

IMPORTANT PLEASE READ

Dear Parents/Guardians

If medication(s) is required for administration for next school year (08-23 to 06-24) please remember to follow these important steps:

Download the appropriate forms from our website. Parents will be able to download the forms from our website, <https://www.amsacs.org/>, as of June 30, 2023. (Click Parents-Health Office-Medical Forms).

- Orders must be written, and are only active, during the current school year. (Need to be dated after 07-01-23)

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 remember 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 07-01-23. 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 08-25-23** 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 ☺

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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 (Only if your child is entering grade 06 or 09, or entering AMSACS for the first time regardless of grade)

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 (Only if your child is entering grade 06 or 09, or entering AMSACS for the first time regardless of grade)

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.)



PARENT/GUARDIAN CONSENT FOR INSULIN MEDICATION ADMINISTRATION 23-24

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:

_____ (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? 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? 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 _____ Date: _____ Date: _____ Date: _____



PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION 23-24

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

7. I consent to have the school nurse or his/her delegate administer the medication: Insulin

_____ (Name of medication)

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

9. 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.

10. 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.

11. 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? 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

12. 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 _____



PARENT/GUARDIAN CONSENT FOR GLUCAGON MEDICATION ADMINISTRATION 23-24

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

13. I consent to have the school nurse or his/her delegate administer the medication: Insulin

_____ (Name of medication)

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

15. 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.

16. 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.

17. 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? 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

18. 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 _____ Date: _____ Date: _____ Date: _____ Date: _____
Date _____ Date: _____ Date: _____ Date: _____

Contract for Permission to Carry & Self Administer Insulin 2023-24

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 these 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: _____

To be completed by School Nurse and Student

Physicians order for Diabetic medication is on file in the Health Office	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
Student can explain the proper storage requirements of his/her medication/supplies and agrees to follow those medication storage requirements	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student demonstrates safe and correct use /administration of medication/supplies.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student agrees to maintain a backup diabetic medication and supplies in the health office & classrooms.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student realizes his/her responsibility in carrying his/her own medication(s) and agrees NEVER share the medication(s)/supplies with others.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Presence of a nurse on a field trip is not guaranteed. Student agrees to be responsible to <u>provide and carry his/her own medication/supplies on field trips/events</u> . 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 <input type="checkbox"/>	No <input type="checkbox"/>
Student agrees that after administering medication on field trips he/she will immediately inform a faculty member/chaperone.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
The student agrees to immediately notify school nurse/chaperone with any questions, concerns, or adverse side effects.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
The student understands that the privilege of carrying and administering his/her own medication(s) and diabetic supplies will be rescinded if he/she does not follow the above agreement.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Expiration date on Insulin Medication in H.O. _____ Expiration date Insulin Medication student is carrying is _____		
Expiration date on Glucagon Medication in H.O. _____ Expiration date Glucagon Medication student is carrying is _____		
Student agrees to carry only the amount of medications required. Amount of medication student can carry		

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 2023-24

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 these 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: _____

To be completed by School Nurse and Student

Physicians order for Diabetic medication is on file in the Health Office	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
Student can explain the proper storage requirements of his/her medication/supplies and agrees to follow those medication storage requirements	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student demonstrates safe and correct use /administration of medication/supplies.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student agrees to maintain a backup diabetic medication and supplies in the health office & classrooms.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student realizes his/her responsibility in carrying his/her own medication(s) and agrees NEVER share the medication(s)/supplies with others.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Presence of a nurse on a field trip is not guaranteed. Student agrees to be responsible to <u>provide and carry his/her own medication/supplies on field trips/events</u> . 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 <input type="checkbox"/>	No <input type="checkbox"/>
Student agrees that after administering medication on field trips he/she will immediately inform a faculty member/chaperone.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
The student agrees to immediately notify school nurse/chaperone with any questions, concerns, or adverse side effects.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
The student understands that the privilege of carrying and administering his/her own medication(s) and diabetic supplies will be rescinded if he/she does not follow the above agreement.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Expiration date on Insulin Medication in H.O. _____ Expiration date Insulin Medication student is carrying is _____		
Expiration date on Glucagon Medication in H.O. _____ Expiration date Glucagon Medication student is carrying is _____		
Student agrees to carry only the amount of medications required. Amount of medication student can carry		

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 2023-24

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 these 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: _____

To be completed by School Nurse and Student

Physicians order for Diabetic medication is on file in the Health Office	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
Student can explain the proper storage requirements of his/her medication/supplies and agrees to follow those medication storage requirements	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student demonstrates safe and correct use /administration of medication/supplies.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student agrees to maintain a backup diabetic medication and supplies in the health office & classrooms.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student realizes his/her responsibility in carrying his/her own medication(s) and agrees NEVER share the medication(s)/supplies with others.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Presence of a nurse on a field trip is not guaranteed. Student agrees to be responsible to <u>provide and carry his/her own medication/supplies on field trips/events</u> . 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 <input type="checkbox"/>	No <input type="checkbox"/>
Student agrees that after administering medication on field trips he/she will immediately inform a faculty member/chaperone.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
The student agrees to immediately notify school nurse/chaperone with any questions, concerns, or adverse side effects.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
The student understands that the privilege of carrying and administering his/her own medication(s) and diabetic supplies will be rescinded if he/she does not follow the above agreement.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Expiration date on Insulin Medication in H.O. _____ Expiration date Insulin Medication student is carrying is _____		
Expiration date on Glucagon Medication in H.O. _____ Expiration date Glucagon Medication student is carrying is _____		
Student agrees to carry only the amount of medications required. Amount of medication student can carry		

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

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.						
18.						



Diabetes Medical Management Plan 23-24

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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bolus correct amount for carbohydrates consumed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculate and administer corrective bolus	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculate and set basal profiles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculate and set temporary basal rate	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Disconnect pump	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reconnect pump at infusion set	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prepare reservoir and tubing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Insert infusion set	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Troubleshoot alarms and malfunctions	<input type="checkbox"/> Yes	<input type="checkbox"/> No

For Students Taking Oral Diabetes Medications

Type of medication: _____ Timing: _____

Other medications: _____ Timing: _____

Meals and Snacks Eaten at School

Is 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 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.

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, 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