

Dear Parents/Guardians

If Diabetes medication(s) is required for administration for the next school year (August 2025-June 2026) please remember to follow these steps:

**Medical Orders must be written and dated after July 1<sup>st</sup>, 2025. Medical orders are only active for the current school.**

- Medical providers must provide **medication orders** that include the name of the medication, form of medication (Insulin, rescue medications- Baqsimi, Glucagon), frequency, times of administration, diagnosis for which medication is being ordered and any side effects or specific directions/information for administration.
- Medical providers must provide a **(1.) Diabetes Action Plan, including rescue medication orders and (2.) Please review and sign with a medical provider the Emergency Action Plan for campus non-medical staff when a nurse is not on campus/after school activities/field trips and bus drivers.**
- Please bring medications to school before the first day of classes. They must be in the original pharmacy packaging with your student's name on it and non-expired. **You may call the Health Office after August 20, 2025, to arrange a drop-off.** No student is allowed to carry any medications to school, even over-the-counter medication.
- Please review the AMSACS medication administration policy.
- **No student will be allowed to attend a field trip until their Diabetes paperwork is completed, and the student has brought their diabetes medication/supplies to the Health Office prior to the event.**

## **PARENT/GUARDIAN DIABETES MEDICATION/SUPPLIES CHECK LISTS**

### Checklist for Required Paperwork for **Diabetes Medication/Supplies**

#### **Documents from the medical provider needed:**

1. \_\_\_\_\_ Medical Order Form
2. \_\_\_\_\_ Diabetes Action Plan/ Health Care Plan for School
3. \_\_\_\_\_ Sign the Diabetes Emergency Action Care Plan for Non-Medical Staff/Bus Driver/After School Activities

#### **Parent to Complete:**

1. \_\_\_\_\_ Parent's Permission for Diabetes Medication Administration (Rescue medications Baqsimi/Glucagon, Insulin & Supplies)- MAPs
2. \_\_\_\_\_ Contract to Carry- Insulin (via pump), Diabetes Rescue Medication, & Supplies
3. \_\_\_\_\_ Sign the Diabetes Emergency Action Care Plan for Non-Medical Staff/Bus Driver/After School Activities

Please be aware that if you feel your child has needs beyond the medical provider's allergy/asthma action plans you may call **Guidance for a 504 Plan.**

If you need this information translated, please copy and paste it into Google Translate. The link to Google Translate is <http://translate.google.com/>

Advanced Math and Science Academy Charter School

2025-26 Parent/Guardian Permission/Medication Administration Plan (MAP) for Diabetes Rescue Medication Baqsimi/Glucagon

Student: _____ DOB: _____ Grade: _____ Name of Licensed Prescriber: _____ Phone Number: _____ Diabetes Nurse Educator: _____ Phone Number: _____ Emergency Contact; Name/Number: _____ _____	Parent/Guardian Name: _____ Home Phone: _____ Cell Phone: _____  Parent/Guardian Name: _____ Cell Phone: _____
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Name of Medication: \_\_\_\_\_ Date of medical order (received after July 1, 2025): \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_  
 Allergies to Food or Medication: ( ) Yes ( ) No Specify Allergy: \_\_\_\_\_  
 Other medication being taken by my student (if not in violation of confidentiality): \_\_\_\_\_

( ) I give permission for my child to carry-on-person their rescue diabetic medication, if the school nurse determines it is safe and appropriate. A second supply of rescue medication will also needs to be left in the Health Office.

Has your student ever needed to use their emergency medication? (explain): \_\_\_\_\_

\*\*\*\* If the student will be self-carry, please fill out second page "Contract for Permission to Carry" one for rescue meds; one for insulin (via pump) and one for diabetic supplies

How do you want to handle diabetes medication administration during times when your child is attending a school function/event, after school hours (clubs/sports, etc.), during off school activities during day/overnight field trips? (Please check one only)

- a.  COP (Carries on Person at all times)
- b.  FTAS (Carries only on field trips and after school activities)
- c.  DNC (Does not carry- Nurse to carry and be with student during entire event)
- d.  Parent to attend field trip/activity

( ) I understand that a parent/guardian must drop off medication to the school nurse and it must be in it the original pharmacy packaging with student's name and the appropriate label.

( ) I give permission to the school nurse to administer the above medication to my child per medical orders/ diabetes care plan. **Once administered 911 will be called and a parent notified**

( ) I give permission to the school nurse to share with appropriate school personnel the information related to the prescribed medication as deemed necessary for my child's health and safety.

Does your student take the bus ( ) Bus #/Name \_\_\_\_\_ ( ) Is your student a parent pick up/drop off

( ) I understand that for this medication to be discontinued I need an updated medical note from the student's provider.

\*\*\*\*\*Please be aware that there is no availability for rescue medication administration during after school activities. 911 will be called. Please call the Health Office to discuss any after-school activities.

Parent/Guardian Signature: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_ Date: \_\_\_\_\_

FOR HEALTH OFFICE USE ONLY: School Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of the medication Ordered: \_\_\_\_\_ Date of Medical Order (received after July 1,2025): \_\_\_\_\_

Required Storage: ( ) Unlocked; labeled Diabetes Supplies/Emergency medication ( ) Locked; Insulin evenings/Unlocked school hours

Duration of Med. (Start Date/End Date): \_\_\_/\_\_\_; \_\_\_/\_\_\_ Quantity of Med. Received and Date \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Dosage: \_\_\_\_\_ Frequency: See medical order/care plan Specific Time: See medical orders/Care Plan Route of Administration: \_\_\_\_\_

Disposal of medication: ( ) Finished ( ) Returned to parent/Guardian ( ) Given to Student Nurse's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

( ) Disposed/Witness \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*\* Attach Medical orders & Medical Care Plan for School\*\*\*\*\* Edited 6/12/25 MGW

Attach Student Photo:

Advanced Math and Science Academy Charter School

2025-26 Parent/Guardian Permission/Medication Administration Plan (MAP) for Diabetes Medication Insulin

Student Name: _____ DOB: _____ Grade: _____ Name of Licensed Prescriber: _____ Phone Number: _____ Diabetes Nurse Educator: _____ Phone number: _____ Emergency Contact; Name/Number: _____	Parent/Guardian Name: _____ Home Phone: _____ Cell Phone: _____  Parent/Guardian Name: _____ Cell Phone: _____
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Name of Medication: \_\_\_\_\_ Date of medical orders (received after July 1, 2025): \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_  
 Allergies to Food or Medication: ( ) Yes ( ) No Specify Allergy: \_\_\_\_\_  
 Other medication being taken by my student (if not in violation of confidentiality): \_\_\_\_\_

( ) I give permission for my child to self-administer this medication, if the school nurse determines it is safe and appropriate. Insulin will be used in the insulin pump used by the student and a second supply will be kept in the Health Office refrigerator.

\*\*\*\* If the student will be self-carry, please fill out second page "Contract to Carry and Self Administer" one for rescue medication; one for insulin (via pump) and one for diabetic supplies.

How do you want to handle diabetes medication administration during times when your child is attending a school function/event, after school hours (clubs/sports, etc.), during off school activities during day/overnight field trips? (Please check one only)

- a.  COP (Carries on Person at all times) via the pump
- b.  FTAS (Carries only on field trips and after school activities)
- c.  DNC (Does not carry- Nurse to carry and be with student during entire event)
- d.  Parent to attend field trip/activity

( ) I understand that a parent/guardian must drop off medication to the school nurse and it must be in its original pharmacy packaging with student's name and the appropriate label.

( ) I give permission to the school nurse to administer the above medication to my child per medical orders/diabetic care plan.

( ) If sensor or pod is dislodged or malfunctioning parent will be notified by nurse or chaperone to make arrangements to replace.

( ) I give permission to the school nurse to share with appropriate school personnel the information related to the prescribed medication as deemed necessary for my child's health and safety.

Does your student take the bus ( ) Bus #/Name: \_\_\_\_\_ ( ) Is your student a parent pick up/drop off

( ) I understand that for this medication to be discontinued I need an updated medical note from the student's provider.

\*\*\*\*Please be aware that there is no availability for medication administration during after school activities. Please call the Health Office to discuss any after-school activities.

Parent/Guardian Signature: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_ Date: \_\_\_\_\_

FOR HEALTH OFFICE USE ONLY: School Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of the Medication Ordered: \_\_\_\_\_ Date of Medical Order (received after July 1, 2025): \_\_\_\_\_

Required Storage: Medication Fridge" ( ) Locked; Insulin evenings/Unlocked school hours

Duration of Med. (Start Date/End Date): \_\_\_/\_\_\_; \_\_\_/\_\_\_ Quantity of Med. Received and Date \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Dosage: see medical orders/care plan Frequency: see medical orders/care plan Specific Time: see medical orders/care plan

Route of Administration: via pump/sub-Q

Disposal of medication: ( ) Finished ( ) Returned to parent/Guardian ( ) Given to Student Nurse's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

( ) Disposed/Witness \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*\* Attach Medical orders & Medical Care Plan for School\*\*\*\*\*

Edited 6/12/25 MGW

Attach Student Photo:

## 2025-26 Contract for Permission to **Carry & Self Administer Insulin(via pump daily)**

Name of Student: \_\_\_\_\_ Date: \_\_\_\_\_ Grade: \_\_\_\_\_

### To be completed by the Parent/Guardian:

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

I request that my child be permitted to carry on his/her person the diabetic rescue medication, insulin & supplies that have been prescribed. My child has been instructed in and understands the purpose, appropriate method, frequency and use of his/her diabetic rescue medication/insulin & supplies. My child understands that he/she will be responsible for carrying and self-administering insulin and 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:

- COP (carries on person at all times) In school/field trips/sports & after school
- FTAS (carries for field trips/sports/ after school activities only)
- DNC (does not carry) Nurse carries and student to be with them for duration of event
- Other to be determined by School Nurse: \_\_\_\_\_

### To be completed by School Nurse and Student

Medical 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 diabetes rescue medication, insulin & supplies and agree to follow those medication storage requirements. Insulin is stored in the worn pump and (un)locked in the Health Office refrigerator.	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 rescue medication, insulin and supplies in the Health Office & on person.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student realizes his/her responsibility in carrying his/her own medication(s) and agrees <b>NEVER</b> share the medication(s)/supplies with others.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
The presence of a nurse on a field trip, sports, after school event is not guaranteed. Student agrees to be responsible to provide and carry his/her own diabetic rescue medication, insulin & supplies on field trips, sports, and after school events/sports	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student agrees that after administering diabetic medication, if there is no 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 medical orders 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"/>

Expiration date on Insulin Medication in H.O. \_\_\_\_\_

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: \_\_\_\_\_

## 2025-26 Contract for Permission to Carry Rescue Medication -Glucagon/Baqsimi

Name of Student: \_\_\_\_\_ Date: \_\_\_\_\_ Grade: \_\_\_\_\_

### To be completed by the Parent/Guardian:

Qualified students will be allowed to carry their diabetic rescue medication, insulin 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 rescue medication/insulin & supplies that has been prescribed. My child has been instructed in and understands the purpose, appropriate method, frequency and use of his/her diabetic rescue medication/insulin & supplies. My child understands that he/she will be responsible for carrying the medication(s)/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:

- COP (carries on person at all times (in school, field trips/sports & after school activities))
- FTAS (Field Trips/Sports/After School Activities Only)
- DNC (Does Not Carry) Nurse carries and student to be with them for duration of event
- Other to be determined by School Nurse: \_\_\_\_\_

### To be completed by School Nurse and Student

Medical order for diabetic rescue 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.	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. The rescue medication will be carried on person and a second dose is unlocked in the Health Office labeled "Diabetic Supplies- Baqsimi/ Glucagon"	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 rescue medication, insulin and supplies in the Health Office & on person.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student realizes his/her responsibility in carrying his/her own medication(s) and agrees <b>NEVER</b> share the medication(s)/supplies with others.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
The presence of a nurse on a field trip, sports, after school event is not guaranteed. Student agrees to be responsible to provide and carry his/her own diabetic rescue medication/insulin/supplies on field trips, sports, and after school events/sports.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student agrees, per medical orders/care plan if a nurse needs to administer a rescue medication 911 will be called.	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"/>

Expiration date on Glucagon/Baqsimi Medication in H.O. \_\_\_\_\_ Expiration date Glucagon/Baqsimi Medication student is carrying is \_\_\_\_\_

I give permission to notify staff of my Carry-On-Person. I understand that if I do not follow the plan of carry on person/ Nurse 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: \_\_\_\_\_

**2025-26 Contract for Permission to Carry & Self Administer Diabetic Medications(glucose tabs)/Supplies**

Name of Student: \_\_\_\_\_ Date: \_\_\_\_\_ Grade: \_\_\_\_\_

**To be completed by the Parent/Guardian:**

Qualified students will be allowed to carry their diabetic rescue medication, insulin 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 rescue medication/insulin & supplies that have been prescribed. My child has been instructed in and understands the purpose, appropriate method, frequency and use of his/her diabetic rescue medication/insulin & supplies. My child understands that he/she will be responsible for carrying and self-administering these medication(s)/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:**

- COP (carries on person at all times) In school/field trips/sports & after school
- FTAS (carries for field trips/sports/ after school activities only)
- DNC (does not carry) Nurse carries and student to be with them for duration of event
- Pre-Physical Education Administration     Other (lunch): \_\_\_\_\_
- Other to be determined by School Nurse: \_\_\_\_\_

**To be completed by School Nurse and Student**

Medical 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, insulin & supplies and agrees to follow those medication storage requirements. The supplies will be carried on person and a second set of supplies is unlocked in the Health Office labeled " Diabetic Supplies/ Baqsimi/Glucagon"	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 & on person.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student realizes his/her responsibility in carrying his/her own medication(s) and agrees <b>NEVER</b> share the medication(s)/supplies with others.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
The presence of a nurse on a field trip, sports, after school event is not guaranteed. Student agrees to be responsible to provide and carry his/her own diabetic rescue medication, insulin, diabetic supplies on field trips, sports, and after school events.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student agrees that after administering medication on field trips he/she will immediately inform a nurse/ 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"/>

Expiration date on Insulin Medication in H.O. \_\_\_\_\_ Expiration date Insulin Medication student is carrying is \_\_\_\_\_  
 Expiration date on Glucagon/Baqsimi Medication in H.O. \_\_\_\_\_ Expiration date Glucagon/Baqsimi Medication student is carrying : \_\_\_\_\_

I give permission to notify staff of my plan of carry on person and 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 2025-26

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.						

**DIABETES EMERGENCY ACTION PLAN FOR SCHOOL 2025-26** NON-MEDICAL STAFF/BUS DRIVER /AFTER SCHOOL ACTIVITIES

Student: _____ DOB: _____ Grade: _____ Name of Licensed Prescriber: _____ Phone Number: _____ Diabetes Nurse Educator: _____ Phone number: _____	Parent/Guardian Name: _____ Home Phone: _____ Cell Phone: _____  Parent/Guardian Name: _____ Cell Phone: _____  Emergency Contact; Name/Number: _____
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**AMSA STAFF/TEACHERS-PLEASE READ STUDENTS 504**

Diagnosis: \_\_\_\_\_  
 Allergies to Food or Medication: (  )Yes (  )No Specify Allergy: \_\_\_\_\_  
 Other medication being taken by my student (if not in violation of confidentiality): \_\_\_\_\_  
 Travels to School By: \_\_\_\_\_ Travels Home By: \_\_\_\_\_ If Bus # \_\_\_\_\_ Driver's name: \_\_\_\_\_  
 Attends After school Activities (list what your student will be involved with so we may contact adult in charge of event): \_\_\_\_\_

- (  )Self-Care: manages diabetes independently
- (  ) supported as needed by (nurse, parent or other person): \_\_\_\_\_
- (  )Self Carries Glucose Supplies- Glucose tabs/Snack/drink; Phone, PDM (personal diabetes manager), glucometer to check finger sticks and emergency medication
- (  )Student wears an Insulin Pump/Pod on their body (Type): \_\_\_\_\_
- (  ) CGM (continuous glucose monitor) is remotely monitored by parent/guardian: \_\_\_\_\_ during school hours (7:30-3pm and after school hours) and (  ) Nurse: during school hours 7:30-3pm.

**\*\*\*\*\*Please allow student access to viewing device(s) and smart watch/phone at all times: Student has AMSA administrative privileges for all devices to be used throughout the day as needed and in class.**

**Lunch Time:** (when they will be checking devices & communicating) with( parent or nurse): \_\_\_\_\_

**Physical Ed.**(may need to check glucose by watch/phone or finger stick): Block: \_\_\_\_\_ (Before or After Lunch) on Day#: \_\_\_\_\_

**URGENT:**

**Symptom/appearance of student if Low Sugar:** \_\_\_\_\_

**Symptom/appearance of student if High Sugar:** \_\_\_\_\_

**If students Glucose (sugar) is Below:** \_\_\_\_\_ **or Sugar is Above:** \_\_\_\_\_ at this time they will be communicating with parent and/or nurse; they may use their permanent nurses pass to access the Health Office, Staff may call the nurse for assistance, Student may be ingesting glucose tabs, snack/drink

**Student will communicate with (parent/nurse) via smart watch/phone and will treat accordingly by oral glucose tab/snack, water, finger stick or need to seek medical care from nurse. Allow student to drink juice, soda, eat a glucose tab or a snack from their emergency snack pack. Student may need to check glucose again then have another snack or juice. IF NO CHANGES STUDENT MAY NEED TO GO TO THE HEALTH OFFICE-NEVER SEND THE STUDENT ALONE OR CALL THE NURSES. If no nurse contact parent or 911.**

**\*\*\*\*\*Never leave a student suspected of low Blood sugar anywhere alone; Call the nurse, identify the student and classroom number**

**EMERGENCY CARE:**

If you see or encounter a student known to be a diabetic on campus who is unconscious or having a seizure during school hours (7:30-3pm) call 911 from a school phone and call the nurse.

**\*\*\*\*\*Emergency Medications that the student is carrying can only be given by a school nurse, if no school nurse is available 911 must be called. Emergency medication would need to be given when the student is: unconscious, seizing or unable to swallow**

- Position student on side
- Monitor for vomiting
- Notify parents
- If glucometer is available check finger stick

Emergency Plan if no nurse is available on campus for a school day(7:30am-3pm): Parent will be notified the morning off or day before if absence is known.

**Physician Signature:** \_\_\_\_\_ **Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_

If you want additional care given, describe action here:

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I want this plan implemented for my child, \_\_\_\_\_, in school. I hereby give my permission for the exchange of confidential information contained in the record of my child between the School Nurse and Medical Provider; my signature is an informed consent to share this medical information with school staff as a need to know for academic success and emergency plan as determined by the nurse.

**Parent/GuardianSignature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Edited 6/12/25 MGW

Attach Student Photo: