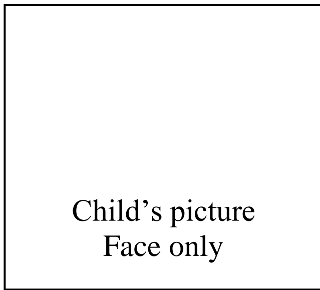
ROCHESTER COMMUNITY SCHOOLS

PRIDE IN EXCELLENCE

School Year 2025-2026


Child's picture
Face only

DIABETES Medical Action Plan (MAP)

Name: ______________________________ School: ____________________________

Date of birth: _______________________ Age: ______

Grade: _____________________________ Teacher: ___________________________

This MAP is validated with signatures and dates, by both the licensed health care provider (Doctor of Osteopathic Medicine, D.O., Medical Doctor, M.D., Nurse Practitioner, N.P., or Physician Assistant, P.A.), and a parent/legal guardian. Recommended orders for medical interventions within this treatment plan, will expire at the end of the 2025-2026 school year.

Transportation Office Use ONLY if needed

Bus #

Driver:

Route #

Medical File

CONTACT INFORMATION

Call First:	Call Second:	Call Third:
Name:	Name:	Name:
Relationship:	Relationship:	Relationship:
Phone 1:	Phone 1:	Phone 1:
Phone 2:	Phone 2:	Phone 2:
Email:	Email:	Email:

PARENT/GUARDIAN CONSENT

I, (parent/guardian), ______________________________, request that my child, ________________________________, receive the attached medical management at school, according to standard school policy. I authorize consent to the ordering licensed health care provider staff and school to share information, as needed, to clarify orders and to assist with my child's health care needs. I agree to have the information, in this entire plan, shared with individuals that need to know. Also, I give permission to use my child's picture on this plan (if I did not supply a photo).

PARENT/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: ________________

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

☐ Student may use cell phone to monitor glucose levels and school will ensure access to school Wi-Fi

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* Type: _____________ (*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:

Based on Michigan law (MCL 380.1178) and best practice, written provider/prescriber instructions are required for all medications administered in the school setting. This includes changes to insulin dosing. Written communication between provider/prescriber and parent/guardian (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.

☐ Parents/Guardians have completed training and are authorized by the provider/prescriber to submit written requests to Designated School Personnel for insulin dosing adjustments to increase or decrease total mealtime insulin dose by: +/- ______ units of insulin.

Please note: Insulin corrections for high glucose levels should NOT be given more frequently than every 3 hours. School staff are not required to administer glucose correction doses outside of mealtimes.

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

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)

   ☐ PUMP Type: ________________ (All settings pre-programmed into pump by parent/guardian)

   ☐ InPen (All settings pre-programmed into app by parent/guardian)

   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 Care and Education Specialist (CDCES) 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/GuardianSignature: ____ Date: ____________________

Reviewed by RN, PA, Physician, or CDCES providing training to Designated School Personnel:

____

Signature/Title Date

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

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

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.

"Rule of 15"

- ☐ 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.**

Treatment for Severe Hypoglycemia

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)**

Administer Glucagon

- ☐ 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   Date   Physician Signature   Date
(Void if not signed)

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 – Additional Supports

☐ 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)

☐ Extra-curricular Activities – Parent and student will inform DSP of participation to ensure trained school personnel are present

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

☐ Staff/student plan to completely silence alarms when hiding for safety developed/implemented, and includes practice during drills

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

☐ Evaluate for eligibility for a Section 504 Academic Accommodations Plan

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 Care and Education Specialist (CDCES)

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

ROCHESTER COMMUNITY SCHOOLS
Authorization for Medication Administration
School Year: 2025-2026

Student name: ____________________ Date of birth: ____________ Grade: ________

To be completed by the Physician or Authorized Prescriber: ONE MEDICATION PER FORM
(Michigan law and district policy require written authorization for a student to take any medication during the school day).

Name of medication: ____________________ Reason for medication: ____________________

Dose (***please do not give a range***): _______ ☐ MG ☐ MG/ML ☐ ML ☐ MCG ☐ UNITS ☐ OTHER: __________

____

Route: ☐ Oral ☐ Injection ☐ Inhalation ☐ Intra-nasal ☐ Rectal ☐ Topical ☐ Transdermal (Patch) ☐ Other: ________

☐ Routine time(s) to be given: ☐ ________ AM ☐ ________ PM ☐ Other: ____________

☐ Frequency: ☐ Daily ☐ Other (*please be specific*): ______________________________

☐ As needed (PRN), (***absent clear and objective criteria, medication cannot be administered during the school day***):

____

____

Special instructions or side effects: ______________________________________

Student is both capable and responsible for self-administering this medication (***applicable ONLY to high school students***):
☐ No ☐ Yes- supervised ☐ Yes- unsupervised

Student may self-carry an inhaler (***applicable to all students***). ☐ Yes ☐ No ☐ Not applicable
Student may self-carry epinephrine (***applicable to all students***). ☐ Yes ☐ No ☐ Not applicable

START: ☐ Date from received ☐ Other date/duration (please be specific): ____________
STOP: ☐ End of school year ☐ Other date/duration (please be specific): ____________

☐ For episodic/emergency events only

Prescriber Name: ______________ Signature: ______________ Date: ________

Clinic/Hospital Name: ______________ Address: ______________________

Phone number: ______________________ Fax number: ______________________

To be completed by Parent/Legal Guardian

I understand and agree that all medication must be in the original container, clearly marked with the student's name, name of medication, and prescribed dosage. I acknowledge that I am required to immediately inform the District of any changes to the healthcare provider's administration instructions. Authorization also includes permission for school personnel and health care provider to contact each other, if needed. I request and authorize the following (***check appropriate direction below***):

☐ School personnel store and administer medication to the above-named student, as authorized by prescriber.
☐ School personnel store medication only. The above-named student shall be responsible for self-administering medication.

Printed Name: ______________ Signature: ______________ Date: ________

ROCHESTER COMMUNITY SCHOOLS
Authorization for Medication Administration
School Year: 2025-2026

Student name: ______________________________ Date of birth: ______________ Grade: __________

To be completed by the Physician or Authorized Prescriber: ONE MEDICATION PER FORM

(Michigan law and district policy require written authorization for a student to take any medication during the school day).

Name of medication: ___________________________ Reason for medication: ______________________

Dose (***please do not give a range***): _______ ☐ MG ☐ MG/ML ☐ ML ☐ MCG ☐ UNITS ☐ OTHER: ____________

____

Route: ☐ Oral ☐ Injection ☐ Inhalation ☐ Intra-nasal ☐ Rectal ☐ Topical ☐ Transdermal (Patch) ☐ Other: __________

☐ Routine time(s) to be given: ☐ __________ AM ☐ __________ PM ☐ Other: ____________________

☐ Frequency: ☐ Daily ☐ Other (*please be specific*): ____

☐ As needed (PRN), (***absent clear and objective criteria, medication cannot be administered during the school day***):

____

____

Special instructions or side effects: ____

Student is both capable and responsible for self-administering this medication (***applicable ONLY to high school students***):
☐ No ☐ Yes- supervised ☐ Yes- unsupervised

Student may self-carry an inhaler (***applicable to all students***). ☐ Yes ☐ No ☐ Not applicable
Student may self-carry epinephrine (***applicable to all students***). ☐ Yes ☐ No ☐ Not applicable

START: ☐ Date from received ☐ Other date/duration (please be specific): ________________
STOP: ☐ End of school year ☐ Other date/duration (please be specific): ________________

☐ For episodic/emergency events only

Prescriber Name: ____________________ Signature: ________________________ Date: __________

Clinic/Hospital Name: ____________________ Address: _____________________________________

Phone number: __________________________ Fax number: __________________________________

To be completed by Parent/Legal Guardian

I understand and agree that all medication must be in the original container, clearly marked with the student's name, name of medication, and prescribed dosage. I acknowledge that I am required to immediately inform the District of any changes to the healthcare provider's administration instructions. Authorization also includes permission for school personnel and health care provider to contact each other, if needed. I request and authorize the following (***check appropriate direction below***):

☐ School personnel store and administer medication to the above-named student, as authorized by prescriber.

☐ School personnel store medication only. The above-named student shall be responsible for self-administering medication.

Printed Name: ______________________ Signature: ________________________ Date: __________

ROCHESTER COMMUNITY SCHOOLS

Medication Procedures

(as per standard school policy)

- Medication authorization is for the current school year only and will expire at the end of the school year.
- Only one medication per form. A separate form is required for each medication, each school year.
- Written authorization with medication order completed, signed by the student's authorized healthcare provider and a parent/guardian, is required before any medication can be given at school. Medications include prescription, and non-prescription over-the-counter, including but not limited to: homeopathic, herbal, vitamin, mineral preparation, topical creams or ointments, eye or ear drops, transdermal patches, nasal sprays or mists.
- Medication administration during school hours will be permitted only when failure to do so will jeopardize the health of a student, or the student would not be able to attend school if the medication or treatment were not available during school hours. Parents/legal guardians are urged to administer medication at home and on a schedule, other than school hours, if possible.
- Medication must be brought to school by the student's parent/legal guardian, unless the student has been authorized to self-carry the medication. The district reserves the right to determine that a student may not self-carry for any reason.
- Medication must be administered by an adult in the presence of a second adult, unless the medication is administered by a licensed registered professional nurse or there is an emergency that threatens the student's life or health.
- Parent/legal guardian will ensure that an adequate amount of medication is on hand at the school for the duration of the student's need to take medication, and responsible for checking the need for refills, including expired medications, and replenishing medication to the school in a timely manner.
- All medication must be in a container as prepared by a pharmacy, authorized healthcare provider, or pharmaceutical company, and clearly marked with the student's name, the name of the medication, the prescribed dose, time and frequency of medication administration and special instructions, if any.
- All controlled substance medication will be counted and recorded in the presence of the parent/legal guardian when brought to school.
- Changes in dosage, frequency, or time of administration cannot be made without written instruction from an authorized healthcare provider.
- Designated staff will be responsible for storage, administering medication and notifying parent/legal guardian, in the event that a student refuses medication.
- Medication left over at the end of the school year, or after a student has left the district shall be picked up by the parent/legal guardian. Any medication not retrieved by the parent/legal guardian will be properly disposed of within 7 days of the last student day of school and documented by the individual who is responsible for administering medication.