School Year: _____ - _____

Place student's picture here

MEDICAL FORM: DIABETES
(EMERGENCY CARE PLAN/MEDICAL 504)

This plan should be completed by the student's personal diabetes health care team, including the parents/guardians. It should be reviewed with relevant school staff and copies should be kept in a place that can be accessed easily by the school nurse, Parent Designated Adult (PDA), and other authorized personnel.

Student Information

Student's Name: _____ Date of birth: _____

Date of diabetes diagnosis: _____ ☐ Type 1 ☐ Type 2 ☐ Other: _____

School: _____ School phone number: _____

Grade: _____ Homeroom teacher: _____

School nurse: _____ Phone number: _____

Contact Information

Parent/guardian 1: _____

Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email address: _____

Parent/guardian 2: _____

Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email address: _____

Student's Physician/Health Care Provider: _____

Address: _____

Phone: _____ Emergency number: _____ Fax:_____

Email address: _____

Other Emergency Contacts:

Contact 1: _____ Relationship:_____

Telephone: Home: _____ Work: _____ Cell: _____

Contact 2: _____ Relationship:_____

Telephone: Home: _____ Work: _____ Cell: _____

Adapted from National Diabetes Education Program

DMMP Revised 3/2018

Checking Blood Glucose

Brand/model of blood glucose meter: _____

Target range of blood glucose before meals: _____

Check blood glucose level:

☐ Before breakfast ☐ After breakfast ☐ _____ Hours after breakfast ☐ ____ Hours after a correction dose
☐ Before lunch ☐ After lunch ☐ _____ Hours after lunch ☐ Before dismissal
☐ Mid-morning ☐ Before P.E. ☐ After P.E. ☐ Other: _____
☐ As needed for signs/symptoms of low or high blood glucose ☐ As needed for signs/symptoms of illness

Student's self-care blood glucose checking skills:

☐ Independently checks own blood glucose
☐ May check blood glucose with supervision
☐ Requires a school nurse or PDA to check blood glucose
☐ Uses a smartphone or other monitoring technology to track blood glucose values

Continuous Glucose Monitor (CGM): ☐ No ☐ Yes Brand/model: _____

Alarms set for: Severe Low: _____ Low: _____ High: _____

Predictive alarm: Low: _____ High: _____ Rate of change: Low: _____ High: _____

Threshold suspend setting: _____

Additional Information for Student with CGM

- Confirm CGM results with a blood glucose meter check before taking action on the sensor blood glucose level.
  If the student has signs or symptoms of hypoglycemia, check fingertip blood glucose level regardless of the CGM
- Insulin injections should be given at least three inches away from the CGM insertion site.
- Do not disconnect from the CGM for sports activities.
- IF the adhesive is peeling, reinforce it with approved medical tape.
- If the CGM becomes dislodged, return everything to the parents/guardians. Do not throw any part away.
- Refer to the manufacturers' instructions on how to use the student's device.

Student's Self-Care CGM Skills	Independent?	
The student troubleshoots alarms and malfunctions.	☐ Yes	☐ No
The student knows what to do and is able to deal with a HIGH alarm.	☐ Yes	☐ No
The student knows what to do and is able to deal with a LOW alarm.	☐ Yes	☐ No
The student can calibrate the CGM.	☐ Yes	☐ No
The student knows what to do when the CGM indicates a rapid trending rise or fall in the blood glucose level.	☐ Yes	☐ No

The student should be escorted to the Health Room if the CGM alarm goes off: ☐ Yes ☐ No

Other instructions for the school health team: _____

Hypoglycemia Treatment

Student's usual symptoms of hypoglycemia (list below): _____

_____

_____

If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than _____ mg/dL, give a quick-acting glucose product equal to _____ grams of carbohydrate.
Recheck blood glucose in 15 minutes and repeat treatment if blood glucose level is less than _____ mg/dL.

Notify parents/guardians if blood glucose is under _____ mg/dL.
Additional Treatment:_____

_____

If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movements):

- Position the student on his or her side to prevent choking
- Give glucagon: ☐ 1 mg ☐ ½ mg ☐ Other (dose): _____
  - Route: ☐ Subcutaneous (SC) ☐ Intramuscular (IM)
  - Site for glucagon injection ☐ Buttocks ☐ Arm ☐ Thigh ☐ Other: _____
- Call 911 (Emergency Medical Services) and the student's parents/guardians.
- Only RN, PDA, parent, or EMS may administer glucagon

Hyperglycemia Treatment

Student's usual symptoms of hyperglycemia (list below): _____

_____

_____

- Check ☐Urine ☐Blood for ketones every ____ hours when blood glucose levels are above ____ mg/dL.
- For blood glucose greater than _____ mg/dL AND at least _____ hours since last insulin dose, give correction dose of insulin (see correction dose orders).
- Notify parents/guardians if blood glucose is over _____ mg/dL.
- For insulin pump users: see Additional Information for Student with Insulin Pump.
- Allow unrestricted access to the bathroom.
- Give extra water and/or non-sugar-containing drinks (not fruit juices): _____ ounces per hour.

Additional treatment for ketones: _____

- Follow physical activity and sports orders. (See Physical Activity and Sports)

If the student has symptoms of a hyperglycemia emergency, call 911 (Emergency Medical Services) and contact the student's parents/guardians and health care provider. Symptoms of a hyperglycemia emergency include: dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy, or depressed level of consciousness.

Insulin Therapy

Insulin delivery device: ☐ Syringe ☐ Insulin pen ☐ Insulin pump

Type of insulin therapy at school: ☐ Adjustable (basal-bolus) insulin ☐ Fixed insulin therapy ☐ No insulin

Name of insulin:_____

Adjustable (Basal-bolus) Insulin Therapy: Carbohydrate Coverage/Correction Dose

- **Carbohydrate Coverage:**
  Insulin-to-carbohydrate ratio:

Breakfast: 1 unit of insulin per _____ grams of carbohydrate

Lunch: 1 unit of insulin per _____ grams of carbohydrate

Snack: 1 unit of insulin per _____ grams of carbohydrate

Carbohydrate Dose Calculation Example
$\frac{\textit{Total Grams of Carbohydrate to be eaten}}{\textit{Insulin-to-Carbohydrate Ratio}} = \_\_\_\_\_ \textit{ Units of Insulin}$

Correction Dose: Blood glucose correction factor (insulin sensitivity factor) = _____ Target blood glucose =_____ mg/dL

Correction Dose Calculation Example
$\frac{\textit{Current Blood Glucose – Target Blood Glucose}}{\textit{Correction Factor}} = \_\_\_\_\_ \textit{ Units of Insulin}$

Correction Dose Scale (use instead of calculation above to determine insulin correction dose):

Blood glucose _____ to _____ mg/dL, give _____ units.

Blood glucose _____ to _____ mg/dL, give _____ units.

Blood glucose _____ to _____ mg/dL, give _____ units.

Blood glucose _____ to _____ mg/dL, give _____ units.

When to Give Insulin:

Breakfast

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.

☐ Other: _____

Lunch

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.

☐ Other: _____

Snack

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.

☐ Other: _____

Insulin Therapy (continued)

Parents/Guardians Authorization to Adjust Insulin Dose

☐ Yes ☐ No	Parents/guardians are authorized to increase or decrease correction dose scale within the following range: +/- _____ units of insulin
☐ Yes ☐ No	Parents/guardians are authorized to increase or decrease insulin-to-carbohydrate ratio within the following range: _____ units per prescribed grams of carbohydrate, +/- _____ grams of carbohydrate.

Student's Self-Care Insulin Administration Skills:

☐ Independently calculates and gives own injections/operates pump.
☐ May calculate/give own injections/operate pump with supervision.
☐ Requires school nurse or PDA to calculate dose and student can give own injection/operate pump with supervision.
☐ Requires school nurse or PDA to calculate dose and give the injection/operate pump.

Additional Information for Student with Insulin Pump

Brand/model of pump: _____ Type of insulin in pump:_____

Basal rates during school: Time: _____ Basal rate: _____ Time: _____ Basal rate: _____

Time: _____ Basal rate: _____ Time: _____ Basal rate: _____

Time: _____ Basal rate: _____ Time: _____ Basal rate: _____

Other pump instructions: _____

_____

Type of infusion set: _____

For blood glucose greater than _____ mg/dL that has not decreased within _____ hours after correction, consider pump failure or infusion site failure. Notify parents/guardians.

Student's Self-Care Pump Skills	Independent?	
Counts carbohydrates	☐ Yes	☐ No
Calculates correct amount of insulin for carbohydrates consumed	☐ Yes	☐ No
Administers correction bolus	☐ Yes	☐ No
Calculates and sets basal profiles	☐ Yes	☐ No
Calculates and sets temporary basal rate	☐ Yes	☐ No
Changes batteries	☐ Yes	☐ No
Disconnects pump	☐ Yes	☐ No
Reconnects pump to infusion set	☐ Yes	☐ No
Prepares reservoir, pod, and/or tubing	☐ Yes	☐ No
Inserts infusion set	☐ Yes	☐ No
Troubleshoots alarms and malfunctions	☐ Yes	☐ No

Other Diabetes Medications

Name: _____ Dose: _____ Route: _____ Times Given: _____

Name: _____ Dose: _____ Route: _____ Times Given: _____

Snack Plan

Meal/Snack	Carbohydrate Content (grams)
Mid-morning snack	_____ to _____
Mid-afternoon snack	_____ to _____

Other times to give snacks and content/amount: _____

_____

Instructions for when food is provided to the class (e.g., as part of a class party)

☐ Student may eat treat ☐ Replace with parent-supplied alternative ☐ Call Parent

☐ Modify the treat _____ ☐ Schedule extra insulin per prearranged plan

☐ Other: _____

Physical Activity, Sports, and Field Trips

A quick-acting source of glucose such as ☐ glucose tabs and/or ☐ sugar-containing juice must be available at the site of physical education activities, sports, and field trips.

Physical Activity and Sports

Student should eat ☐ 15 grams ☐ 30 grams ☐ Other: _____

☐Before P.E. ☐After P.E. ☐Other: _____

If most recent blood glucose is less than _____ mg/dL, student cannot participate in physical activity until blood glucose is corrected and above _____ mg/dL.

Avoid physical activity when blood glucose is greater than _____ mg/dL or if urine/blood ketones are moderate to large.

Field Trips:

All diabetes supplies (extra snacks, glucose monitoring kit, copy of health plan, glucose tabs, and other emergency supplies) must accompany student on field trips. Student will bring their own testing kit and supplies if they are independent. If student is dependent, testing kit and supplies will be brought by the school.

Care will be provided by:

☐ Accompanying parent/guardian ☐ PDA ☐ Other: _____

Disaster Plan

To prepare for an unplanned disaster or emergency (72 hours), obtain emergency supply kit from parents/guardians.

Parent is responsible for providing and maintaining “disaster kit” and to notify school nurse. Use above BG correction scale + carb ratio coverage for disaster insulin dosing every 3-4 hours. If Lantus or Levemir long-acting insulin is available, may administer 80% of their usual dose. If long-acting insulin is not available, may administer rapid-acting insulin every 3-4 hours as indicated by blood glucose levels.

Signatures

This Diabetes Emergency Care Plan/Medical 504 has been approved by:

Student's Physician/Health Care Provider *Date*

PARENT/GUARDIAN CONSENT for 504 Health Care Plan:

- I understand that a 504 meeting with the school nurse must occur. I request to have this meeting: (please initial one) ____ via telephone OR ____ in person, at my child's school

[Office use only: Date of 504 meeting ___/___/___]

- I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I consent for my child to be evaluated for a health care plan/medical 504 plan. I have received a copy of the Notice of Parent/Student Rights under Section 504 (Form 504-1). I agree with this health care plan/medical 504, consent for the placement outlined, and request designated school personnel to follow this plan as it is written. I understand that if I disagree with this plan, I have the right to request a hearing by filing a written request using the 504-7 form. I understand that this health care plan/medical 504, including the medical treatment/medication orders provided, must be renewed and reviewed annually. I understand that my child will be reevaluated every three years to determine if my child continues to qualify for a school health care plan/medical 504.

- I give health services staff permission to communicate with the LHCP's office about any medical treatment/ medication orders that I provide to the school, in accordance with HIPPA/FERPA regulations. I understand the school may share this plan with emergency responders if student requires services.

- If medication is prescribed within this plan, the medication is to be furnished by me in the original container, and BROUGHT TO SCHOOL BY AN ADULT. Prescription medication must be labeled by the pharmacy with the name of the patient, health care provider, medication, dosage, and the time of day to be given. I understand medication may be administered by non-licensed trained designated staff members in accordance with state regulations and district policy. I understand that at the end of the school year, an adult must pick up any mediation, otherwise it will be discarded.

Acknowledged and received by:

Student's Parent/Guardian *Date*

School Nurse *Date*

RICHLAND SCHOOL DISTRICT NOTICE OF PARENT/STUDENT RIGHTS UNDER SECTION 504
(Form 504-1)

The Rehabilitation Act of 1973 ("Act"), commonly referred to as "Section 504," is a non- discrimination statute enacted by the United States Congress. The purpose of the Act is to prohibit discrimination and to assure that disabled students have educational opportunities and benefits equal to those provided to non-disabled students.

This is a notice of your rights under Section 504. This document is not intended to address the rights afforded under the Individuals with Disabilities Education Act ("IDEA") that applies to students eligible for special education services. The Office of the Superintendent of Public Instruction's ("OSPI") Notice of Special Education Procedural Safeguards for Students and Their Families is available through the District's Special Education Department and sets out the rights assured by the IDEA. It is the purpose of this notice to set out the rights assured by Section 504 to those disabled students who have a physical or mental impairment that substantially limits one or more major life activity who do not qualify under the IDEA.

Federal laws and regulations provide parent(s)/guardian(s) and students with the following rights:

1. You have the right to be informed by the District of your rights under Section 504 (the purpose of this notice is to advise you of those rights).

2. You have the right to have your child participate in and benefit from the District's education program without discrimination based on disability.

3. You have the right to receive notice before the District takes any action regarding the identification, evaluation, and/or placement of your child.

4. Your child has a right to an evaluation prior to an initial Section 504 placement and any subsequent significant change in placement. You have the right to refuse consent for the initial evaluation and initial placement of your child.

5. You have the right to have your child receive a free appropriate public education ("FAPE"). This includes your child's right to be educated with non-disabled students to the maximum extent appropriate. It also includes the right to have the District provide related aids and/or services to allow your child an equal opportunity to participate in school activities, educational, and/or related aids and services provided to your child without cost except for those fees imposed on the parent(s)/guardian(s) of non-disabled children.

6. Your child has a right to facilities, services, and/or activities that are comparable to those provided for non-disabled students.

7. You have the right to have evaluation, educational, and/or placement decisions for your child based upon information from a variety of sources, by a group of persons who know your child, your child's evaluation data, and/or placement options.

8. You have the right to have your child be provided an equal opportunity to participate in non-academic and extracurricular activities offered by the District.

9. You have the right to examine your child's education records and obtain a copy of such records. You also have the right to receive a response to reasonable requests for explanations and interpretations of your child's education records.

10. You have the right to request the District to amend your child's education records if you believe that they are inaccurate, misleading, and/or otherwise in violation of the privacy rights of your child. If the District refuses this request, you have the right to challenge such refusal under the Family Educational Rights and Privacy Act ("FERPA").

11. You have the right to request mediation or an impartial hearing with respect to the District's actions regarding your child's identification, evaluation, and/or educational placement with opportunity for parental participation in the hearing and representation by an attorney.

12. If you wish to challenge the actions of the District in regard to your child's identification, evaluation, and/or education placement, you should file a written request for a hearing with Mike Hansen, Student Section 504 Program Coordinator, 615 Snow Ave, Richland, Washington 99352; email to: mike.hansen@rsd.edu using the Request for a Hearing (Form 504-2). A hearing will be scheduled before an impartial hearing officer and you will be notified in writing of the date, time, and place of the hearing.

13. If you disagree with the decision of the impartial hearing officer, you have a right to review that decision by a court of competent jurisdiction. If you prevail in a civil rights action against the District, you have the right to seek the payment of reasonable attorney's fees through the court.

14. You have the right to file a local grievance or complaint with the U.S. Department of Education's Office for Civil Rights or file a complaint in federal court. The address of the Regional Office that covers Richland:

U.S. Department of Education Office of Civil Rights
915 Second Avenue, Room 3310
Seattle, Washington 98174-1099
Phone: (206) 607-1600
Website: www.ed.gov/OCR
Email Address: OCR.seattle@ed.gov