Simi Valley Schools
SIMI VALLEY UNIFIED SCHOOL DISTRICT
Sean Goldman,
Assistant Superintendent,
Student Support Services

Board of Education
Sofya Bagdasaryan, President
Bob LaBelle, Clerk
Kareem Jubran
Kristina Pine
Dawn Smollen

Dear Parent:

The health and safety of our students are of the utmost importance to us. Our records indicate that your student has Type 1 diabetes. We have enclosed the paperwork needed provide the best possible care for your student while at school.

To ensure the health and safety of your student, we require the following **forms and supplies to be brought to school before the first day of school**. The school office will be open on August 1st. By law, we must have doctor's orders before the nurse or child can administer insulin at school. (California Education Code, Section 49423).

Please ask their doctor to complete the paperwork, over summer break, before school starts. Some doctors have their own forms for diabetic care at school, which are accepted. In this event, please have the doctor review our form to ensure they include all the information we need.

Required Forms:

- ☐ Physician's Authorization for Diabetes Care at School/Management Plan
- ☐ Medication form for Fast Acting Insulin
- ☐ Medication form for Long Acting Insulin (for disaster purposes)
- ☐ Medication form for Glucagon

Supplies: (should be in a closed box with name on it)

- ☐ Glucometer, test strips (office & class-recommended)
- ☐ alcohol swabs
- ☐ Lancing device(office & class-recommended)
- ☐ Lancets (office & class-recommended)
- ☐ Syringes/ Insulin pen needles
- ☐ Insulin: Fast Acting (vial or cartridge)
- ☐ Insulin: Fast Acting (Extra sealed-disaster supply)
- ☐ Insulin: Long Acting (Extra sealed-disaster supply)
- ☐ Glucagon
- ☐ Insulin pump supplies (recommended)
- ☐ Fast-acting source of glucose (office & class)
- ☐ Carbohydrate/protein snacks (office & class)
- ☐ Non-Carb snacks (when BG is >____ -recommended)
- ☐ Batteries (pump & meter)
- ☐ Urine ketone strips (sealed, new container)
- ☐ Other:_____
- ☐ Other:_____

We look forward to working with you and your student to make it a safe, healthy, and rewarding year. Have a fun and restful summer. We will see you in August.

Sincerely,

Your School Nurse

101 W. Cochran Street ▪ Simi Valley, CA 93065 ▪ Telephone: 805-306-4500 Ext. 4302 ▪ Fax: 805-520-6586 ▪ sean.goldman@simivalleyusd.org

SimiValleySchools
SIMI VALLEY UNIFIED SCHOOL DISTRICT
Sean Goldman,
Superintendente Adjunto,
Servicios de Apoyo al Estudiante

Junta Directiva de Educación
Sofya Bagdasaryan, President
Bob LaBelle, Clerk
Kareem Jubran
Kristina Pine
Dawn Smollen

Estimado Padre de Familia:

La salud y seguridad de nuestros estudiantes son de extrema importancia para nosotros. Nuestros expedientes indican que su estudiante tiene diabetes tipo 1, por lo que hemos incluido los documentos necesarios para proporcionarle a su estudiante el mejor cuidado posible mientras este en la escuela.

Para asegurar la salud y seguridad de su estudiante, requerimos que los siguientes **formularios y suministros sean traídos a la escuela antes del primer día de clases.** La oficina de la escuela estará abierta el 1ero de agosto. Por ley, debemos tener físicamente órdenes del médico antes de que la enfermera o menor puedan administrar insulina en la escuela. (Código de Educación de California, sección 49423).

Por favor solicite al médico de su menor que complete los formularios durante el descanso de verano, antes de que inicie la escuela. Algunos médicos tienen sus propios formularios para cuidado diabético en la escuela, los cuales son aceptados. Si este es el caso, por favor pídale a su médico revise nuestro formulario para asegurarse de incluir toda la información que necesitamos.

Formularios requeridos:

- ☐ Autorización médica para cuidado de la diabetes en la escuela/Physician's Authorization for Diabetes Care at School/Management Plan
- ☐ Autorización médica para tomar medicina durante el horario escolar/Authorization for Medication Taken During School Hours Form

Suministros: (deben venir en caja cerrada con el nombre impreso)

- ☐ Glucómetro, tirillas reactivas (recomendamos tener en oficina y salón)
- ☐ toallitas de alcohol
- ☐ Dispositivo de punción (recomendamos tener en oficina y salón)
- ☐ Lancetas (recomendamos tener en oficina y salón)
- ☐ Jeringas/ Agujas para plumas de insulina
- ☐ Insulina: Acción rápida (vial o cartucho)
- ☐ Insulina: Acción rápida (Sellado extra-en caso de desastres)
- ☐ Insulina: Acción prolongada (Sellado extra-en caso de desastres)
- ☐ Glucagón
- ☐ Suministros de bomba de insulina (recomendado)
- ☐ Fuente de glucosa de acción rápida (oficina y clase)
- ☐ Bocadillos de carbohidratos/proteínas (oficina y clase)
- ☐ Bocadillos sin carbohidratos (cuando el nivel de glucosa en la sangre está a >____ - recomendado)
- ☐ Pilas (bomba y glucómetro)
- ☐ Tirillas de cetona en la orina (selladas, contenedor nuevo)
- ☐ Otro:_____
- ☐ Otro:_____

Esperamos trabajar con usted y su estudiante para que sea un año seguro, sano y remunerador. Tenga un verano divertido y relajante. Nos vemos en agosto.
Atentamente,

Enfermera escolar

101 W. Cochran Street ▪ Simi Valley, CA 93065 ▪ Telephone: 805-306-4500 Ext. 4302 ▪ Fax: 805-520-6586 ▪ sean.goldman@simivalleyusd.org

Simi Valley Schools
SIMI VALLEY UNIFIED SCHOOL DISTRICT

School Year:_____
Grade:_____
Teacher:_____
P.E Days.: M / T / W / Th / F
Times:_____

Physician's Authorization for Diabetes Care at School/Management Plan

DEMOGRAPHICS

Date:_____(valid for the current school year) School:_____ ☐ Type 1 ☐ Type 2
Student Name:_____ DOB:_____ Date of Diagnosis:_____
Medical Conditions/Current Medications that may affect diabetes care: ☐ Food Allergies ☐Celiac Disease ☐Medications
Parent/Legal Guardian:_____Hm:_____Cell:_____Wk:_____
Parent/ Legal Guardian:_____Hm:_____Cell:_____Wk_____
Notify for the following situations: ☐ Mother ☐ Father ☐ Guardian ☐ Other:_____(# in order of who to contact 1st)
☐ BG <_____☐ BG >_____☐ Ketones: >_____☐ Other:_____

COMPETENCY

Independent self-management (Ind): Student is capable of performing tasks without adult supervision or assistance
Self-management with supervision (Supv): Designated trained adult personnel will observe and assist with tasks identified
Total care (Total): Designated trained adult personnel to perform ALL aspects of the tasks identified

Blood glucose testing	☐ Ind ☐ Supv ☐ Total	Give insulin by insulin pen	☐ Ind ☐ Supv ☐ Total
Carbohydrate counting	☐ Ind ☐ Supv ☐ Total	Give insulin by insulin pump	☐ Ind ☐ Supv ☐ Total
Give insulin by injection	☐ Ind ☐ Supv ☐ Total	Ketone testing	☐ Ind ☐ Supv ☐ Total
Hypoglycemia*	☐ Ind ☐ Supv ☐Total	Hyperglycemia*	☐ Ind ☐Supv ☐ Total

NOTE: *If cognitively impaired or BG <_____or >_____, checks & treatment should be ☐ Supv ☐ Total

BLOOD GLUCOSE MONITORING

Target Range: ☐ 70-150 ☐ 70-180 ☐ Other:_____
Check BG: ☐ Mid-morning/before snack ☐ Before lunch ☐ Before P.E. or exercise
Additional: ☐ As needed, for signs/symptoms of LOW or HIGH blood glucose or illness ☐ After P.E. or exercise
☐ 2 hours after correction ☐ Before getting on bus ☐ Other:_____
Brand/Model of Glucometer:_____☐ Continuous Glucose Monitor (CGM) Type:_____# mo./yrs? _____
Alarms for: ☐ HIGH =_____☐ LOW=_____Remote Monitoring: (Type)_____☐ Cell phone ☐ Wi-Fi Access

☐ **Finger stick** before administering any insulin ☐ **CGM** (Dexcom only) may be used to give corrections/boluses
☐ Treatment parameters, depending on sensor trend, and any additional instructions are attached
****Student/Parent is responsible for calibration of sensor to maintain best accuracy****

INSULIN ADMINISTRATION

Fast Acting Insulin_____ Long Acting Insulin:_____

Device (Choose all that may apply): ☐ Pen ☐ Syringe ☐ Pump: Manufacturer:_____Model:_____
Insulin bolus/correction for: ☐ Mid-morning/snack time ☐ Lunchtime ☐ Other_____

Insulin/Carb Ratio:	Correction Factor:	Calculating Correction Dose:
1u:____ grams	1 u:___ mg/dL >_____(Target BG)	Actual BG – Target BG ÷ CF = # of units of insulin

☐ Contact parent before administering any insulin or carbohydrates, if BG >_____
☐ Parents are trained and authorized to adjust the insulin dosage ☐ Parameters: +/-_____units or % (circle one)

PUMPS

☐ Follow attached pump settings, in the event of a disaster, lockdown, or pump failure
☐ Parents are trained and authorized to adjust pump settings/dosing ☐ Parameters: +/-_____units or % (circle one)

****Parent must notify school of changes to pump settings****

101 W. Cochran Street ▪ Simi Valley, CA 93065 ▪ Telephone: 805-306-4500 Ext. 4302 ▪ Fax: 805-520-6586 ▪
sean.goldman@simivalleyusd.org

Simi Valley Schools
SIMI VALLEY UNIFIED SCHOOL DISTRICT

School Year:_____
Grade: _____
Teacher: _____
P E Days.: M / T / W / Th / F
Times: _____

MILD – MODERATE HYPOGLYCEMIA

STUDENT'S TYPICAL SYMPTOMS:

Step 1	Always treat symptoms, assuming BG is low, if unable to test blood glucose level.
Step 2	Give 15 grams of **readily available** fast acting carbohydrate ☐ **Give only** what parent provides (if medically indicated) i.e. *4 oz. apple or orange juice, 4 oz. soda (regular not diet), 3- 4 glucose tablets, 6 Lifesaver candies (circle with hole), 15 grams of glucose gel, 1 tablespoon sugar or honey with or without 4 oz. of water.*
Step 3	Monitor and re-check in_____minutes. • If BG is <_____mg, or if symptoms persist/recur, repeat Steps 2 & 3 • If BG still <_____mg/dL after 3rd check, parent will be contacted to pick student up *(as per district policy)* • If symptoms subside and BG is >_____mg, resume usual activity. ☐ If symptoms subside and BG is >_____mg **and** lunch or snack is **> 1 hour away**, give_____grams of complex carbohydrates: **(E.g.- *cheese & crackers, peanut butter & crackers, granola/protein bar - parent will provide)***
Step 4	Notify parent/guardian and school nurse, as soon as reasonably possible.

SEVERE HYPO

SYMPTOMS: Unable *to swallow, begins losing consciousness, or seizures*

Step 1	Administer Glucagon – Dose: ☐ 0.5 mg IM ☐ 1 mg IM
Step 2	Call 911. Keep student on side. Ensure open airway.
Step 3	Notify parent/guardian and school nurse as soon as reasonably possible. Contact doctor if unable to reach parent.

HYPERGLYCEMIA

STUDENT'S TYPICAL SYMPTOMS:

Administer insulin per protocol ☐ **No <**_____hours, after previous insulin dose.
☐ **According** to pump recommendations

Check urine/blood for ketones ☐ blood glucose > _____
☐blood glucose is >____for___consecutive readings_____hrs apart (for insulin pump users)

EXERCISE

☐ Test before exercise ☐ Test after exercise ☐ Snack before exercise:_____grams when BG < _____

Student should **NOT** exercise if BG is <_____, or >_____, or has urine/blood ketones.

DISASTER

☐ Follow orders contained in this authorization or ☐ See attached

***Medications/Supplies:** Must have extra **unopened** emergency supply of insulin (short and long acting). Extra pump supplies & inserters are strongly recommended.*

SIGNATURES

Physician Name:_____ **Phone:** _____
Address:_____ **Fax:** _____
Signature_____ **Date:** _____

I give permission to the school nurse and trained personnel and staff to provide care as outlined above. The school nurse may contact the Diabetes Team and release information contained in this document to all staff members, who have custodial care of my child at school or school sponsored events to maintain my child's health and safety.

Student's Parent/Guardian: _____ **Date:** _____

101 W. Cochran Street ▪ Simi Valley, CA 93065 ▪ Telephone: 805-306-4500 Ext. 4302 ▪ Fax: 805-520-6586 ▪ sean.goldman@simivalleyusd.org

AUTHORIZATION FOR ALL MEDICATIONS TAKEN DURING SCHOOL HOURS, SCHOOL ACTIVITIES AND FIELD TRIPS

This form must be completed at least annually and more frequently if the prescription changes in any way or as designated in the Individual Education Program (IEP) or in the Rehabilitation Act, Section 504 Plan.

PARENT OR LEGAL GUARDIAN

1. Parent or Legal Guardian Section

Note: All medications must be prescribed, including over-the-counter medications. Medications must be in the original container and the label must include the child's name, name of the medication, dosage, method of administration, time schedule and name of physician or other licensed health care provider (LHCP). Please refer to Legal References Governing the Administration of Medication in Schools on the reverse side of this form.

I request that designated unlicensed, trained school staff or licensed nurse assist my child in taking this prescribed medication(s) (including prescribed over-the-counter medication). I understand that my child may not be assisted with medication at school until all requirements are met. I hereby give consent for a school nurse to communicate with my child's prescriber and/or the pharmacist and to counsel school personnel as needed with regard to my child's health. I agree to comply with local educational agency policies and regulations related to administering medication at school.

Name of Child	Birth Date	Student Identification Number
Name of School	Grade	Teacher/Room Number

List all medications routinely taken outside of school hours: _____

I will immediately notify the school if there are any changes in medications my child is taking at school.

☐ If ordered by a LHCP, I give consent for my child to self-administer emergency medication at school. I agree to and do hereby release and hold the local educational agency and its governing board, officers, agents, employees and volunteers harmless for any and all claims, demands, causes of action, liability or loss of any sort, because of or arising out of self-administration of the medication(s).

Signature of Parent or Legal Guardian	Date	Primary Telephone	Alternate Telephone

Licensed Health Care Provider

2. Licensed Health Care Provider Section

The child named above is under my care for these diagnoses: _____

It is necessary for the child to receive the following prescribed medication(s) during school hours.

Name of Medication _____ Dosage (be specific, i.e. milligrams, etc.) _____
Time of day to be given _____ Frequency and Indication if "as needed" _____
Method of administration _____ Duration _____
Precautions or side effects _____
Storage and handling
☐ Routine handling, medication in locked storage and administered by authorized school personnel
☐ On-site 72 hour disaster supply only
☐ It is *Medical Necessity* for child *to carry* prescription for anaphylaxis, asthma, or diabetes, and indicate:
☐ Designated school personnel to administer
☐ Child trained to self-administer

Name of Medication _____ Dosage (be specific, i.e. milligrams, etc.) _____
Time of day to be given _____ Frequency and Indication if "as needed" _____
Method of administration _____ Duration _____
Precautions or side effects _____
Storage and handling
☐ Routine handling, medication in locked storage and administered by authorized school personnel
☐ On-site 72 hour disaster supply only
☐ It is *Medical Necessity* for child *to carry* prescription for anaphylaxis, asthma, or diabetes, and indicate:
☐ Designated school personnel to administer
☐ Child trained to self-administer

Name of Medication _____ Dosage (be specific, i.e. milligrams, etc.) _____
Time of day to be given _____ Frequency and Indication if "as needed" _____
Method of administration _____ Duration _____
Precautions or side effects _____
Storage and handling
☐ Routine handling, medication in locked storage and administered by authorized school personnel
☐ On-site 72 hour disaster supply only
☐ It is *Medical Necessity* for child *to carry* prescription for anaphylaxis, asthma, or diabetes, and indicate:
☐ Designated school personnel to administer
☐ Child trained to self-administer

Stamp LHCP name/address below:

Signature of LHCP or Supervising Physician	Date
Name of LHCP (please print) License Number	Office telephone

Copy –Local Educational Agency
SFA 5030, Rev. 10/19/2021

Copy – Parent or Legal Guardian

Copy –Licensed Health Care Provider

AUTORIZACIÓN PARA TODO MEDICAMENTO TOMADO DURANTE HORAS ESCOLARES, ACTIVIDADES ESCOLARES, Y XCURSIONES

Este formulario debe completarse al menos una vez al año y con mayor frecuencia si la receta cambia de alguna manera o como indicado en el Programa Educativo Individualizado (IEP por sus siglas en inglés) o en la Sección de la Ley de rehabilitación Plan 504.

PADRE O TUTOR LEGAL

1. Sección de padre o tutor legal

AVISO: Todos los medicamentos deben ser recetados, **incluso los medicamentos a venta libre.** Los medicamentos deben estar en su recipiente/frasco original y la etiqueta debe llevar el nombre del niño, el nombre del medicamento, la dosis, la forma de administración, el horario de tomar la medicina y el nombre del médico u otro proveedor de atención médica autorizado (LHCP por sus siglas en inglés). Por favor, consulte las Referencias legales que rigen la administración de medicamentos en las escuelas en el reverso de este formulario.

Solicito que el personal escolar designado, sin licencia y capacitado, o la enfermera con licencia, ayuden a mi hijo a tomar esta(s) medicación(es) recetada(s) (incluyendo la medicación recetada de venta libre). Entiendo que mi hijo no puede ser asistido con la medicación en la escuela hasta que se cumplan todos los requisitos. Por la presente doy mi consentimiento para que la enfermera de la escuela se comunique con el médico prescriptor de mi hijo y/o con el farmacéutico y para que asesore al personal de la escuela según sea necesario con respecto a la salud de mi hijo. Estoy de acuerdo en cumplir con las políticas y regulaciones de la agencia educativa local relacionadas con la administración de medicamentos en la escuela.

Nombre del niño	Fecha de nacimiento	Núm. de Identificación
Nombre de la Escuela	Grado	Maestro / No. de Salón de Clase

Apunte todos los medicamentos que se tomen con regularidad fuera de las horas escolares: _____

Avisaré a la escuela inmediatamente si hay cambios de cualquier tipo en los medicamentos que mi hijo toma en la escuela.

- ☐ Si lo ordena un LHCP, doy mi consentimiento para que mi hijo se auto administre medicamentos de emergencia en la escuela. Estoy de acuerdo y por la presente libero y eximo de responsabilidad a la agencia educativa local y a su consejo directivo, funcionarios, agentes, empleados y voluntarios por cualquier reclamo, demanda, causa de acción, responsabilidad o pérdida de cualquier tipo, debido a la autoadministración de los medicamentos o que surja de ella

Firma del Padre o Tutor Legal	Fecha	Teléfono principal	Teléfono alternativo

PROVEEDOR DE SERVICIOS DE SALUD LICENCIADO

2. Sección de proveedores de servicios de salud autorizados

El niño nombrado arriba está bajo mi cuidado por estos diagnósticos: _____

Es necesario que el niño reciba los siguientes medicamentos recetados durante el horario escolar.

Nombre of medicamento _____ Dosis (sea especifico, p.ej. miligramos, etc.) _____
Hora de administración _____ Frecuencia e indicación si es "según necesidad" _____
Método de administración _____ Duración _____
Precauciones o efectos secundarios _____
Almacenamiento y manipulación

- ☐ Manejo rutinario, el medicamento se almacena bajo llave y es administrado por personal escolar autorizado
- ☐ Suministro de 72 horas en caso de catástrofe
- ☐ Es una *Necesidad médica* que el niño *lleve* una receta para el asma, anafilaxia o la diabetes, e indicar:
  - ☐ Personal escolar designado para administrar
  - ☐ El niño está capacitado para auto administrarse

Nombre of medicamento _____ Dosis (sea especifico, p.ej. miligramos, etc.) _____
Hora de administración _____ Frecuencia e indicación si es "según necesidad" _____
Método de administración _____ Duración _____
Precauciones o efectos secundarios _____
Almacenamiento y manipulación

- ☐ Manejo rutinario, el medicamento se almacena bajo llave y es administrado por personal escolar autorizado
- ☐ Suministro de 72 horas en caso de catástrofe solo en la escuela
- ☐ Es una *Necesidad médica* que el niño lleve una receta para el asma, anafilaxia o la diabetes, e indicar:
  - ☐ Personal escolar designado para administrar
  - ☐ El niño está capacitado para auto administrarse

Nombre of medicamento _____ Dosis (sea especifico, p.ej. miligramos, etc.) _____
Hora de administración _____ Frecuencia e indicación si es "según necesidad" _____
Método de administración _____ Duración _____
Precauciones o efectos secundarios _____
Almacenamiento y manipulación

- ☐ Manejo rutinario, el medicamento se almacena bajo llave y es administrado por personal escolar autorizado
- ☐ Suministro de 72 horas en caso de catástrofe solo en la escuela
- ☐ Es una *Necesidad médica* que el niño lleve una receta para el asma, anafilaxia o la diabetes, e indicar:
  - ☐ Personal escolar designado para administrar
  - ☐ El niño está capacitado para auto administrarse

Firma del LHCP o médico supervisor	Fecha
Nombre del LHCP (imprimir) / Número de licencia	Nº de teléfono de la oficina

Sello LHCP
nombre/dirección abajo:

LEGAL REFERENCES GOVERNING THE ADMINISTRATION OF MEDICATION IN SCHOOLS

California *Business and Professions Code.*

Health Care Providers licensed to prescribe medication include:

Section 2051, California licensed physicians and surgeons

Section 1625, California licensed dentists

Section 3041, California licensed optometrists

Section 2472, California licensed podiatrists

Section 2836.1, California licensed nurse practitioners

Section 2746.51, California-certified nurse midwives

Section 3502.1, California licensed physician assistants

California *Education Code.*

Section 33031, State Board of Education adopt rules and regulations

Section 49423, Auto-injectable epinephrine, assistance at school or carry and self-administer

Section 49423.1, Inhaled asthma medication, assistance at school or carry and self-administer

Section 49423.6, Regulations regarding administration of medication in public schools

NOTE: California *Education Code* 49423.5, specialized physical health care services, i.e., catheterization, gastric tube feeding, suctioning, or other services that require medically related training, may require additional forms and instructions signed by parent or legal guardian and physician. Request *Specialized Services* forms from school.

California Code of Regulations, Title 5, Education.

Section 601, Definitions

(a) Authorized health care provider
(b) Medication
(c) Medication Log
(d) Medication Record
(e) Other designated school personnel
(f) Parent or legal guardian
(g) Regular school day
(h) School nurse

Section 602, Written Statement of Authorized Health Care Provider.

Section 603, Written Statement of the Parent or Legal Guardian.

Section 604, Administration of Medication to Pupils or Otherwise Assisting Pupils in the Administration of Medication.

Section 605, Self-Administration of Medication.

Local Educational Agency Policies

Board Policy 5141.21, Administering Medication and Monitoring Health Conditions

Administrative Regulation 5141.21, Administering Medication and Monitoring Health Conditions