201 Forest Street, Marlborough, MA 01752
OFFICE OF SCHOOL NURSE
Phone 508 597-2475/2473 Medical FAX 508 597-2494

IMPORTANT PLEASE READ

Dear Parents/Guardians

If medication(s) is required for administration for the next school year (8-1-24 to 6-30-25) please remember to follow these steps:
Download the appropriate forms from our website https://www.amsacs.org/

Orders must be written, and are only active, during the current school year. The must be dated after 07-01-2024.

Physicians have their own office forms for medication orders and actions plans (allergy/asthma/diabetic/seizure action). It is the parents responsibility to request these forms from your child's physician. Please remeber we cannot administer medications without those forms.

- **Physicians must provide medication orders that include the name of the medication, form of medication (tablet/capsule/ liquid/injection), frequency, times of administration, diagnosis for which medication is being ordered and any side effects or specific directions/information for administration.**
- **Physicians must provide any action plans. If your child is having medication ordered for allergies/asthma/ diabetes/seizures, then the Physician must supply an Action plan for that specific medication.**
- No order can be accepted that is dated before 07-01-24. Please have the physician date the orders accordingly.
- Remember **only one medication per order form** Please copy or print additional forms from the website if more forms are needed.
- Please review the AMSACS medication administration policy.
- Bring medications to school before the first day of school in original container. You may call the health office **after 08-19-24** to arrange drop off. No student is allowed to carry any medications to school, even over-the-counter medications.
- We have included a check list (on the back of this form) for your convenience. **Please print double sided**.

Thank you and have a healthy, happy safe summer ☺

PARENT MEDICATION CHECK LISTS

Checklist for Required Paperwork for **Epinephrine Orders**

PHYSICIAN TO PROVIDE

1. _____ Physician's Order Form
2. _____ Allergy Action Plans (If your child's MD does not have an action plan, he/she must send a note stating they do not have action plan one and why.

Parent to Complete:

1. _____ Parent's Permission for Epinephrine Administration
2. _____ Parent's Permission for Antihistamine Administration (if applicable)
3. _____ Epinephrine Contract to carry if applicable
4. _____ Antihistamine Contract to carry one dose only (if applicable)
5. _____ Allergy History

Checklist for Required Paperwork for **Metered Dose Inhalers**

PHYSICIAN TO PROVIDE:

1. _____ Physician's Order Form
2. _____ Asthma Action Plans (If your child's MD does not have an action plan he/she must send a note stating they do not have action plan one and why.

Parent to Complete:

1. _____ Parent's Permission for Metered Dose Inhaler Administration
2. _____ Metered Dose Contract to carry
3. _____ Asthma History

Checklist for Required Paperwork **for Other (prescription/Over the Counter) Medications (Daily/PRN)**

PHYSICIAN TO PROVIDE

1. _____ Physician's Order Form
2. _____ Physicians Action plan, if applicable for Diabetic/Seizure Medications Only

Parent to Complete:

1. _____ Parent Consent Form(s). (Insulin, glucagon, seizure medication(s) etc)
2. _____ Contracts to carry diabetic/seizure (Insulin, glucagon, diabetic supplies, seizure medications, etc.)

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PARENT/GUARDIAN CONSENT FOR INSULIN MEDICATION ADMINISTRATION 2024-25

Name of Student _____ Date of Birth: _____Grade 6 7 8 9 10 11 12

My child is currently receiving the following medications:(please list all medications the child is receiving, including those given during the school day.)

1. _____ 2._____ 3._____4. _____

My son/daughter has the following food or drug allergies: _____

* * * * * * * * * * * * * * * * * *

Consent

1. I consent to have the school nurse(s) administer the medication:
   _____
   (Name of Medication)

2. I give permission for my child to self-administer medication, if the school nurse determines it is safe and appropriate (check one) _____ yes _____ no

3. I give permission to the school nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.

4. I agree to provide unexpired medications in the original, properly dated and labeled container. I will keep a dosage count and record of expiration date at home and will deliver refills as needed. I will promptly pick up any unused medications. I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or on the last day of this school year.

5. How do you want to handle medication administration during times when your child is attending a field trip?
   - My child needs this medication on field trips □ Yes □ No
   - When there is not a nurse on the field trip, do you want to be notified? (check student's 504 for a nurse to attend a field trip if a parent cannot attend) □ Yes □ No
   - When there is not a nurse on the field trip, a parent will attend the Field Trip to administer the medication □ Yes □ No
   - My child has a Contract to carry and self-administer diabetic medication/supplies. □ Yes No
6. Please be aware that there is not availability for medication administration during afterschool events (sports/clubs, etc.)

_____ _____ _____
Parent/Guardian Signature **Relationship to student** **Date**

FOR HEALTH OFFICE USE ONLY

Possible Side effects and Required Storage Conditions: See attached form(s) Name of Medication: _____
Date. received _____ amount _____delivered by _____ expires on: ____/____/____

Location where medication administration will occur: ☐ Health Office ☐ Other (specify): _____
Notes/Information

Disposition of Medication: ☐ Finished ☐ Returned to parent/guardian ☐ Given to Student ☐ Disposed- Witness_____
Date_____

PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION 2024-25

Name of Student _____ Date of Birth: _____Grade 6 7 8 9 10 11 12

My child is currently receiving the following medications:(please list all medications the child is receiving, including those given during the school day.)

1. _____ 2._____ 3._____4. _____

My son/daughter has the following food or drug allergies: _____

* * * * * * * * * * * * * * * * * *

Consent

1. I consent to have the school nurse(s) or his/her delegate administer the medication: **Insulin**
   Type:_____
   (Name of medication)
2. I give permission for my child to self-administer medication, if the school nurse determines it is safe and appropriate (check one) _____ yes _____ no
3. I give permission to the school nurse(s) to share information relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.
4. I agree to provide unexpired medications in the original, properly dated and labeled container. I will keep a dosage count and record of expiration date at home and will deliver refills as needed. I will promptly pick up any unused medications. I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or on the last day of this school year.
5. How do you want to handle medication administration during times when your child is attending a field trip? Please be aware that school nurses are not always on field trips.

- My child needs this medication on field trips ☐ Yes ☐ No
- When there is not a nurse on the field trip, do you want to be notified? (check student's 504 for a nurse to attend a field trip if a parent cannot attend) □ Yes □ No
- When there is not a nurse on the field trip, a parent will attend the Field Trip to administer the medication ☐ Yes ☐ No
- My child has a Contract to carry and self-administer diabetic medication/supplies. ☐ Yes No

6. Please be aware that there is not availability for medication administration during afterschool events (sports/clubs, etc.)

_____ _____ _____

Parent/Guardian Signature **Relationship to student** **Date**

FOR HEALTH OFFICE USE ONLY

Possible Side effects and Required Storage Conditions: See attached form(s) Name of Medication: _____
Date. received _____ amount _____delivered by _____ expires on: ____/____/____

Location where medication administration will occur: ☐ Health Office ☐ Other (specify): _____
Notes/Information:

Disposition of Medication: ☐ Finished ☐ Returned to parent/guardian ☐ Given to Student ☐ Disposed- Witness_____
Date:_____

PARENT/GUARDIAN CONSENT FOR GLUCAGON/BAQSIMI MEDICATION ADMINISTRATION 2024-25

Name of Student _____ Date of Birth: _____Grade 6 7 8 9 10 11 12

My child is currently receiving the following medications:(please list all medications the child is receiving, including those given during the school day.)

1. _____ 2._____ 3._____4. _____

My son/daughter has the following food or drug allergies: _____

* * * * * * * * * * * * * * * * * *

Consent

1. I consent to have the school nurse or his/her delegate administer the medication:
   Type:_____
   (Name of medication)
2. I give permission for my child to self-administer medication, if the school nurse determines it is safe and appropriate (check one) _____ yes _____ no
3. I give permission to the school nurse(s) to share information relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.
4. I agree to provide unexpired medications in the original, properly dated and labeled container. I will keep a dosage count and record of expiration date at home and will deliver refills as needed. I will promptly pick up any unused medications. I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or on the last day of this school year.
5. How do you want to handle medication administration during times when your child is attending a field trip? Please be aware that school nurses are not always on field trips.

- My child needs this medication on field trips □ Yes □ No
- When there is not a nurse on the field trip, do you want to be notified? (check student's 504 for a nurse to attend a field trip if a parent cannot attend) □ Yes □ No
- When there is not a nurse on the field trip, a parent will attend the Field Trip to administer the medication □ Yes □ No
- My child has a Contract to carry and self-administer diabetic medication/supplies. □ Yes No

6. Please be aware that there is not availability for medication administration during afterschool events (sports/clubs, etc.)

_____ _____ _____

Parent/Guardian Signature **Relationship to student** **Date**

FOR HEALTH OFFICE USE ONLY

Possible Side effects and Required Storage Conditions: See attached form(s) Name of Medication: _____
Date. received _____ amount _____delivered by _____ expires on: ____/____/____

Location where medication administration will occur: ☐ Health Office ☐ Other (specify): _____
Notes/Information:

Disposition of Medication: ☐ Finished ☐ Returned to parent/guardian ☐ Given to Student ☐ Disposed- Witness_____
Date_____

Contract for Permission to Carry & Self Administer Insulin(via pump daily) 2024-25

Name of Student: _____ Date: _____ Grade: _____

To be completed by the Parent/Guardian:
Qualified students will be allowed to carry their diabetic medications and supplies with them in school and on field trips at the discretion of the school nurse. Parents only need to sign the agreement. Please sign at the bottom of this form below and return to the health

office. The school nurse and your child will complete the rest of the form. Please contact the School Nurse(s) if there are any changes to your child's medication and/or treatment plan during the school year.

I request that my child be permitted to carry on his/her person the diabetic medication/supplies that has been prescribed. My child has been instructed in and understands the purpose, appropriate method, frequency and use of his/her diabetic medication/supplies. My child understands that he/she is responsible and accountable for carrying and using his/her diabetic medication/supplies. My child understands that he/she will be responsible for carrying and self-administering theses medication/diabetic supplies while on field trips. It is understood that if there is irresponsible behavior or safety risk, the privilege of carrying his/her medication/diabetic supplies will be rescinded. I will support my child in following the agreement.

Parent/Guardian Signature: Date:

CONTRACT AGREEMENT: ☐ Always (in school, FT, and ASA) ☐ Field Trips & After Sch. Act. Only
☐ Pre-Physical Education Administration ☐ Other(lunch): _____

To be completed by School Nurse and Student		
Physicians order for Diabetic medication is on file in the Health Office	Yes ☐	No ☐
Student is consistently able to name and identify the correct medication, knows the correct dosage, and can explain the purpose of the medication/supplies and when it(they) is to be taken.	Yes ☐	No ☐
Student can explain the proper storage requirements of his/her medication/supplies and agrees to follow those medication storage requirements	Yes ☐	No ☐
Student demonstrates safe and correct use /administration of medication/supplies.	Yes ☐	No ☐
Student agrees to maintain a backup diabetic medication and supplies in the health office & classrooms.	Yes ☐	No ☐
Student realizes his/her responsibility in carrying his/her own medication(s) and agrees ***NEVER*** share the medication(s)/supplies with others.	Yes ☐	No ☐
Presence of a nurse on a field trip/after school event is not guaranteed. Student agrees to be responsible to provide and carry his/her own medication/supplies on field trips/after school events. If student forgets to bring his/her medication/supplies and there is no backup in H.O. and/or no nurse on the field trip parents will need to approve attendance.	Yes ☐	No ☐
Student agrees that after administering medication on field trips he/she will immediately inform a nurse/faculty member/chaperone.	Yes ☐	No ☐
Student agrees that after administering diabetic medication, if there is not marked improvement, he/she will immediately see the School Nurse or seek medical attention	Yes ☐	No ☐
Student agrees to immediately notify the school nurse when treating for hyper/hypoglycemia levels above the target blood glucose set by their physicians or if there are insulin pump issues.	Yes ☐	No ☐
The student agrees to immediately notify school nurse/chaperone with any questions, concerns, or adverse side effects.	Yes ☐	No ☐

Expiration date on Insulin Medication in H.O. _____ Expiration date Insulin Medication student is carrying is _____
Expiration date on Glucagon/Baqsimi Medication in H.O. _____Expiration date Glucagon/Baqsimi Medication student is carrying is _____

I give permission to notify staff of my plan of self-administration. I understand that if I do not follow the plan of self-administration according to guidelines stated above, or misuse my medication in any way, this agreement will be immediately terminated. Written notification of termination will be sent by nurse to my parents and teachers within 24 hours.

Student Signature: Date:

This student ☐ does ☐ does not demonstrate the required responsibilities.
This student ☐ may ☐ may not carry/self-administer the diabetic medication/supplies.

Nurse Signature: Date:

Contract for Permission to Carry & Self Administer Glucagon/Baqsimi 2024-25

Name of Student: _____ Date: _____ Grade: _____

To be completed by the Parent/Guardian:

Qualified students will be allowed to carry their diabetic medications and supplies with them in school and on field trips at the discretion of the school nurse. Parents only need to sign the agreement. Please sign at the bottom of this form below and return to the health office. The school nurse and your child will complete the rest of the form. Please contact the School Nurse if there are any changes to your child's medication and/or treatment plan during the school year.

I request that my child be permitted to carry on his/her person the diabetic medication/supplies that has been prescribed. My child has been instructed in and understands the purpose, appropriate method, frequency and use of his/her diabetic medication/supplies. My child understands that he/she is responsible and accountable for carrying and using his/her diabetic medication/supplies. My child understands that he/she will be responsible for carrying and self-administering theses medication/diabetic supplies while at school/at a school event/on field trips. It is understood that if there is irresponsible behavior or safety risk, the privilege of carrying his/her medication/diabetic supplies will be rescinded. I will support my child in following the agreement.

Parent/Guardian Signature: Date:

CONTRACT AGREEMENT: ☐ Always (in school, FT, and ASA) ☐ Field Trips & After Sch. Act. Only
☐ Pre-Physical Education Administration ☐ Other(lunch): _____

To be completed by School Nurse and Student		
Physicians order for Diabetic medication is on file in the Health Office	Yes ☐	No ☐
Student is consistently able to name and identify the correct medication, knows the correct dosage, and can explain the purpose of the medication/supplies and when it(they) is to be taken.	Yes ☐	No ☐
Student can explain the proper storage requirements of his/her medication/supplies and agrees to follow those medication storage requirements	Yes ☐	No ☐
Student demonstrates safe and correct use /administration of medication/supplies.	Yes ☐	No ☐
Student agrees to maintain a backup diabetic medication and supplies in the health office & classrooms.	Yes ☐	No ☐
Student realizes his/her responsibility in carrying his/her own medication(s) and agrees ***NEVER*** share the medication(s)/supplies with others.	Yes ☐	No ☐
Presence of a nurse on a field trip/after school event is not guaranteed. Student agrees to be responsible to provide and carry his/her own medication/supplies on field trips/after school events. If student forgets to bring his/her medication/supplies and there is no backup in H.O. and/or no nurse on the field trip/event parents will need to approve attendance.	Yes ☐	No ☐
Student agrees that after administering medication on field trips he/she will immediately inform a nurse/ faculty member/chaperone.	Yes ☐	No ☐
Student agrees that after administering diabetic medication, if there is not marked improvement, he/she will immediately see the School Nurse or seek medical attention	Yes ☐	No ☐
Student agrees to immediately notify the school nurse when treating for hyper/hypoglycemia levels above the target blood glucose set by their physicians or if there are insulin pump issues.	Yes ☐	No ☐
The student agrees to immediately notify school nurse/chaperone with any questions, concerns, or adverse side effects.	Yes ☐	No ☐

Expiration date on Insulin Medication in H.O. _____ Expiration date Insulin Medication student is carrying is _____
Expiration date on Glucagon/Baqsimi Medication in H.O. _____Expiration date Glucagon/Baqsimi Medication student is carrying is _____

I give permission to notify staff of my plan of self-administration. I understand that if I do not follow the plan of self-administration according to guidelines stated above, or misuse my medication in any way, this agreement will be immediately terminated. Written notification of termination will be sent by nurse to my parents and teachers within 24 hours.

Student Signature: Date:

This student ☐ does ☐ does not demonstrate the required responsibilities.
This student ☐ may ☐ may not carry/self-administer the diabetic medication/supplies.

Nurse Signature: Date:

Contract for Permission to Carry & Self Administer Diabetic Medications/Supplies 2024-25

Name of Student: _____ Date: _____ Grade: _____

To be completed by the Parent/Guardian:

Qualified students will be allowed to carry their diabetic medications and supplies with them in school and on field trips at the discretion of the school nurse. Parents only need to sign the agreement. Please sign at the bottom of this form below and return to the health office. The school nurse and your child will complete the rest of the form. Please contact the School Nurse if there are any changes to your child's medication and/or treatment plan during the school year.

I request that my child be permitted to carry on his/her person the diabetic medication/supplies that has been prescribed. My child has been instructed in and understands the purpose, appropriate method, frequency and use of his/her diabetic medication/supplies. My child understands that he/she is responsible and accountable for carrying and using his/her diabetic medication/supplies. My child understands

that he/she will be responsible for carrying and self-administering theses medication/diabetic supplies while on field trips. It is understood that if there is irresponsible behavior or safety risk, the privilege of carrying his/her medication/diabetic supplies will be rescinded. I will support my child in following the agreement.

Parent/Guardian Signature: Date:

CONTRACT AGREEMENT: ☐ Always (in school, FT, and ASA) ☐ Field Trips & After Sch. Act. Only
☐ Pre-Physical Education Administration ☐ Other (lunch): _____

To be completed by School Nurse and Student		
Physicians order for Diabetic medication is on file in the Health Office	Yes ☐	No ☐
Student is consistently able to name and identify the correct medication, knows the correct dosage, and can explain the purpose of the medication/supplies and when it(they) is to be taken.	Yes ☐	No ☐
Student can explain the proper storage requirements of his/her medication/supplies and agrees to follow those medication storage requirements	Yes ☐	No ☐
Student demonstrates safe and correct use /administration of medication/supplies.	Yes ☐	No ☐
Student agrees to maintain a backup diabetic medication and supplies in the health office & classrooms.	Yes ☐	No ☐
Student realizes his/her responsibility in carrying his/her own medication(s) and agrees ***NEVER*** share the medication(s)/supplies with others.	Yes ☐	No ☐
Presence of a nurse on a field trip/after school event is not guaranteed. Student agrees to be responsible to provide and carry his/her own medication/supplies on field trips/afterschool events. If student forgets to bring his/her medication/supplies and there is no backup in H.O. and/or no nurse on the field trip parents will need to approve attendance.	Yes ☐	No ☐
Student agrees that after administering medication on field trips he/she will immediately inform a nurse/ faculty member/chaperone.	Yes ☐	No ☐
Student agrees that after administering diabetic medication, if there is not marked improvement, he/she will immediately see the School Nurse or seek medical attention	Yes ☐	No ☐
Student agrees to immediately notify the school nurse when treating for hyper/hypoglycemia levels above the target blood glucose set by their physicians or if there are insulin pump issues.	Yes ☐	No ☐
The student agrees to immediately notify school nurse/chaperone with any questions, concerns, or adverse side effects.	Yes ☐	No ☐

Expiration date on Insulin Medication in H.O. _____ Expiration date Insulin Medication student is carrying is _____
Expiration date on Glucagon/Baqsimi Medication in H.O. _____ Expiration date Glucagon Medication student is carrying is _____

I give permission to notify staff of my plan of self-administration. I understand that if I do not follow the plan of self-administration according to guidelines stated above, or misuse my medication in any way, this agreement will be immediately terminated. Written notification of termination will be sent by nurse to my parents and teachers within 24 hours.

Student Signature: Date:

This student ☐ does ☐ does not demonstrate the required responsibilities.
This student ☐ may ☐ may not carry/self-administer the diabetic medication/supplies.

Nurse Signature: Date:

DIABETIC SUPPLIES 2024-25

TO BE COMPLETED BY SCHOOL NURSE ONLY

	Name of Diabetic Supply	Amount received for HO	Expiration date of item in HO	Amount student is carrying	Expiration Date of item student is carrying	Comments
1.						
2.						

3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						

201 Forest Street, Marlborough, MA 01752
OFFICE OF LOWER SCHOOL NURSE Phone 508 597-2473 – Medical FAX 508 597-2494
OFFICE OF UPPER SCHOOL NURSE Phone 508 597-2475 – Medical FAX 508 597-2494

Nurse Care Plan: Diabetes Medical Management 2024-25

This plan should be completed by the student's personal health care team and parents/guardian. It should be reviewed with relevant school staff and copies should be kept in a place that is easily accessed by the school nurse, trained diabetes personnel, and other authorized personnel.

Date of Plan: _____

Effective Dates: _____

Student's Name: _____

Date of Birth: _____ Date of Diabetes Diagnosis: _____

Grade: _____ Homeroom Teacher: _____

Physical Condition: ☐ Diabetes type 1 ☐ Diabetes type 2

Contact Information

Mother/Guardian: _____

Address: _____

_____

Telephone: Home _____ Work _____ Cell_____

Father/Guardian: _____

Address: _____

_____

Telephone: Home _____ Work _____ Cell _____

Student's Doctor/Health Care Provider:

Name: _____

Address: _____

Telephone: _____ Emergency Number: _____

Other Emergency Contacts:

Name: _____

Relationship: _____

Telephone: Home _____ Work _____ Cell _____

Notify parents/guardian or emergency contact in the following situations: _____

Blood Glucose Monitoring

Target range for blood glucose is 70-150 70-180 other _____

Usual times to check blood glucose _____

Times to do extra blood glucose checks (*check all that apply*)

Before exercise

After exercise

When student exhibits symptoms of hyperglycemia

When student exhibits symptoms of hypoglycemia

Other (explain): _____

Can student perform own blood glucose checks? Yes No

Exceptions: _____

_____

Type of blood glucose meter student uses: _____

_____

Insulin

Usual Lunchtime Dose

Base dose of Humalog/Novolog /Regular insulin at lunch (circle type of rapid-/short-acting insulin used) is _____ units or does flexible dosing using _____ units/ _____ grams carbohydrate.

Use of other insulin at lunch: (circle type of insulin used): intermediate/NPH/lente _____ units or basal/Lantus/Ultralente _____ units.

Insulin Correction Doses

Parental authorization should be obtained before administering a correction dose for high blood

glucose levels. Yes No

_____ units if blood glucose is _____ to _____ mg/dl

_____ units if blood glucose is _____ to _____ mg/dl

_____ units if blood glucose is _____ to _____ mg/dl

_____ units if blood glucose is _____ to _____ mg/dl

_____ units if blood glucose is _____ to _____ mg/dl

Can student give own injections? Yes No

Can student determine correct amount of insulin? Yes No

Can student draw correct dose of insulin? Yes No

_____ Parents are authorized to adjust the insulin dosage under the following circumstances:

_____

_____

For Students with Insulin Pumps

Type of pump: _____ Basal rates: _____ 12 am to _____

_____ _____ to _____

_____ _____ to _____

Type of insulin in pump: _____

Type of infusion set: _____

Insulin/carbohydrate ratio: _____ Correction factor: _____

Student Pump Abilities/Skills: ***Needs Assistance***

Count carbohydrates	☐ Yes	☐ No
Bolus correct amount for carbohydrates consumed	☐ Yes	☐ No
Calculate and administer corrective bolus	☐ Yes	☐ No
Calculate and set basal profiles	☐ Yes	☐ No
Calculate and set temporary basal rate	☐ Yes	☐ No
Disconnect pump	☐ Yes	☐ No
Reconnect pump at infusion set	☐ Yes	☐ No
Prepare reservoir and tubing	☐ Yes	☐ No
Insert infusion set	☐ Yes	☐ No
Troubleshoot alarms and malfunctions	☐ Yes	☐ No

For Students Taking Oral Diabetes Medications

Type of medication: _____ Timing: _____

Other medications: _____ Timing: _____

Meals and Snacks Eaten at School

Is the student independent in carbohydrate calculations and management? Yes No

Meal/Snack Time Food content/amount

Breakfast _____ _____

Mid-morning snack _____ _____

Lunch _____ _____

Mid-afternoon snack _____ _____

Dinner _____ _____

Snack before exercise? ☐ Yes ☐ No Snack after exercise? ☐ Yes ☐ No

Other times to give snacks and content/amount:

_____

Preferred snack foods: _____

Foods to avoid, if any: _____

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

_____

_____

Exercise and Sports

A fast-acting carbohydrate such as _____ should be available at the site of exercise or sports.

Restrictions on activity, if any: _____ student should not exercise if blood glucose level is below _____ mg/dl or above _____ mg/dl or if moderate to large urine ketones are present.

Hypoglycemia (Low Blood Sugar)

Usual symptoms of hypoglycemia: _____

_____

Treatment of hypoglycemia:_____

_____

Glucagon/Baqsimi should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow.

Route _____, Dosage _____, site for glucagon injection: _____arm, _____thigh, _____other(Nasal).

If glucagon is required, administer it promptly. Then, call 911 (or another emergency assistance) and the parents/guardian.

Hyperglycemia (High Blood Sugar)

Usual symptoms of hyperglycemia: _____

_____

Treatment of hyperglycemia: _____

_____

Urine should be checked for ketones when blood glucose levels are above _____ mg/dl.

Treatment for ketones: _____

_____

Supplies to be kept at School

_____Blood glucose meter, blood glucose test strips, batteries for meter

_____ Lancet device, lancets, gloves, etc.

_____Urine ketone strips

_____Insulin pump and supplies

_____Insulin pen, pen needles, insulin cartridges

_____Fast-acting source of glucose

_____Carbohydrate containing snack

_____Glucagon emergency kit

_____ Other: List here: _____

Signatures

This Diabetes Medical Management Plan has been approved by:

_____ _____

Student's Physician/Health Care Provider Date

I give permission to the school nurse(s), trained diabetes personnel, and other designated staff members of Advanced Math and Science Academy Charter School to perform and carry out the diabetes care tasks as outlined by _____'s Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

Acknowledged and received by:

_____ _____

Student's Parent/Guardian Date

_____ _____

Student's Parent/Guardian Date