Birmingham PUBLIC SCHOOLS

Permission to Administer Medication

Prescription and/or non-prescription medication that must be taken by students at school requires a written request from the parent/legal guardian together with a written set of instructions from the physician who has ordered the medication. The child's name, doctor's name, name of the medicine, dosage, route, frequency or time of administration, expected duration of medication regimen, possible side effects and special instructions, shall be clearly listed by the doctor on this form. Signatures are required from both the parent/legal guardian and physician. Medication must be in the original container and labeled with child's name, doctor's name, name of the medication, dosage, route, and frequency or time of administration. Please give initial dose of any new non-emergency medication at home; monitor for side effect, reaction.

Student Name _____ Birth Date _____School _____Grade_____

Student Emergency Contact #1_____ Phone Number _____

Student Emergency Contact #2 _____ Phone Number _____

Name of Attending Physician(s) _____

Physician Address _____

Physician Telephone _____Fax_____

MEDICATION INFORMATION (THIS SECTION SHOULD BE COMPLETED BY THE PRESCRIBING HEALTHCARE PROVIDER)

1) Medication Name _____ **Dose/Quantity**_____ **Route**_____ **Time of Administration** _____

Reason for Medication_____ _____

Adverse Reactions or Side Effects _____

_____ **Start Date** _____**End Date** (Valid for one school year only)

2) Medication Name _____ **Dose/Quantity**_____ **Route**_____ **Time of Administration** _____

Reason for Medication _____

Adverse Reactions or Side Effects _____

_____ **Start Date** _____**End Date** (Valid for one school year only)

Physician certifies this student requires the above medication during school hours.

Date _____Physician Signature _____ (required for medication administration)

PHYSICIAN: If student requires an EpiPen or Inhaler, and an additional EpiPen or Inhaler is required for bus transportation or other activity, please provide an extra prescription to the parent.

SELF-POSSESSION/SELF-ADMINISTRATION AUTHORIZATION

Students may possess/carry and/or self-administer medication only if authorized by the physician and parent/legal guardian.

This student is capable of □ **self-carrying** □ **self-administering**: □ Epinephrine □ Inhaler

Physician Signature for student self-carry/administration of EpiPen/Inhaler_____Date _____

Parent/Legal Guardian Signature for child to self-carry/administer EpiPen/Inhaler _____Date _____

A student's authorization to possess and self-administer medication may be limited or revoked by the building principal after consultation with the school nurse and the student's parents/guardian if the student demonstrates an inability to responsibly possess and self-administer such medication. Please contact the building principal to develop a plan to address how to keep a record of administrations and when the student must seek assistance.

PARENT/LEGAL GUARDIAN AUTHORIZATION

I hereby request that my child be administered medication at school, by school personnel. I understand that the medication will be administered exactly as per directions of my above-named physician. I will notify the school of changes or discontinuance of this medication(s) by completing a new form. I consent and authorize the healthcare provider staff and school to share information as needed to clarify orders and assist with my child's healthcare needs. I agree that information contained herein shall be shared with individuals and staff that need to know.

Parent/Legal Guardian Signature _____ Date _____

Print Parent/Legal Guardian Name _____

NOTICE OF DISCONTINUATION OF MEDICATION ADMINISTRATION

Please discontinue medication administration described above for my child _____ as of _____

Parent/Legal Guardian Signature _____ Date_____

Student Name: _____ **This Plan expires June 30, 20___**

School-based Medical Management Plan for the Student with Diabetes Mellitus

To be completed by Parent/Guardian

Student Name: _____ Birthdate: _____ Grade: _____

Address: _____

Mother/Guardian: _____ Phone: (home) _____ (cell) _____

Father/Guardian: _____ Phone: (home) _____ (cell) _____

Other Emergency Contact: _____ Phone: _____ Relationship: _____

Diabetes Health Care Provider: _____ Phone: _____

To be completed by Diabetes Team

Date of Diabetes Diagnosis: _____ ☐ Type 1 ☐ Type 2 ☐ Other:_____

SECTION I - Routine Management

Glucose Levels:

Monitoring method: ☐ Continuous glucose monitor (CGM) Type _____ **OR** ☐ Finger Stick

Preferred location: ☐ Classroom ☐ Office ☐ Where convenient

Glucose check performed by: ☐ Student, Independently ☐ Student, Supervised **OR** ☐ Designated School Personnel

Check prior to: ☐ Breakfast ☐ Snack ☐ Lunch ☐ Before PE/Recess ☐ Before leaving school

☐ Ensure that glucose level is above 100 before physical activity or boarding the bus ☐ Other: _____

Always: ☑ Check when symptomatic ☑ Perform finger stick if symptoms do not match CGM values

- **If glucose level is low (< _____ or < _____ with symptoms), see Section III, Low Glucose Level (Hypoglycemia)**
- **If glucose level is high (> _____), see Section IV, High Glucose Level (Hyperglycemia)**

Insulin Administration: (Type of Insulin per Medication Administration Authorization Form, see Section II)

Preferred administration location: ☐ Classroom ☐ Office ☐ Where convenient

☐ Pen/Syringe - Dosing per: ☐ Card ☐ Chart ☐ Scale ☐ InPen* ☐ PUMP* *All settings pre-programmed by parent

Breakfast: ☐ Prior to ☐ Immediately after **Lunch:** ☐ Prior to ☐ Immediately after **Snack (carb coverage only):** ☐ Prior to ☐ NA ☐ Immediately after

Insulin dosage calculated by: ☐ Student, Independently ☐ Student, Supervised **OR** ☐ Designated School Personnel

☐ Student will determine all carb counts independently **OR** ☐ Family will provide carb counts to school staff daily

☐ For foods provided by school nutrition services, school staff will ensure student/family has access to carb counts

Insulin administered by: ☐ Student, Independently ☐ Student, Supervised **OR** ☐ Designated School Personnel

Adjustments to Insulin Dosing:

☐ Parents/Guardians have sufficient training and experience and are authorized by the prescriber to submit written requests to Designated School Personnel for insulin dosing adjustments within the following parameters:

☐ Yes ☐ No Adjust correction/sensitivity factor within the following range: 1 unit:_____ to 1 unit:_____ (Target Glucose:_____)

☐ Yes ☐ No Adjust insulin-to-carbohydrate ratio within the following range: 1 unit:_____ to 1 unit:_____

☐ Yes ☐ No Increase or decrease fixed insulin dose within the following range: +/- _____ units of insulin.

☐ Designated School Personnel should contact provider if parents request insulin dosing adjustments > _____ times/week.

☐ **Written communication between Provider & Parent** (e.g. emails, clinic visit summary, etc.) may be used to adjust insulin dosing until updated Insulin Dosing Tool is received by the Designated School Personnel.

SECTION II – Medication Administration Authorization (MAA) Form

This form must be completed fully in order for schools to administer the required medication. The school nurse (RN) will call the prescriber, as allowed by HIPAA, if questions arise about the student's medications and/or related diabetes care.

Prescriber's Authorization:

Student Name: _____ Date of Birth:_____ Grade: _____

1. **Medication Name:** Insulin: ☐ Admelog ☐ Humalog/Lispro ☐ Novolog/Aspart ☐ Apidra ☐ Fiasp
   Dose: Per Accompanying Insulin Dosing Tool
   Route: ☐ Pen/Syringe (Insulin dosing per ☐card ☐chart ☐scale InPen)
   ☐ PUMP (All settings pre-programmed into pump by parent)
   ☐ InPen (All settings pre-programmed into app by parent)
   Time: Breakfast: ☐ Prior to ☐ Immediately after
   Lunch: ☐ Prior to ☐ Immediately after
   Snack: ☐ Prior to ☐ Immediately after
   Potential Side Effects: _____
   Student may self-carry insulin: ☐ Yes ☐ No **Student may self-administer insulin**: ☐ Yes ☐ No
2. **Medication Name:** Glucagon
   Route & Dose: ☐ Injection, Glucagon/Glucagen/Gvoke PFS: ☐ 0.5 mg ☐ 1.0 mg
   ☐ Auto-Injection, Gvoke HypoPen: ☐0.5mg/0.1mL ☐1mg/0.2mL
   ☐ Nasal, Baqsimi Glucagon Nasal Powder: ☐ 3mg
   Time: When severe low glucose levels are suspected as indicated by unconsciousness, seizure, or extreme disorientation with inability to safely swallow oral quick-acting glucose.
   Potential Side Effects: Nausea, Vomiting, Rebound Hyperglycemia, Other:_____
   Student may self-carry Glucagon: ☐ Yes ☐ No

☐ Please see attached supplemental MAA Form for additional medication orders. Additional training provided by a RN, PA, physician, or Certified Diabetes Educator to Designed School Personnel is required.

Prescriber's Signature: _____ Date: _____

(No stamped signatures, please)

Print Name/Title: _____ NPI#: _____

Address: _____

Phone: _____ FAX: _____

Parent/Guardian Authorization:

I request Designated School Personnel to administer the medications as prescribed by the above prescriber. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medications at school. I authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature:: _____ Date: _____

Reviewed by RN, PA, Physician, or Certified Diabetes Educator providing training to Designated School Personnel:

_____

Signature/Title Date

SECTION III - Responding to a Low Glucose Level (Hypoglycemia)

Below are common symptoms that may be observed when glucose levels are **low**.
Reminder: These symptoms can change and some students may not display any symptoms.
Parents **may** choose to circle their child's most common symptoms.

Symptoms of a Low Glucose Level (Hypoglycemia)

Shaky Weak Sweaty Rapid heartbeat Dizzy Hungry Headache Lack of coordination Seizure Tiredness
Loss of consciousness Pale Confusion Irritability/Personality changes Continuous Glucose Monitor (CGM) alarm/arrows
Other: _____

Actions for Treating Hypoglycemia

Treatment for Mild to Moderate Hypoglycemia	Treatment for Severe Hypoglycemia
Notify School Nurse or Designated School Personnel as soon as you observe symptoms. If possible, check glucose level via finger stick. **Do NOT send student to office alone!** Treat for hypoglycemia if glucose level is: ☐ less than _____ or less than _____ with symptoms. **WHEN IN DOUBT, ALWAYS TREAT FOR HYPOGLYCEMIA AS SPECIFIED BELOW.**	**Student is:** ✓ **Unconscious** ✓ **Having a seizure** ✓ **Having difficulty swallowing** **Follow Emergency Steps** 1. **Administer Glucagon** 2. **Call 9-1-1** 3. **Activate MERT (Medical Emergency Response Team)**
"Rule of 15"	**Administer Glucagon**
☐ Treat with **15 grams of quick-acting glucose** (4 oz. juice or 3-4 glucose tabs) **OR** ☐ Treat with **30 grams of quick-acting glucose** (8 oz. juice or 6-8 glucose tabs) **if glucose level is less than _____** ☐ Wait 15 minutes. Recheck glucose level. ☐ Repeat quick-acting glucose treatment if glucose level is less than _____ mg/dL. ☐ Contact the student's parents/guardians. **Then:** ☐ If an hour or more before next meal, give a snack of protein and complex carbohydrates ☐ If mealtime and no difficulty swallowing, monitor and allow student to eat lunch while waiting to recheck glucose level. ☐ Once glucose level is greater than _____ and student has finished eating lunch, give insulin to **cover meal carbs only.**	☑ Stay with student, protect from injury, turn on side ☑ Do not put anything into the student's mouth ☐ Suspend or remove insulin pump (if worn) ☑ Administer Glucagon Per MAA Form: ☐ Injection, Glucagon/Glucagen/Gvoke PFS: ☐ 0.5 mg ☐ 1.0 mg ☐ Auto-Injection, Gvoke HypoPen: ☐ 0.5mg/0.1ml ☐ 1mg/0.2ml ☐ Nasal, Baqsimi Glucagon Nasal Powder: ☐ 3mg ☐ Implement Medical Emergency Response: ✓ Take AED and any emergency medical supplies to location; ✓ Inform Central Administration of Emergency; ✓ Contact parents; Meet them in the parking lot; ✓ Meet the ambulance/direct traffic; ✓ Provide copy of student medical record to EMS; ✓ Control the scene; ✓ Document emergency and response on Emergency Response/Incident Report form; ✓ Conduct debriefing session of incident and response following the event.

Student Name: _____ **This Plan expires June 30, 20___**

SECTION IV - Responding to High Glucose Levels (Hyperglycemia)

Below are common symptoms that may be observed when glucose levels are **high**.
Reminder: These symptoms can change and some students may not display any symptoms.
Parents **may** choose to circle their child's most common symptoms.

Symptoms of a High Glucose Level (Hyperglycemia)

Increased thirst Increased urination Tiredness Increased appetite Decreased appetite Blurred Vision Headache
Sweet, fruity breath Dry, itchy skin Achiness Stomach pain/nausea/vomiting Seizure Loss of consciousness/coma
Continuous Glucose Monitor (CGM) alarm/arrows Other: _____

Actions for Treating Hyperglycemia

Treatment for Hyperglycemia	Treatment for Hyperglycemia Emergency
Notify School Nurse or Designated School Personnel as soon as you observe symptoms.	**Call 9-1-1** **Activate Medical Emergency Response**
☐ **For glucose level less than 300:** ✓ If not mealtime – do not give correction dose of insulin, offer water, return to normal routine if feeling well ✓ If mealtime, give insulin as prescribed (see Section I, Routine Management, Insulin Administration) ☐ **For glucose level 300 or greater:** ✓ If mealtime, give insulin as prescribed (see Section I, Routine Management, Insulin Administration) ✓ Have student check ketones ☐ **Positive Ketones:** ✓ Call parent/guardian ▪ Trace or Small - attempt to flush, remain in school if feeling well and no vomiting ▪ Moderate or Large - parent pick-up immediately ✓ Give 8-16 oz. of water hourly ✓ No exercise, physical education, or recess ✓ Recheck ketones at next urination ✓ If on pump, check infusion set/pump site: ▪ Is tubing disconnected? ▪ Is there wetness around the pump site, etc.? ☐ **Negative Ketones:** ✓ If not mealtime - offer water, return to normal routine if feeling well ☐ **If no ketone strips are available:** ✓ Treat as Positive Ketones ✓ Request strips from family	☐ Call 9-1-1 if severe symptoms are present. Severe symptoms **may** include: ✓ Abdominal pain ✓ Nausea/Repetitive Vomiting ✓ Change in level of consciousness ✓ Lethargy ☐ Implement Medical Emergency Response: ✓ Take AED and any emergency medical supplies to location; ✓ Inform Central Administration of Emergency; ✓ Contact parents; Meet them in the parking lot; ✓ Meet the ambulance/direct traffic; ✓ Provide copy of student medical record to EMS; ✓ Control the scene; ✓ Document emergency and response on Emergency Response/Incident Report form; ✓ Conduct debriefing session of incident and response following the event.

_____ _____

Parent/Guardian Signature (Void if not signed) Date Physician Signature Date

Student Name: _____ This Plan expires June 30, 20___

To be completed by Trainer of Student-specific School Health (SSH) Team in collaboration with all SSH Team members.

SECTION IV - Food and Miscellaneous

☐ Snack daily at: _____ ☐ Snack as needed for low glucose level ☐ Allow unlimited access to food

☐ Allow unlimited access to water or bathroom ☐ Have 15 grams of quick-acting glucose available at site of physical activity

☐ For special occasions that involve food: ☐ always contact parent for guidance **OR** ☐ student can self-manage

☐ Out of classroom, student will travel with: ☐ buddy ☐ adult

☐ always **OR** ☐ when support is requested or is obviously needed

☐ Fieldtrips - Student will be accompanied by trained school personnel, unless parent volunteers to attend (parent attendance not required)

☐ Plan for access to food and appropriate support during School Emergencies developed/implemented

☐ Record all care provided/send documentation home: ☐ Weekly ☐ When requested by parent ☐ Other: _____

Location of Glucagon (Glucagon/Gvoke/Baqsimi): ☐ In Office ☐ In Classroom ☐ With Student ☐ Other: _____

Location of Other Diabetes Supplies (see attached list): ☐ In Office ☐ In Classroom ☐ With Student ☐ Other: _____

School Name: _____ Principal: _____

School Address: _____

SSH Team consists of:

Parent, Student, Designated School Personnel

AND

RN, Physician, PA, or Certified Diabetes Educator (Trainer)

The following Designated School Personnel have received training to support implementation of this plan:

_____ **Name**	_____ **Title**
_____ **Name**	_____ **Title**
_____ **Name**	_____ **Title**
_____ **Name**	_____ **Title**
_____ **Name**	_____ **Title**

Training provided by:

_____

Signature/Title Date