLAN:

	Time	Location	CHO Content		Time	Location	CHO Content
❑ Bkft	_____	_____	_____	❑ Mid-PM	_____	_____	_____
❑ Mid-AM	_____	_____	_____	❑ Before PE	_____	_____	_____
❑ Lunch	_____	_____	_____	❑ After PE:	_____	_____	_____

Meal/snack will be considered mandatory. Times of meals/snacks will be at routine school times unless alteration is indicated. School nurse will contact diabetes care provider for adjustment in meal times. Content of meal/snack will be determined by:
❑ Student ❑ Parent ❑ School nurse ❑ Diabetes provider
Please provide school cafeteria with a copy of this meal plan order to fulfill USDA requirements.
Parent to provide and restock snacks and low blood sugar supplies box.

LOCATION OF SUPPLIES/EQUIPMENT: (To be completed by school personnel)

Blood glucose equipment: ❑ Clinic/health room ❑ With student
Insulin administration supplies: ❑ Clinic/health room ❑ With student
Glucagon emergency kit: _____ **Glucose gel:** _____ **Ketone testing supplies:** _____
Fast acting carbohydrate: ❑ Clinic/health room ❑ With student **Snacks:** ❑ Clinic/health room ❑ With student

SIGNATURES: I understand that all treatments and procedures may be performed by the student and/or unlicensed personnel within the school or by EMS in the event of loss of consciousness or seizure. I also understand that the school is not responsible for damage, loss of equipment, or expenses utilized in these treatments and procedures. I give permission for school personnel to contact my child's diabetes provider for guidance and recommendations. I have reviewed this information form and agree with the indicated information. This form will assist the school in developing a health plan and in providing appropriate care for my child.

PARENT SIGNATURE: _____ DATE: _____

SCHOOL NURSE SIGNATURE: _____ DATE: _____

HEALTH CARE PROVIDER AUTHORIZATION FOR SCHOOL MANAGEMENT OF DIAB ETES

STUDENT: _____ DOB: _____ DATE: _____

BLOOD GLUCOSE (BG) MONITORING: (Target range: _____ mg/dl to _____mg/dl.)

- ☐ Before meals
- ☐ PRN for suspected low/high BG
- ☐ Midmorning
- ☐ 2 hours after correction
- ☐ Mid-afternoon

INSULIN ADMINISTRATION: Dose determined by: ☐ Student ☐ Parent ☐ School nurse

Insulin delivery system ☐ Syringe ☐ Pen ☐ Pump (Use supplemental form for Student Wearing Insulin Pump)

BEFORE MEAL INSULIN:

Insulin Type _____

☐ Insulin to Carbohydrate Ratio: _____ units per _____ grams carbohydrate
☐ Give _____ units

CORRECTION INSULIN for high blood sugar (Check only those which apply)
☐ Use the following correction formula: BG - _____ / _____ (for pre lunch blood sugar over _____)

☐ Sliding Scale:
BG from _____ to _____ = _____ u
BG from _____ to _____ = _____ u
BG from _____ to _____ = _____ u
BG from _____ to _____ = _____ u
BG from _____ to _____ = _____ u

Add before meal insulin to correction/ sliding scale insulin for total meal time insulin dose

MANAGEMENT OF LOW BLOOD GLUCOSE :

MILD: Blood Glucose < ____

- ☐ Never leave student alone
- ☐ Give 15 gms glucose; recheck in 15 min.
- ☐ If BG < 70, retreat and recheck q 15 min x 3
- ☐ Notify parent if not resolved.
- ☐ Provide snack with carbohydrate, fat, protein after treating and meal not scheduled > 1 hr

SEVERE: Loss of consciousness or seizure

- ☐ Call 911. Open airway. Turn to side.
- ☐ Glucagon injection ☐ 0.25 mg ☐ 0.50 mg ☐ 1.0 mg IM/SQ
- ☐ Notify parent.

MANAGEMENT OF HIGH BLOOD GLUCOSE (Above _____ mg/dl)

- ☐ Sugar-free fluids/frequent bathroom privileges.
- ☐ If BG is greater than 300, and it's been 2 hours since last dose, give ☐ HALF ☐ FULL correction formula noted above.
- ☐ IfBG is greater than 300, and it's been 4 hours since last dose, give FULL correction formula noted above.
- ☐ If BG is greater than 300 check for ketones. Notify parent if ketones are present.
- ☐ Note and document changes in status.
- ☐ Child should be allowed to stay in school unless vomiting and/or moderate or large ketones are present.

EXERCISE:

Faculty/staff must be informed and educated regarding management. Staff should provide easy access to fast-acting carbohydrates, snacks, and BG monitoring equipment during activities. Child should NOT exercise if blood glucose levels are below 70mg/dl or above 300 mg/dl and urine contains moderate or large ketones.

- ☐ Check blood sugar right before PE to determine need for additional snack.
- ☐ If BG is less than target range, eat 15-45 grams carbohydrate before, depending on intensity and length of exercise.
- ☐ Student may disconnect insulin pump for _____ hours or decrease basal rate by _____.

My signature provides authorization for the above orders. I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.

- ☐ If changes are indicated, I will provide new written authorized orders (may be faxed).
- ☐ Dose/treatment changes may be relayed through parent.

Healthcare Provider Signature: _____ Date: _____

Address: _____

I want to be able to: _____

_____

Children's
Healthcare of Atlanta
Dedicated to All Better

My asthma action plan

Patient name: _____ DOB: _____

Doctor's name: _____ Signature: _____

Doctor's phone #: _____ Date: _____

Inhaler Location:
clinic ☐
on student ☐

Controller medicines	How much to take	How often	Other instructions
		____ times per day EVERY DAY	☐ Gargle or rinse mouth after use
		____ times per day EVERY DAY	
		____ times per day EVERY DAY	

Quick-relief medicines	How much to take	How often	Other instructions
	☐ 2 puffs ☐ 4-6 puffs ☐ 1 nebulizer treatment	Take ONLY as needed (see below — starting in Yellow Zone or before excercise)	**NOTE: If you need this medicine more than 2 days a week, call your doctor.**

Asthma triggers (check all that apply):

☐ Exercise ☐ Change in temperature ☐ Molds ☐ Animals ☐ Strong odors or fumes ☐ Smoke
☐ Pollens ☐ Respiratory infections ☐ Dust ☐ Strong emotions ☐ Food/Other_____

Special instructions when I am ● *Doing well* ○ *Be careful* ● *Ask for help*

GREEN ZONE

Doing *well.*

- No coughing, wheezing, chest tightness, shortness of breath during the day or night
- Can go to school and play

PREVENT asthma symptoms every day:

☐ Take my controller medicines (above) every day

☐ Before exercise, take____ puff(s) of _____

☐ Avoid triggers that make my asthma worse (See above)

YELLOW ZONE

Be *careful.*

- Coughing, wheezing, chest tightness, shortness of breath
- Waking at night due to asthma symptoms
- Can do some, but not all, usual activities
- Runny nose, watery eyes

CAUTION. Continue taking my controller medicines every day.

☐ Take ____ puffs or ____ nebulizer treatment(s) of quick relief medicine. If I am not back in the ***Green Zone*** within one hour, then I should:

☐ Continue using quick relief medicine every 4 hours as needed. Call provider if not improving in _____ days.

☐ Increase _____

☐ Add _____

RED ZONE

Ask for *help.*

- Very short of breath
- Continual coughing
- Skin between ribs is pulling inwards
- Difficulty speaking without running out of breath
- Quick-relief medicines have not helped
- Symptoms same or worse after 48 hours in Yellow Zone

MEDICAL ALERT! Get help!

☐ Take quick-relief medicine:____ puffs every ____ minutes and get help immediately.

☐ Take _____

☐ Call _____

If skin, fingernail or lip color is blue at any time:

Call 911 for help or go to the nearest Emergency Department

Written Authorization for Self-Administration of Asthma Medication by Minor Children at School

Student Name: _____ Date of Birth: _____ Grade: _____

I, _____, Parent/Legal Guardian of the above-named student hereby request authorization for self-administration and possession of asthma medication by this student while in school, at a school-sponsored activity, while under supervision of school personnel, and while in before-school or after-school care on school-operated property. The student demonstrates full understanding of the proper use of his/her asthma medication.

I understand that:

- the school district and its employees and agents shall incur no liability for: a) any injury to the student caused by his or her self-administration of medication except for injury caused by willful or wanton misconduct; b) the student's use, misuse, overuse, or neglected or failed use of his or her asthma medication; and c) lost, misplaced, outdated, inaccessible, empty, or faulty asthma medication and asthma devices.
- the school may choose to require supervision of medication administration in the event that the student does not demonstrate appropriate use or proper technique with asthma medication. • the school has the authority to enforce rules and consequences for inappropriate behavior demonstrated by the student in association with the possession and/or self-administration of asthma medication, and that the school has the authority to require supervision of medication use as deemed appropriate for the safety of all students and staff.

I take sole responsibility for:

- the monitoring of asthma medication, medication use, and refilling of prescriptions for asthma medication as the school will not be responsible for the supervising, recording, and monitoring of self-administered asthma medication.
- ensuring the student always carries his/her asthma medication on his/her person.
- deciding if back-up medication will be kept at the school and providing the school with the back-up medication.
- informing school staff in writing of any changes in the student's treatment or asthma management.
- informing the school of any asthma exacerbations, hospital visits, and/or new or changed student medical information.
- informing school staff in writing of any medication side effects that warrant communication to the parent/guardian
- coordinating distribution of the student's asthma management and emergency plan to school staff (school health worker, teachers, physical educators, coaches, bus driver, before-school and after-school staff).

I understand and agree to the conditions of the school system policy. I permit the school to seek emergency medical treatment for the student when deemed necessary and appropriate. I accept legal responsibility should the medication be misused or given or taken by a person other than the above-named student. I release the School System and its employees and agents of any legal responsibility related to the above-named student's possession and self-administration of his/ her asthma medication.

_____ _____

Parent/Legal Guardian Signature Date

I, _____, the above-named student have been instructed in the proper use of my prescription asthma medication and fully understand how and when to use this medication. I will always carry my medication with me and will not allow another student to use my medication under any circumstance. I understand and agree to the terms of the school policy.

_____ _____

Student's Signature Date

The above-named student has been instructed and demonstrates understanding of the proper use of his/her asthma medication. It is my professional opinion that the student be permitted to carry and self-administer his/her asthma medication. I have provided the parent/guardian with a written asthma emergency/management plan including the name, purpose, dosage, and administration directions of the asthma medication.

_____ _____

Healthcare Provider Signature Date

Children's℠ Healthcare of Atlanta

Children's Pediatric Neurology Practice
404-785-KIDS (5437)

SEIZURE ACTION PLAN

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name: Date of Birth:

Parent/Guardian: Phone: Cell:

Other Emergency Contact: Phone: Cell:

Treating Provider: Phone:

Significant Medical History:

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Emergency Medications

Medication	Dosage	Common Side Effects & Special Instructions

Green Zone Less than 2 minutes	Yellow Zone 2 to 5 minutes	Red Zone More than 5 minutes or 3 or more seizures in an hour
✱ Begin seizure First Aid ✱ Closely observe student until recovered from seizure ✱ Notify parent/guardian ✱ Return student to class	✱ Continue Seizure First Aid ✱ Call for help ✱ Prepare to administer Diastat/Versed ✱ Closely observe student until recovered ✱ Notify parent/guardian ✱ Student may return to class/home as instructed by parent/guardian	✱ Continue Seizure First Aid ✱ Administer Diastat/Versed ✱ Monitor respirations and heart beat and start CPR if needed ✱ Notify parent/guardian ✱ Call 911 if seizure is greater than 7 minutes

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Record seizure in log
- Stay with child until fully conscious

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Special Considerations and Precautions (regarding school activities, sports, trips, etc)

Describe any special considerations or precautions:

Provider Signature Date Time

Parent/Guardian Signature Date Time

Section V Nurse

Food Allergy Action Plan

Place Child's Picture Here

Student's Name:_____ **D.O.B:**_____ **Teacher:** _____

ALLERGY TO: _____

Asthmatic Yes* No *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:		**Give Checked Medication**:**
▪	If a food allergen has been ingested, but *no symptoms*:	☐ Epinephrine ☐ Antihistamine
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
▪ Throat†	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
▪ Lung†	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
▪ Heart†	Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
▪ Other†	_____	☐ Epinephrine ☐ Antihistamine
▪	If reaction is progressing (several of the above areas affected), give:	☐ Epinephrine ☐ Antihistamine

The severity of symptoms can quickly change. †Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg *(see reverse side for instructions)*

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ at _____

3. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.)_____	2.) _____
b. _____	1.)_____	2.)_____
c. _____	1.)_____	2.)_____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED,
DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature_____ Date_____

Physician Signature_____ Date_____

TRAINED STAFF MEMBERS

1. _____ Room _____

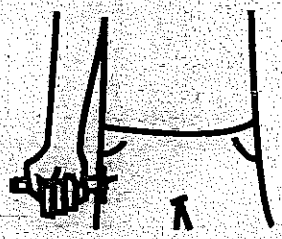
2. _____ Room _____

3. _____ Room _____

EpiPen® and EpiPen® Jr. Directions

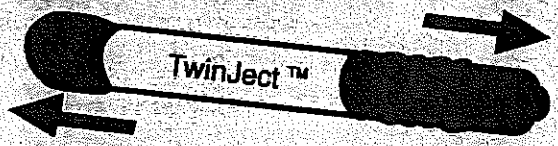
- Pull off gray activation cap.

- Hold black tip near outer thigh (always apply to thigh).

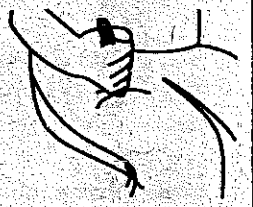


- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Twinject™ 0.3 mg and Twinject™ 0.15 mg Directions



- Pull off green end cap, then red end cap.



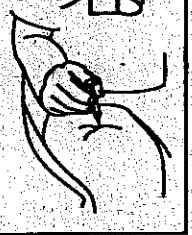
- Put gray cap against outer thigh, press down firmly until needle penetrates. Hold for ten seconds, then remove.

SECOND DOSE ADMINISTRATION:

If symptoms don't improve after 10 minutes, administer second dose:

- Unscrew gray cap and remove syringe from barrel by holding blue collar at needle base.

- Slide yellow or orange collar off plunger.

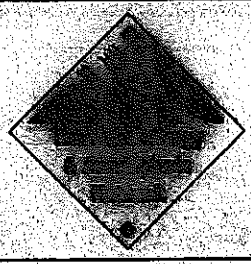


- Put needle into thigh through skin, push plunger down all the way, and remove.

Once EpiPen® or Twinject™ is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods.

**Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.



EMERGENCY HEALTH CARE PLAN

ALLERGY TO:_____

Student's Name:_____D.O.B._____

Teacher:_____ Classroom: _____
Is child asthmatic? Yes _____ No _____

SIGNS OF AN ALLERGIC REACTION INCLUDE:

MOUTH: itching and swelling of the lips, tongue, or mouth
THROAT: itching and/ or a sense of tightness in the throat, hoarseness, and hacking cough
SKIN: hives, itchy rash, and/ or swelling about the face or extremities
GI TRACT: uncommonly--nausea, abdominal cramps, vomiting and/ or diarrhea
LUNGS: shortness of breath, repetitive coughing, and/ or wheezing
HEART: weak and "thready" pulse, "passing-out"

The severity of symptoms can change quickly. All of the above symptoms can potentially progress to a life-threatening situation.

ACTION:

1. If ingestion, exposure, or sting is suspected, give _____
   (medication, dose, route)
   and _____immediately.

2. Call 911 or local Emergency Medical Services.
3. Call: Mother _____ Father _____
   Or emergency contacts_____
4. Call Dr. _____ at _____

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL EMS EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED.

_____ _____
Parent/ Guardian Signature Date

_____ _____
Health Care Provider's Signature Date

Emergency Contacts (name and phone)	Trained Staff Members (name and room)
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

Written Authorization for Self-Administration of EpiPen®, EpiPenJr. ® or other epinephrine auto-injectors by Minor Children at School

Student Name: _____ **Date of Birth:** _____ **Grade:** _____

I, _____, Parent/Legal Guardian of the above-named student hereby request authorization for self-administration and possession of EpiPen® and EpiPenJr.® or other epinephrine auto-injectors by this student while in school, at a school-sponsored activity, while under supervision of school personnel, and while in before-school or after-school care on school-operated property. The student demonstrates full understanding of the proper use of his/her allergy medication.

I understand that:

- the school district and its employees and agents shall incur no liability for: a) any injury to the student caused by his or her self-administration of medication except for injury caused by willful or wanton misconduct; b) the student's use, misuse, overuse, or neglected or failed use of his/ her allergy medication; and c) lost, misplaced, outdated, inaccessible, empty, or faulty allergy medication and allergy devices.
- the school may choose to require supervision of medication administration in the event that the student does not demonstrate appropriate use or proper technique with allergy medication.
- the school has the authority to enforce rules and consequences for inappropriate behavior demonstrated by the student in association with the possession and/or self-administration of allergy medication, and that the school has the authority to require supervision of medication use as deemed appropriate for the safety of all students and staff.

I take sole responsibility for:

- the monitoring of allergy medication, medication use, and refilling of prescriptions for allergy medication as the school will not be responsible for the supervising, recording, and monitoring of self-administered allergy medication.
- ensuring the student always carries his/her allergy medication on his/her person.
- deciding if back-up medication will be kept at the school and providing the school with the back-up medication.
- informing school staff in writing of any changes in the student's treatment or allergy management.
- informing the school of any allergy exacerbations, hospital visits, and/or new or changed student medical information.
- informing school staff in writing of any medication side effects that warrant communication to the parent/guardian.
- coordinating distribution of the student's allergy management and emergency plan to school staff (school health worker, teachers, physical educators, coaches, bus driver, before-school and after-school staff).

I understand and agree to the conditions of the school system policy. I permit the school to seek emergency medical treatment for the student when deemed necessary and appropriate. I accept legal responsibility should the medication be misused or given or taken by a person other than the above-named student. I release the School System and its employees and agents of any legal responsibility related to the above-named student's possession and self-administration of his/ her allergy medication.

_____ _____

Parent/Legal Guardian Signature Date

I, _____, the above-named student have been instructed in the proper use of my prescription allergy medication and fully understand how and when to use this medication. I will always carry my medication with me and will not allow another student to use my medication under any circumstance. I understand and agree to the terms of the school policy.

_____ _____

Student's Signature Date

The above-named student has been instructed and demonstrates understanding of the proper use of his/her allergy medication. It is my professional opinion that the student be permitted to carry and self-administer his/her allergy medication. I have provided the parent/guardian with a written allergy emergency/management plan including the name, purpose, dosage, and administration directions of the allergy medication.

_____ _____

Healthcare Provider Signature Date

Individual Healthcare Plan

Student: _____ **Date of Birth:** _____

Date: _____

Health Information to Teacher:

_____ has a health condition which you as his teacher need to be aware of. The description of this problem, as well as emergency care and individual considerations, are listed below:

Medical Diagnosis/Condition:

_____

_____

_____

_____

Actions:

_____

_____

_____

_____

Individual Considerations/Accommodations needed:

_____

_____

_____

_____

_____

_____

_____

_____

Parent Signature: _____ **Date:** _____

Physician or School Nurse Signature: _____ **Date:** _____

Section 504 Plan Sample

Student's Name:_____ DOB: _____ Date developed/reviewed: _____

School: _____ Grade:_____ School year: _____

Multidisciplinary team:

_____

_____

_____

Type of referral: Initial _____ Reevaluation_____ Modification _____

Disability(s) identified (i.e. medical condition, communicable disease, physical or learning disability--temporary or permanent): _____

_____

_____

Life Activity(s) substantially limited/educational impact:

_____

_____

_____

Necessary academic accommodations:

_____

_____

_____

_____

_____

_____

Necessary non-academic accommodations:

_____

_____

_____

_____

_____

_____

Location of accommodations: ( ) Regular class ( ) Other _____

Reevaluation date: _____ or earlier, if deemed appropriate.