Notice to Families Regarding Medication Administration

Dear Parent/Guardian:

To protect your child's safety, the school licensed practical nurse (LPN) and/or Health Aide (as designated by the principal) will adhere to the following medication administration requirements. It is required that BOTH legal guardian AND physician signatures are on file before any prescription can be given.

Although this may cause some inconvenience, we believe these requirements are best for the continued protection of your child's safety and therefore must be followed. If we do not have your written permission and the written permission of your physician, the medication will not be given. Permission forms can be obtained by contacting your school LPN, Health Aide, or the school office.

For your child to receive any medication at school, please follow the requirements below:

- All Action/Care Plans will need to be submitted with a Medication Consent form.
- Medication Consent Form must be completed and signed by physician and parent/legal guardian. **NO VERBAL CONSENT OR PHONE CONSENT WILL BE ACCEPTED.**
- New permission forms must be re-submitted each school year and are necessary for any changes in medication orders.
- Parent/Legal Guardian must notify the school if a student's physician changes or if the prescription is changed or discontinued.
- Prescription medication must be in the original container with the pharmacy (U.S.A. only) label. The container must have a proper label with the name of the patient, the name of the medicine, and the dosage.
- Only students with written authorization from their physician and parents/legal guardian are allowed to self-carry emergency medications. This authorization shall be provided to the clinic prior to the student's ability to self-carry emergency medications.
- Medication will be kept in a secure place in the health clinic during school hours. No medication shall be held in classrooms or backpacks at any time. Any medications brought in by students or found in a student's possession will be taken to the health clinic and remain in the clinic until a parent/legal guardian signs the consent form or picks up medication.
- The medication and the signed permission forms must be brought to the school by the parent/legal guardian and delivered to the campus clinic LPN or Health Aide. Students are not to be sent to campus with medications.
- Wherever possible, please include a photo of your child with the permission form.
- It is the parent/legal guardian's responsibility to deliver the medication to the school health clinic and have the medication picked up at the end of the year. Medication not picked up by the end of the year will be discarded.
- When the medication is almost completed, please bring the refill to school promptly. Parents must bring refill of medication to the clinic. Can not be brought in by student.
- If your student is taken off medication, will no longer receive it at school, or if the prescription otherwise changes, a dated, written note with updated prescription information of such changes must be provided. If medication is not picked up from the school office within ten (10) days, it will be properly disposed of.
- Medication that is expired or has a listed discard date will not be administered to students past indicated date.
- The first dose of any new medication shall not be administered at school due to the possibility of an allergic reaction.

Please contact the principal or their designee if you have any questions. Thank you for your cooperation.

Aviso a las familias sobre la administración de medicamentos

Estimado Padre / Tutor:

Para proteger la seguridad de su hijo, la enfermera practicante con licencia de la escuela y/o el asistente de salud (según lo designe el director) se adherirá a la siguiente política de medicamentos. Se requiere que AMBOS padres y las firmas del médico estén archivadas antes de cualquier receta.

Aunque esto puede causar algunos inconvenientes, creemos que esta política es la mejor para la protección continua de la seguridad de su hijo y, por lo tanto, debe seguirse. Si no tenemos su permiso por escrito y el permiso por escrito de su médico, no se administrará el medicamento. Los formularios de permiso se pueden obtener comunicándose con la enfermera práctica autorizada o el asistente de salud de su escuela o con la oficina de la escuela.

Para que su hijo reciba cualquier medicamento en la escuela, siga la siguiente política de medicamentos:

Todos los planes de acción/cuidado deberán presentarse con un formulario de consentimiento de medicamentos.

- El formulario de consentimiento de administración debe ser completado y firmado por un médico, padre o tutor legal. **NO SE ACEPTARÁ CONSENTIMIENTO VERBAL NI TELEFÓNICO.**
- Los nuevos formularios de permiso deben volver a presentarse cada año escolar y son necesarios para cualquier cambio en las órdenes de medicamentos.
- Acepto notificar a la escuela si cambio de médico o si la receta se cambia o se interrumpe.
- Los medicamentos recetados deben estar en el envase original con la etiqueta de la farmacia (solo en EE. UU.). El envase debe tener una etiqueta adecuada con el nombre del paciente, el nombre del medicamento y la dosis.
- Solo los estudiantes con autorización por escrito de su médico y sus padres pueden llevar sus propios medicamentos. Esta autorización se proporcionará a la clínica antes de que el estudiante pueda llevar consigo los medicamentos de emergencia.
- Los medicamentos se mantendrán en un lugar seguro en la clínica de salud durante el horario escolar. No se guardarán medicamentos en las aulas o mochilas en ningún momento. Cualquier medicamento traído por los estudiantes o que se encuentre en posesión de un estudiante será llevado a la clínica de salud y permanecerá en la clínica hasta que un padre firme el formulario de consentimiento o recoja el medicamento.
- El medicamento y los formularios de permiso firmados deben ser llevados a la escuela por el padre o tutor y entregados al asistente de salud de la clínica del campus. Los estudiantes no deben ser enviados al campus con medicamentos.
- Siempre que sea posible, incluya una foto de su hijo con el formulario de autorización.
- Es responsabilidad del padre o tutor entregar el medicamento a la clínica de salud de la escuela y recoger el medicamento al final del año. Los medicamentos que no sean recogidos al final del año serán desechados.
- Cuando el medicamento esté casi terminado, envíe la recarga a la escuela de inmediato. No envíe resurtidos de medicamentos con el estudiante; los padres deben traerlos.
- Si a su hijo se le retira el medicamento, ya no lo recibirá en la escuela, o si la receta cambia de otro modo, proporcione una nota escrita con fecha con información actualizada de la receta de dichos cambios tan pronto como sea posible. Si el medicamento no se recoge en la oficina de la escuela dentro de los diez (10) días, se desechará correctamente.
- Los medicamentos que estén vencidos o que tengan una fecha de descarte indicada no se administrarán a los estudiantes después de la fecha indicada.
- La primera dosis de cualquier medicamento nuevo no se administrará en la escuela debido a la posibilidad de una reacción alérgica.

Comuníquese con el director o su designado si tiene alguna pregunta. Gracias por su cooperación.

American Diabetes Association.
Connected for Life

Safe at School®

Diabetes Medical Management Plan

SCHOOL YEAR:

(Add student photo here.)

STUDENT LAST NAME: FIRST NAME: DOB:

TABLE OF CONTENTS

PARENTS/GUARDIANS: Please complete pages 1 and 2 of this form and approve the final plan on page 6.

1. DEMOGRAPHIC INFORMATION—PARENT/GUARDIAN TO COMPLETE

Student First Name: Last Name: DOB: Student's Cell #: Diabetes Type: Date Diagnosed: Month: Year:

School Name: School Phone #: School Fax #: Grade:

Home Room: School Point of Contact: Contact Phone #:

STUDENT'S SCHEDULE Arrival Time: Dismissal Time:

Travels to school by (check all that apply):
- ☐ Foot/Bicycle
- ☐ Car
- ☐ Bus
- ☐ Attends Before School Program

Meals Times:
- ☐ Breakfast
- ☐ AM Snack
- ☐ Lunch
- ☐ PM Snack
- ☐ Pre Dismissal Snack

Physical Activity:
- ☐ Gym
- ☐ Recess
- ☐ Sports
- ☐ Additional information:

Travels to:
- ☐ Home ☐ After School Program
- Via: ☐ Foot/Bicycle
- ☐ Car
- ☐ Student Driver
- ☐ Bus

Parent/Guardian #1 (contact first): Relationship:

Cell #: Home #: Work #:

E-mail Address:

Indicate preferred contact method:

Parent/Guardian #2: Relationship:

Cell #: Home #: Work #:

E-mail Address:

Indicate preferred contact method:

2. NECESSARY SUPPLIES / DISASTER PLANNING / EXTENDED FIELD TRIPS

1. A 3-day minimum of the following Diabetes Management Supplies should be provided by the parent/guardian and accessible for the care of the student at all times.

- Insulin
- Syringe/Pen Needles
- Ketone Strips
- Treatment for lows and snacks
- Glucagon
- Antiseptic Wipes
- Blood Glucose (BG) Meter with (test strips, lancets, extra battery) – required for all Continuous Glucose Monitor (CGM) users
- Pump Supplies (Infusion Set, Cartridge, extra Battery/Charging Cord) if applicable
- Additional supplies:

2. View Disaster/Emergency Planning details – refer to Safe at School Guide

3. Please review expiration dates and quantities monthly and replace items prior to expiration dates

4. In the event of a disaster or extended field trip, a school nurse or other designated personnel will take student's diabetes supplies and medications to student's location.

Name of Health Care Provider/Clinic: Contact #: Fax #:

Email Address (non-essential communication): Other:

STUDENT LAST NAME: FIRST NAME: DOB:

3. SELF-MANAGEMENT SKILLS (DEFINITIONS BELOW)

		Full Support	Supervision	Self-Care
Glucose Monitoring:	Meter	☐	☐	☐
	CGM ☐(Requires Calibration)	☐	☐	☐
Carbohydrate Counting		☐	☐	☐
Insulin Administration:	Syringe	☐	☐	☐
	Pen	☐	☐	☐
	Pump	☐	☐	☐
Can Calculate Insulin Doses		☐	☐	☐
Glucose Management:	Low Glucose	☐	☐	☐
	High Glucose	☐	☐	☐

Self-Carry Diabetes Supplies: ☐ Yes ☐ No Please specify items:
Smart Phone: ☐ Yes ☐ No

Device Independence: ☐ CGM ☐ Interpretation & Alarm Management ☐ Sensor Insertion ☐ Calibration ☐ Insulin Pumps ☐ Bolus
☐ Connects/Disconnects ☐ Temp Basal Adjustment ☐ Interpretation & Alarm Management ☐ Site Insertion ☐ Cartridge Change

Full Support: All care performed by school nurse and trained staff (as permitted by state law).
Supervision: Trained staff to assist & supervise. Guide & encourage independence.
Self-Care: Manages diabetes independently. Support is provided upon request and as needed.

4. STUDENT RECOGNITION OF HIGH OR LOW GLUCOSE SYMPTOMS (CHECK ALL THAT APPLY)

Symptoms of High:
☐ Thirsty ☐ Frequent Urination ☐ Fatigued/Tired/Drowsy ☐ Headache ☐ Blurred Vision ☐ Warm/Dry/Flushed Skin
☐ Abdominal Discomfort ☐ Nausea/Vomiting ☐ Fruity Breath ☐ Unaware ☐ Other:

Symptoms of Low:
☐ None ☐ Hungry ☐ Shaky ☐ Pale ☐ Sweaty ☐ Tired/Sleepy ☐ Tearful/Crying ☐ Dizzy Irritable
☐ Unable to Concentrate ☐ Confusion ☐ Personality Changes ☐ Other:

Has student lost consciousness, experienced a seizure or required Glucagon: ☐ Yes ☐ No If yes, date of last event:
Has student been admitted for DKA after diagnosis: ☐ Yes ☐ No If yes, date of last event:

5. GLUCOSE MONITORING AT SCHOOL

Monitor Glucose:
☐ Before Meals ☐ With Physical Complaints/Illness (include ketone testing) ☐ High or Low Glucose Symptoms
☐ Before Exams ☐ Before Physical Activity ☐ After Physical Activity ☐ Before Leaving School ☐ Other:

CONTINUOUS GLUCOSE MONITORING (CGM)

(Specify Brand & Model:

Specify Viewing Equipment: ☐ Device Reader ☐ Smart Phone
☐ Insulin Pump ☐ Smart Watch ☐ iPod/iPad/Tablet

☐ CGM is remotely monitored by parent/guardian.
Document individualized communication plan in Section 504 or other plan to minimize interruptions for the student.
☐ May use CGM for monitoring/treatment/insulin dosing unless symptoms do not match reading.

CGM Alarms:

Low alarm mg/dL

High alarm mg/dL if applicable

☐ **Section 1-5 completed by Parent/Guardian**

Please:
- Permit student access to viewing device at all times
- Permit access to School Wi-Fi for sensor data collection and data sharing
- Do not discard transmitter if sensor falls

Perform finger stick if:
- Glucose reading is below mg/dL or above mg/dL
- If CGM is still reading below mg/dL (DEFAULT 70 mg/dL) 15 minutes following low treatment
- CGM sensor is dislodged or sensor reading is unavailable. (see CGM addenda for more information)
- Sensor readings are inconsistent or in the presence of alerts/alarms
- Dexcom does not have both a number and arrow present
- Libre displays Check Blood Glucose Symbol
- Using Medtronic system with Guardian sensor

Notify parent/guardian if glucose is:

below mg/dL (<55 mg/dL DEFAULT)

above mg/dL (>300 mg/d DEFAULT)

Name of Health Care Provider/Clinic: Contact #: Fax #:
Email Address (non-essential communication): Other:

STUDENT LAST NAME: FIRST NAME: DOB:

6. INSULIN DOSES AT SCHOOL - HEALTHCARE PROVIDER TO COMPLETE

Insulin Administered Via:

☐ Syringe ☐ Insulin Pen (☐ Whole Units ☐ Half Units) ☐ Insulin Pump (Specify Brand & Model:)
☐ i-Port ☐ Smart Pen
☐ Other

☐ Insulin Pump is using Automated Insulin Delivery (automatic dosing) using an FDA-approved device
☐ Insulin Pump is using DIY Looping Technology (child/parent manages device independently, nurse will assist with all other diabetes management)

☐ **DOSING** to be determined by Bolus Calculator in insulin pump or smart pen/meter unless moderate or large ketones are present or in the event of device failure (provide insulin via injection using dosing table in section 6A).

Insulin Administration Guidelines

Insulin Delivery Timing: Pre-meal insulin delivery is important in maintaining good glucose control. Late or partial doses are used with students that demonstrate unpredictable eating patterns or refuse food. Provide substitution carbohydrates when student does not complete their meal.

☐ **Prior to Meal** (DEFAULT)
☐ **After Meal** as soon as possible and within 30 minutes
☐ **Snacking** avoid snacking hours (DEFAULT 2 hours) before and after meals

Partial Dose Prior to Meal: (preferred for unpredictable eating patterns using **insulin pump therapy**)

☐ Calculate meal dose using grams of carbohydrate prior to the meal
☐ Follow meal with remainder of grams of carbohydrates (may not be necessary with advanced hybrid pump therapy)
☐ May advance to Prior to Meal when student demonstrates consistent eating patterns.

For Injections, Calculate Insulin Dose To The Nearest:

☐ Half Unit (round down for < 0.25 or < 0.75 and round up for ≥ 0.25 or ≥ 0.75)
☐ Whole Unit (round down for < 0.5 and round up for ≥ 0.5)

Supplemental Insulin Orders:

☐ Check for **KETONES** before administering insulin dose if BG > mg/dL (DEFAULT >300 mg/dL or >250 mg/dL on insulin pump) or if student complains of physical symptoms. Refer to section 9. for high blood glucose management information.

☐ Parents/guardians are authorized to adjust insulin dose +/- units

- ☐ Insulin dose +/- units
- ☐ Insulin dose +/- %
- ☐ Insulin to Carb Ratio +/- grams/units
- ☐ Insulin Factor +/- mg/dL/unit

Additional guidance on parent adjustments:

Name of Health Care Provider/Clinic: Contact #: Fax #:
Email Address (non-essential communication): Other:

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Diabetes Medical Management Plan

STUDENT LAST NAME: _____ FIRST NAME: _____ DOB: _____

6A. DOSING TABLE—HEALTHCARE PROVIDER TO COMPLETE – SINGLE PAGE UPDATE ORDER FORM

Insulin: (administered for food and/or correction)

Rapid Acting Insulin: ☐ Humalog/Admelog (Lispro), Novolog (Aspart), Apidra (Glulisine) ☐ Other: _____

Ultra Rapid Acting Insulin: ☐ Fiasp (Aspart) ☐ Lyumjev (Lispro-aabc) ☐ Other: _____

Other insulin: ☐ Humulin R ☐ Novolin R

Meal & Times	Food Dose		Glucose Correction Dose ☐ Use Formula ☐ See Sliding Scale 6B	☐ PE/Activity Day Dose
Select if dosing is required for meal	☐ **Carbohydrate Ratio:** Total Grams of Carbohydrate divided by Carbohydrate Ratio = Carbohydrate Dose	☐ **Fixed Meal Dose**	**Formula:** (Pre-Meal Glucose Reading minus **Target Glucose**) divided by **Correction Factor** = Correction Dose ☐ May give Correction dose every ____ hours as needed (DEFAULT 3 hours)	**Adjust:** ☐ **Carbohydrate Dose** ☐ **Total Dose** Indicate dose instructions below:
☐ **Breakfast**	Breakfast Carb Ratio = ____ g/unit	**Breakfast** ____ units	☐ **Target Glucose** is: ____ mg/dL & **Correction Factor** is: ____ mg/dL/unit ☐ **No Correction dose**	Carb Ratio ____ g/unit Subtract ____ % Subtract ____ units
☐ **AM Snack**	AM Snack Carb Ratio = ____ g/unit ☐ No Carb Dose ☐ No Insulin if < ____ grams	**AM Snack** ____ units	☐ **Target Glucose** is: ____ mg/dL & **Correction Factor** is: ____ mg/dL/unit ☐ **No Correction dose**	Carb Ratio ____ g/unit Subtract ____ % Subtract ____ units
☐ **Lunch**	Lunch Carb Ratio = ____ g/unit	**Lunch** ____ units	☐ **Target Glucose** is: ____ mg/dL & **Correction Factor** is: ____ mg/dL/unit ☐ **No Correction dose**	Carb Ratio ____ g/unit Subtract ____ % Subtract ____ units
☐ **PM Snack**	PM Snack Carb Ratio = ____ g/unit ☐ No Carb Dose ☐ No Insulin if < ____ grams	**PM Snack** ____ units	☐ **Target Glucose** is: ____ mg/dL & **Correction Factor** is: ____ mg/dL/unit ☐ **No Correction dose**	Carb Ratio ____ g/unit Subtract ____ % Subtract ____ units
☐ **Dinner**	Dinner Carb Ratio = ____ g/unit	**Dinner** ____ units	☐ **Target Glucose** is: ____ mg/dL & **Correction Factor** is: ____ mg/dL/unit ☐ **No Correction dose**	Carb Ratio ____ g/unit Subtract ____ % Subtract ____ units

6B. CORRECTION SLIDING SCALE

☐ Meals Only ☐ Meals and Snacks ☐ Every ____ hours as needed

____ to ____ mg/dL = ____ units	____ to ____ mg/dL = ____ units	____ to ____ mg/dL = ____ units
____ to ____ mg/dL = ____ units	____ to ____ mg/dL = ____ units	____ to ____ mg/dL = ____ units
____ to ____ mg/dL = ____ units	____ to ____ mg/dL = ____ units	____ to ____ mg/dL = ____ units

6C. LONG ACTING INSULIN

Time		units		
____	☐ Lantus, Basaglar, Toujeo (Glargine) ☐ Levemir (Detemir) ☐ Tresiba (Degludec) ☐ Other ____	____	☐ Daily Dose ☐ Overnight Field Trip Dose ☐ Disaster/Emergency Dose	Subcutaneously

6D. OTHER MEDICATIONS

Time		units		
____	☐ Metformin ☐ Other ____	____	☐ Daily Dose ☐ Overnight Field Trip Dose ☐ Disaster/Emergency Dose	Route ____

Signature is required here if sending ONLY this one-page dosing update.

Diabetes Provider Signature: _____ **Date:** _____

Name of Health Care Provider/Clinic: _____ Contact #: _____ Fax #: _____

Email Address (non-essential communication): _____ Other: _____

STUDENT LAST NAME: FIRST NAME: DOB:

7. LOW GLUCOSE PREVENTION (HYPOGLYCEMIA)

Allow Early Interventions

☐ Allow Mini-Dosing of carbohydrate (i.e.,1-2 glucose tablets) when low glucose is predicted, sensor readings are dropping (down arrow) at mg/dL (DEFAULT 80 mg/dL or 120 mg/dL prior to exercise) or with symptoms.

☐ Allow student to carry and consume snacks ☐ School staff to administer

☐ Allow Trained Staff/Parent/Guardian to adjust mini dosing and snacking amounts (DEFAULT)

Insulin Management (Insulin Pumps)

Temporary Basal Rate Initiate pre-programmed rate as indicated below to avoid or treat hypoglycemia.

☐ Pre-programmed Temporary Basal Rate Named (OmniPod)

☐ Temp Target (Medtronic) ☐ Exercise Activity Setting (Tandem) ☐ Activity Feature (Omnipod 5)

Start: minutes prior to exercise for minutes duration (DEFAULT 1 hour prior, during, and 2 hours following exercise).

Initiated by: ☐ Student ☐ Trained School Staff ☐ School Nurse

☐ May disconnect and suspend insulin pump up to minutes (DEFAULT 60 minutes) to avoid hypoglycemia, personal injury with certain physical activities or damage to the device (keep in a cool and clean location away from direct sunlight).

Exercise (Exercise is a very important part of diabetes management and should always be encouraged and facilitated).

Exercise Glucose Monitoring

☐ prior to exercise ☐ every 30 minutes during extended exercise ☐ following exercise ☐ with symptoms

Delay exercise if glucose is < mg/dL (120 mg/dL DEFAULT)

Pre-Exercise Routine

☐ **Fixed Snack:** Provide grams of carbohydrate prior to physical activity if glucose < mg/dL

☐ **Added Carbs:** If glucose is < mg/dL (120 DEFAULT) give grams of carbohydrates (15 DEFAULT)

☐ **TEMPORARY BASAL RATE as indicated above**

Encourage and provide access to water for hydration, carbohydrates to treat/prevent hypoglycemia, and bathroom privileges during physical activity

8. LOW GLUCOSE MANAGEMENT (HYPOGLYCEMIA)

Low Glucose below mg/dL (below 70 mg/dL DEFAULT) or below mg/dL before/during exercise (DEFAULT is < 120 mg/dl).

1. If student is awake and able to swallow give grams of fast acting carbohydrate (DEFAULT 15 grams). Examples include 4 ounces of juice or regular soda, 4 glucose tabs, 1 small tube glucose gel.
   ☐ School nurse/parent may change amount given
2. Check blood glucose every 15 minutes and re-treat until glucose > mg/dL (DEFAULT is 80 mg/dL or 120 mg/dL before exercise).

SEVERE LOW GLUCOSE (unconscious, seizure, or unable to swallow)
Administer Glucagon, position student on their side and monitor for vomiting, call 911 and notify parent/guardian. If BG meter is available, confirm hypoglycemia via BG fingerstick. Do not delay treatment if meter is not immediately available. If wearing an insulin pump, place pump in suspend/stop mode or disconnect tubing from infusion site. Keep pump with student.

☐ Glucagon Emergency Kit by IM injection ☐ Gvoke by SC injection ☐ Auto-Injection, Gvoke HypoPen
Dose: ☐ 0.5 mg or ☐ 1.0 mg

☐ Zegalogue (dasiglucagon) 0.6 mg SC by Auto-Injector ☐ Zegalogue (dasiglucagon) 0.6 mg SC by Pre-Filled Syringe

☐ Baqsimi Nasal Glucagon 3 mg

Diabetes Medical Management Plan

STUDENT LAST NAME: FIRST NAME: DOB:

9. HIGH GLUCOSE MANAGEMENT (HYPERGLYCEMIA)

Management of High Glucose over mg/dL (Default is 300 mg/dL OR 250 mg/dl if on an insulin pump).

1. Provide and encourage consumption of water or sugar-free fluids. Give 4-8 ounces of water every 30 minutes. May consume fluids in classroom. Allow frequent bathroom privileges.
2. Check for Ketones (before giving insulin correction)

   a. If Trace or Small Urine Ketones (0.1 – 0.5 mmol/L if measured in blood)

   - Consider insulin correction dose. Refer to the "Correction Dose" Section 6.A-B. for designated times correction insulin may be given.
   - *Can return to class and PE unless symptomatic*
   - Recheck glucose and ketones in 2 hours

   b. If Moderate or Large Urine Ketones (0.6 – 1.4 mmol/L or >1.5 mmol/L blood ketones). This may be serious and requires action.

   - Contact parents/guardian or, if unavailable, healthcare provider
   - **Administer correction dose via injection.** If using Automated Insulin Delivery contact parent/provider about turning off automatic pump features. Refer to the "Blood Glucose Correction Dose" Section 6.A-B
   - If using insulin pump change infusion site/cartridge or use injections until dismissal.
   - No physical activity until ketones have cleared
   - Report nausea, vomiting, and abdominal pain to parent/guardian to take student home.
   - Call 911 if changes in mental status and labored breathing are present and notify parents/guardians.

☐ Send student's diabetes log to Health Care Provider (include details): If pre-meal blood glucose is below 70 mg/dL or above 240 mg/dL more than 3 times per week or you have any other concerns.

SIGNATURES

This Diabetes Medical Management Plan has been approved by:

Student's Physician/Health Care Provider: Date:

I, (parent/guardian) give permission to the school nurse or another qualified health care professional or trained diabetes personnel of (school) to perform and carry out the diabetes care tasks as outlined in this Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified health care professional to collaborate with my child's physician/health care provider.

Acknowledged and received by:

Student's Parent/Guardian: Date:

Acknowledged and received by:

School Nurse or Designee: Date:

Name of Health Care Provider/Clinic: Contact #: Fax #:

Email Address (non-essential communication): Other:

MEDICATION ADMINISTRATION CONSENT FORM

STUDENT INFORMATION

Student Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

School: _____ Grade: _____ Teacher: _____ School Year: _____

List any known drug allergies/reactions: _____ Height (inches): _____ Weight (lbs.): _____

Parent Name: _____ Phone Number: _____

PHYSICIAN AUTHORIZATION

(To be completed by physician/licensed prescriber)

Name of Medication: _____ Reason for taking: _____

Dosage: _____ Route: _____ Time(s) and Interval to be administered: _____

Date of Authorization: _____ Begin/End Dates: _____

Special Instructions for Administration and Storage of Medication:

Is medication necessary to be given during school hours (7:30 AM to 3 PM)? Yes ☐ No ☐

If yes, please provide recommended administration time(s): _____

Is the medication a controlled substance? Yes ☐ No ☐ Does medication require refrigeration? Yes ☐ No ☐

Special Instructions or Storage: _____

Potential Side Effects/Contraindications/Adverse Reactions: _____

Treatment Order in the event of an adverse reaction: _____

(Attach additional sheet or use the back of this form if necessary)

Provider Name: _____ Provider Signature: _____

Phone Number: _____ Date: _____

PARENT AUTHORIZATION

(To be completed by parent/guardian)

- I authorize the delegated personnel the task of assisting my child with medication administration.
- I agree to notify the school if I change physicians or if the prescription is changed or discontinued.
- Only medication prescribed and provided by the United States will be administered in school.
- Medication that is expired or has a listed discard date will not be administered to students past indicated date.
- Prescription medication must be in the original container with the pharmacy (U.S.A. only) label. The container must have a proper label with the name of the patient, the name of the medicine, and the dosage.
- This Medication Administration Consent form must be completed and signed by physician, parent, or legal guardian. NO VERBAL CONSENT OR PHONE CONSENT WILL BE ACCEPTED.
- Medication will be kept in a secure place in the health clinic during school hours. No medication shall be held in classrooms or backpacks at any time. Any medications brought in by students or found in a student's possession will be taken to the health clinic and remain in the clinic until a parent signs the consent form or picks up medication.
- Only students with written authorization from their physician and parents are allowed to self-carry emergency medications. This authorization shall be provided to the clinic prior to the student's ability to self-carry emergency medications.
- It is the parent or guardian's responsibility to deliver the medication to the school health clinic and have the medication picked up at the end of the year. Medication not picked up by the end of the year will be discarded.
- The first dose of any new medication shall not be administered at school due to the possibility of an allergic reaction.

Parent/Guardian Name: _____ Parent/Guardian Signature: _____

Secondary Contact Number: _____ Date: _____

MEDICATION ADMINISTRATION CONSENT FORM

STUDENT INFORMATION

Student Name: _____ Date of Birth: _____
(Nombre del Estudiante) *(Fecha de Nacimiento)*

Address: _____ City/State/Zip: _____
(Dirección) *(Ciudad/estado/codigo postal)*

School: _____ Grade: _____ Teacher: _____ School Year: _____
(Escuela) *(Grado)* *(Maestro/a)* *(Año escolar)*

List any known drug allergies/reactions: _____ Height (inches): _____ Weight (lbs.): _____
(Alergia/Reacción Conocida a Medicamentos) *(Altura)* *(Peso)*

Parent Name: _____ Phone Number: _____
(Nombre del Padre) *(Número de Teléfono)*

PHYSICIAN AUTHORIZATION

(To be completed by physician/licensed prescriber)

Name of Medication: _____ Reason for taking: _____

Dosage: _____ Route: _____ Time(s) and Interval to be administered: _____

Date of Authorization: _____ Begin/End Dates: _____

Special Instructions for Administration and Storage of Medication:

Is medication necessary to be given during school hours (7:30 AM to 3 PM)? Yes ☐ No ☐

If yes, please provide recommended administration time(s): _____

Is the medication a controlled substance? Yes ☐ No ☐ Does medication require refrigeration? Yes ☐ No ☐

Special Instructions or Storage: _____

Potential Side Effects/Contraindications/Adverse Reactions: _____

Treatment Order in the event of an adverse reaction: _____
(Attach additional sheet or use the back of this form if necessary)

Provider Name: _____ Provider Signature: _____

Phone Number: _____ Date: _____

AUTORIZACIÓN DE LOS PADRES

(Para ser completado por el padre/tutor)

- Autorizo al personal delegado la tarea de asistir a mi hijo en la administración de medicamentos.
- Acepto notificar a la escuela si cambio de médico o si la receta se cambia o se interrumpe.
- Sólo se administrarán en la escuela los medicamentos prescritos y proporcionados por los Estados Unidos.
- Los medicamentos que estén vencidos o que tengan una fecha de descarte indicada no se administrarán a los estudiantes después de la fecha indicada.
- Los medicamentos recetados deben estar en el envase original con la etiqueta de la farmacia (solo en EE. UU.). El envase debe tener una etiqueta adecuada con el nombre del paciente, el nombre del medicamento y la dosis.
- El formulario de consentimiento de administración debe ser completado y firmado por un médico, padre o tutor legal. NO SE ACEPTARÁ CONSENTIMIENTO VERBAL NI TELEFÓNICO.
- Los medicamentos se mantendrán en un lugar seguro en la clínica de salud durante el horario escolar. No se guardarán medicamentos en las aulas o mochilas en ningún momento. Cualquier medicamento traído por los estudiantes o que se encuentre en posesión de un estudiante será llevado a la clínica de salud y permanecerá en la clínica hasta que un padre firme el formulario de consentimiento o recoja el medicamento.
- Solo los estudiantes con autorización por escrito de su médico y sus padres pueden llevar sus propios medicamentos. Esta autorización se proporcionará a la clínica antes de que el estudiante pueda llevar consigo los medicamentos de emergencia.
- Es responsabilidad del padre o tutor entregar el medicamento a la clínica de salud de la escuela y recoger el medicamento al final del año. Los medicamentos que no sean recogidos al final del año serán desechados.
- La primera dosis de cualquier medicamento nuevo no se administrará en la escuela debido a la posibilidad de una reacción alérgica.

Parent/Guardian Name: _____ Parent/Guardian Signature: _____
(Nombre del Padre de Familia / Guardian) *(Firma del Padre / Tutor)*

Secondary Contact Number: _____ Date: _____
(Número de Contacto Secundario) *(Fecha)*