

## Notice to Families Regarding Medication Administration



Dear Parent/Guardian:

To protect your child's safety, the school personnel 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 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 receptionist. 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 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 campus. 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 Director of Student Support Services or designee if you have any questions. Thank you for your cooperation.

Estimado Padre / Tutor:

Para proteger la seguridad de su hijo, el personal escolar designado por el director cumplirá con los siguientes requisitos para la administración de medicamentos. Se requiere que las firmas de AMBOS, el tutor legal Y el médico, estén registradas antes de que se pueda administrar cualquier medicamento recetado.

Aunque esto puede causar algunos inconvenientes, creemos que estos requisitos son los mejores para la protección continua de la seguridad de su hijo y, por lo tanto, deben cumplirse. Si no contamos con su autorización por escrito y la autorización por escrito de su médico, el medicamento no será administrado. Los formularios de autorización pueden obtenerse comunicándose con la oficina de su 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 autorización firmados deben ser llevados a la escuela por el padre, la madre o el tutor legal y entregados a la recepcionista del campus. No se debe enviar a los estudiantes al campus con medicamentos.
- Siempre que sea posible, incluya una foto de su hijo con el formulario de autorización.
- Es responsabilidad del padre/madre o tutor legal entregar el medicamento a la escuela y recogerlo al final del año. El medicamento que no sea recogido al final del año será desechado.
- Cuando el medicamento esté casi terminado, por favor lleve el resurtido a la escuela lo antes posible. Los padres deben llevar el resurtido del medicamento al campus. No puede ser traído por el estudiante.
- 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.

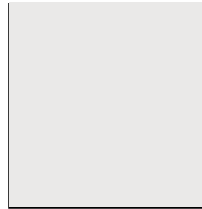
Por favor, comuníquese con el Director de Servicios de Apoyo Estudiantil o la persona designada si tiene alguna pregunta. Gracias por su cooperación.



# Safe at School®

# Diabetes Medical Management Plan

SCHOOL YEAR:



(Add student photo here.)

STUDENT LAST NAME: FIRST NAME: DOB:

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**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<br>(check all that apply): | Meals Times:           | Physical Activity:      | Travels to:               |
| Foot/Bicycle                                    | Breakfast              | Gym                     | Home After School Program |
| Car                                             | AM Snack               | Recess                  | Via: Foot/Bicycle         |
| Bus                                             | Lunch                  | Sports                  | Car                       |
| Attends Before<br>School Program                | PM Snack               | Additional information: | Student Driver            |
|                                                 | Pre Dismissal<br>Snack |                         | Bus                       |

Parent/Guardian #1 (contact first): Relationship: Parent/Guardian #2: Relationship:

Cell #: Home #: Work #: Cell #: Home #: Work #:

E-mail Address: E-mail Address:

Indicate preferred contact method: 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.

- |                                                                                                                                                                                                                                            |                                                                                                                                                                                                        |                                                                                                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Insulin</li> <li>• Syringe/Pen Needles</li> <li>• Ketone Strips</li> <li>• Treatment for lows and snacks</li> <li>• Glucagon</li> <li>• Antiseptic Wipes</li> <li>• Blood Glucose (BG)</li> </ul> | <ul style="list-style-type: none"> <li>• Meter with (test strips, lancets, extra battery) – required for all Continuous Glucose Monitor (CGM) users</li> <li>• Pump Supplies (Infusion Set,</li> </ul> | <ul style="list-style-type: none"> <li>• Cartridge, extra Battery/Charging Cord) if applicable</li> <li>• Additional supplies:</li> </ul> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|

**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:

Email Address (non-essential communication):

Contact #:

Other:

Fax #:

STUDENT LAST NAME:

FIRST NAME:

DOB:

### 3. SELF-MANAGEMENT SKILLS (DEFINITIONS BELOW)

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

#### 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/dL DEFAULT)

Section 1-5 completed by Parent/Guardian

Name of Health Care Provider/Clinic:

Email Address (non-essential communication):

Contact #:

Other:

Fax #:

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     |             |             | Insulin Pump is using Automated Insulin Delivery (automatic dosing) using an FDA-approved device                                               |
| Other   |               |             |             | 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:

Email Address (non-essential communication):

Contact #:

Other:

Fax #:

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

## 6C. LONG ACTING INSULIN

|      |                                                                                         |       |                                                                    |                |
|------|-----------------------------------------------------------------------------------------|-------|--------------------------------------------------------------------|----------------|
| Time | Lantus, Basaglar, Toujeo (Glargine)<br>Levemir (Detemir)<br>Tresiba (Degludec)<br>Other | units | Daily Dose<br>Overnight Field Trip Dose<br>Disaster/Emergency Dose | Subcutaneously |
|------|-----------------------------------------------------------------------------------------|-------|--------------------------------------------------------------------|----------------|

## 6D. OTHER MEDICATIONS

|      |                    |       |                                                                    |       |
|------|--------------------|-------|--------------------------------------------------------------------|-------|
| Time | Metformin<br>Other | units | Daily Dose<br>Overnight Field Trip Dose<br>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:

Email Address (non-essential communication):

Contact #:

Other:

Fax #:

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

Name of Health Care Provider/Clinic:

Contact #:

Fax #:

Email Address (non-essential communication):

Other:

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:



## MEDICATION ADMINISTRATION CONSENT FORM

### STUDENT INFORMATION **(Only 1 Medication Per Form)**

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: \_\_\_\_\_ ICD 10 CODE \_\_\_\_\_

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

Replace Previous Order: Y ☐ N ☐ 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 (Only 1 Medication Per Form)

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Nombre del Estudiante) (Fecha de Nacimiento)  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
(Dirección) (Ciudad/estado/código 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: \_\_\_\_\_ ICD 10 CODE \_\_\_\_\_  
Dosage: \_\_\_\_\_ Route: \_\_\_\_\_ Time(s) and Interval to be administered: \_\_\_\_\_  
Replace Previous Order: Y ☐ N ☐ 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)