



# Summer@Taft

## Students with Special Health Conditions

Students with the following conditions are asked to complete and upload additional action plans to their Magnus Health Dashboard:

- Asthma with current inhaler or maintenance medication
- Food or medicine allergy with epi-pen or nasal epinephrine spray prescribed
- Seizure disorder (with or without rescue meds)
- Diabetes

Blank action plans may be accessed below, or through the “conditional questions” section on your child’s Magnus Health dashboard. Please print out and take for your provider to complete and sign, then upload to Magnus.

# ASTHMA ACTION PLAN



Asthma and Allergy  
Foundation of America  
aafa.org

Name:	Date:
Doctor:	Medical Record #:
Doctor's Phone #: Day	Night/Weekend
Emergency Contact:	
Doctor's Signature:	

The colors of a traffic light will help you use your asthma medicines.



- GREEN means Go Zone!**  
Use preventive medicine.
- YELLOW means Caution Zone!**  
Add quick-relief medicine.
- RED means Danger Zone!**  
Get help from a doctor.

Personal Best Peak Flow: \_\_\_\_\_

GO		Use these daily controller medicines:		
<p><b>You have <i>all</i> of these:</b></p> <ul style="list-style-type: none"> <li>Breathing is good</li> <li>No cough or wheeze</li> <li>Sleep through the night</li> <li>Can work &amp; play</li> </ul>	<p><b>Peak flow:</b></p> <p>from _____</p> <p>to _____</p>	MEDICINE	HOW MUCH	HOW OFTEN/WHEN
		For asthma with exercise, take:		
CAUTION		Continue with green zone medicine and add:		
<p><b>You have <i>any</i> of these:</b></p> <ul style="list-style-type: none"> <li>First signs of a cold</li> <li>Exposure to known trigger</li> <li>Cough</li> <li>Mild wheeze</li> <li>Tight chest</li> <li>Coughing at night</li> </ul>	<p><b>Peak flow:</b></p> <p>from _____</p> <p>to _____</p>	MEDICINE	HOW MUCH	HOW OFTEN/ WHEN
		CALL YOUR ASTHMA CARE PROVIDER.		
DANGER		Take these medicines and call your doctor now.		
<p><b>Your asthma is getting worse fast:</b></p> <ul style="list-style-type: none"> <li>Medicine is not helping</li> <li>Breathing is hard &amp; fast</li> <li>Nose opens wide</li> <li>Trouble speaking</li> <li>Ribs show (in children)</li> </ul>	<p><b>Peak flow:</b></p> <p>reading below _____</p>	MEDICINE	HOW MUCH	HOW OFTEN/WHEN

**GET HELP FROM A DOCTOR NOW! Your doctor will want to see you right away. It's important! If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT.**

Make an appointment with your asthma care provider within two days of an ER visit or hospitalization.

**PLACE  
PICTURE  
HERE**

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergic to: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs. Asthma:  **Yes (higher risk for a severe reaction)**  **No**

**NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

**Extremely reactive to the following allergens:** \_\_\_\_\_

**THEREFORE:**

If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.

If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:

## SEVERE SYMPTOMS

 <b>LUNG</b> Shortness of breath, wheezing, repetitive cough	 <b>HEART</b> Pale or bluish skin, faintness, weak pulse, dizziness	 <b>THROAT</b> Tight or hoarse throat, trouble breathing or swallowing	 <b>MOUTH</b> Significant swelling of the tongue or lips
 <b>SKIN</b> Many hives over body, widespread redness	 <b>GUT</b> Repetitive vomiting, severe diarrhea	 <b>OTHER</b> Feeling something bad is about to happen, anxiety, confusion	<b>OR A COMBINATION</b> of symptoms from different body areas.

↓ ↓ ↓

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
  - Consider giving additional medications following epinephrine:
    - » Antihistamine
    - » Inhaler (bronchodilator) if wheezing
  - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
  - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
  - Alert emergency contacts.
  - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

## MILD SYMPTOMS

 <b>NOSE</b> Itchy or runny nose, sneezing	 <b>MOUTH</b> Itchy mouth	 <b>SKIN</b> A few hives, mild itch	 <b>GUT</b> Mild nausea or discomfort
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**FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.**

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**FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:**

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

## MEDICATIONS/DOSES

Epinephrine Brand or Generic: \_\_\_\_\_

Epinephrine Dose:  0.1 mg IM  0.15 mg IM  0.3 mg IM

Antihistamine Brand or Generic: \_\_\_\_\_

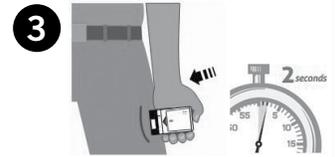
Antihistamine Dose: \_\_\_\_\_

Other (e.g., inhaler-bronchodilator if wheezing): \_\_\_\_\_

\_\_\_\_\_

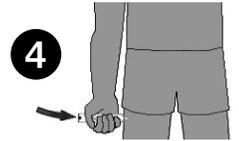
## HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



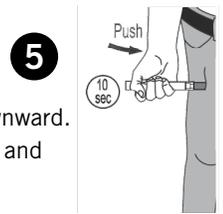
## HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



## HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



## HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



## HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.



## ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

## OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

### EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: \_\_\_\_\_

DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

### OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME/RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME/RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

# Diabetes Medical Management Plan (DMMP)

This plan should be completed by the student's personal diabetes health care team, including the parents/guardians. It should be reviewed with relevant school staff and copies should be kept in a place that can be accessed easily by the school nurse, trained diabetes personnel, and other authorized personnel.

Date of plan: \_\_\_\_\_ This plan is valid for the current school year: \_\_\_\_\_ – \_\_\_\_\_

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## Student information

Student's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Date of diabetes diagnosis: \_\_\_\_\_  Type 1  Type 2  Other: \_\_\_\_\_  
School: \_\_\_\_\_ School phone number: \_\_\_\_\_  
Grade: \_\_\_\_\_ Homeroom teacher: \_\_\_\_\_  
School nurse: \_\_\_\_\_ Phone: \_\_\_\_\_

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## Contact information

**Parent/guardian 1:** \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Email address: \_\_\_\_\_

**Parent/guardian 2:** \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Email address: \_\_\_\_\_

**Student's physician/health care provider:** \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Emergency number: \_\_\_\_\_  
Email address: \_\_\_\_\_

### Other emergency contacts:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

## Checking blood glucose

Brand/model of blood glucose meter: \_\_\_\_\_

Target range of blood glucose:

Before meals:  90–130 mg/dL  Other: \_\_\_\_\_

Check blood glucose level:

- Before breakfast     After breakfast     \_\_\_\_ Hours after breakfast     2 hours after a correction dose  
 Before lunch     After lunch     \_\_\_\_ Hours after lunch     Before dismissal  
 Mid-morning     Before PE     After PE     Other: \_\_\_\_\_  
 As needed for signs/symptoms of low or high blood glucose     As needed for signs/symptoms of illness

Preferred site of testing:  Side of fingertip  Other: \_\_\_\_\_

Note: The side of the fingertip should always be used to check blood glucose level if hypoglycemia is suspected.

Student's self-care blood glucose checking skills:

- Independently checks own blood glucose  
 May check blood glucose with supervision  
 Requires a school nurse or trained diabetes personnel to check blood glucose  
 Uses a smartphone or other monitoring technology to track blood glucose values

Continuous glucose monitor (CGM):  Yes  No Brand/model: \_\_\_\_\_

Alarms set for: Severe Low: \_\_\_\_\_ Low: \_\_\_\_\_ High: \_\_\_\_\_

Predictive alarm: Low: \_\_\_\_\_ High: \_\_\_\_\_ Rate of change: Low: \_\_\_\_\_ High: \_\_\_\_\_

Threshold suspend setting: \_\_\_\_\_

## Additional information for student with CGM

- Confirm CGM results with a blood glucose meter check before taking action on the sensor blood glucose level. If the student has signs or symptoms of hypoglycemia, check fingertip blood glucose level regardless of the CGM.
- Insulin injections should be given at least three inches away from the CGM insertion site.
- Do not disconnect from the CGM for sports activities.
- If the adhesive is peeling, reinforce it with approved medical tape.
- If the CGM becomes dislodged, return everything to the parents/guardians. Do not throw any part away.
- Refer to the manufacturer's instructions on how to use the student's device.

Student's Self-care CGM Skills	Independent?	
The student troubleshoots alarms and malfunctions.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The student knows what to do and is able to deal with a HIGH alarm.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The student knows what to do and is able to deal with a LOW alarm.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The student can calibrate the CGM.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The student knows what to do when the CGM indicates a rapid trending rise or fall in the blood glucose level.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

The student should be escorted to the nurse if the CGM alarm goes off:  Yes  No

Other instructions for the school health team: \_\_\_\_\_

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## Hypoglycemia treatment

Student's usual symptoms of hypoglycemia (list below): \_\_\_\_\_

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If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than \_\_\_\_\_ mg/dL, give a quick-acting glucose product equal to \_\_\_\_\_ grams of carbohydrate.

Recheck blood glucose in 15 minutes and repeat treatment if blood glucose level is less than \_\_\_\_\_ mg/dL.

Additional treatment: \_\_\_\_\_

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**If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movement):**

- Position the student on his or her side to prevent choking.
- Give glucagon:  1 mg       ½ mg       Other (dose) \_\_\_\_\_
  - Route:  Subcutaneous (SC)       Intramuscular (IM)
  - Site for glucagon injection:  Buttocks       Arm       Thigh       Other: \_\_\_\_\_
- Call 911 (Emergency Medical Services) and the student's parents/guardians.
- Contact the student's health care provider.

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## Hyperglycemia treatment

Student's usual symptoms of hyperglycemia (list below): \_\_\_\_\_

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- Check  Urine     Blood for ketones every \_\_\_\_ hours when blood glucose levels are above \_\_\_\_\_ mg/dL.
- For blood glucose greater than \_\_\_\_\_ mg/dL AND at least \_\_\_\_ hours since last insulin dose, give correction dose of insulin (see correction dose orders).
- Notify parents/guardians if blood glucose is over \_\_\_\_\_ mg/dL.
- For insulin pump users: see **Additional Information for Student with Insulin Pump**.
- Allow unrestricted access to the bathroom.
- Give extra water and/or non-sugar-containing drinks (not fruit juices): \_\_\_\_\_ ounces per hour.

Additional treatment for ketones: \_\_\_\_\_

- Follow physical activity and sports orders. (See **Physical Activity and Sports**)

If the student has symptoms of a hyperglycemia emergency, call 911 (Emergency Medical Services) and contact the student's parents/guardians and health care provider. Symptoms of a hyperglycemia emergency include: dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy, or depressed level of consciousness.

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## Insulin therapy

Insulin delivery device:  Syringe       Insulin pen       Insulin pump

Type of insulin therapy at school:  Adjustable (basal-bolus) insulin     Fixed insulin therapy     No insulin

## Insulin therapy (continued)

### Adjustable (Basal-bolus) Insulin Therapy

- **Carbohydrate Coverage/Correction Dose:** Name of insulin: \_\_\_\_\_
- **Carbohydrate Coverage:**  
**Insulin-to-carbohydrate ratio:** \_\_\_\_\_ **Lunch:** 1 unit of insulin per \_\_\_\_\_ grams of carbohydrate  
**Breakfast:** 1 unit of insulin per \_\_\_\_\_ grams of carbohydrate **Snack:** 1 unit of insulin per \_\_\_\_\_ grams of carbohydrate

#### Carbohydrate Dose Calculation Example

$$\frac{\text{Total Grams of Carbohydrate to Be Eaten}}{\text{Insulin-to-Carbohydrate Ratio}} = \text{Units of Insulin}$$

**Correction dose:** Blood glucose correction factor (insulin sensitivity factor) = \_\_\_\_\_ Target blood glucose = \_\_\_\_\_ mg/dL

#### Correction Dose Calculation Example

$$\frac{\text{Current Blood Glucose} - \text{Target Blood Glucose}}{\text{Correction Factor}} = \text{Units of Insulin}$$

**Correction dose scale** (use instead of calculation above to determine insulin correction dose):

Blood glucose \_\_\_\_\_ to \_\_\_\_\_ mg/dL, give \_\_\_\_\_ units    Blood glucose \_\_\_\_\_ to \_\_\_\_\_ mg/dL, give \_\_\_\_\_ units

Blood glucose \_\_\_\_\_ to \_\_\_\_\_ mg/dL, give \_\_\_\_\_ units    Blood glucose \_\_\_\_\_ to \_\_\_\_\_ mg/dL, give \_\_\_\_\_ units

See the worksheet examples in **Advanced Insulin Management: Using Insulin-to-Carb Ratios and Correction Factors** for instructions on how to compute the insulin dose using a student's insulin-to-carb ratio and insulin correction factor.

### When to give insulin:

#### Breakfast

- Carbohydrate coverage only
- Carbohydrate coverage plus correction dose when blood glucose is greater than \_\_\_\_\_ mg/dL and \_\_\_\_ hours since last insulin dose.
- Other: \_\_\_\_\_

#### Lunch

- Carbohydrate coverage only
- Carbohydrate coverage plus correction dose when blood glucose is greater than \_\_\_\_\_ mg/dL and \_\_\_\_ hours since last insulin dose.
- Other: \_\_\_\_\_

#### Snack

- No coverage for snack
- Carbohydrate coverage only
- Carbohydrate coverage plus correction dose when blood glucose is greater than \_\_\_\_\_ mg/dL and \_\_\_\_ hours since last insulin dose.
- Correction dose only: For blood glucose greater than \_\_\_\_\_ mg/dL AND at least \_\_\_\_ hours since last insulin dose.
- Other: \_\_\_\_\_

## Insulin therapy (continued)

**Fixed Insulin Therapy** Name of insulin: \_\_\_\_\_

- \_\_\_\_\_ Units of insulin given pre-breakfast daily
- \_\_\_\_\_ Units of insulin given pre-lunch daily
- \_\_\_\_\_ Units of insulin given pre-snack daily
- Other: \_\_\_\_\_

### Parents/Guardians Authorization to Adjust Insulin Dose

- Yes  No Parents/guardians authorization should be obtained before administering a correction dose.
- Yes  No Parents/guardians are authorized to increase or decrease correction dose scale within the following range: +/- \_\_\_\_\_ units of insulin.
- Yes  No Parents/guardians are authorized to increase or decrease insulin-to-carbohydrate ratio within the following range: \_\_\_\_\_ units per prescribed grams of carbohydrate, +/- \_\_\_\_\_ grams of carbohydrate.
- Yes  No Parents/guardians are authorized to increase or decrease fixed insulin dose within the following range: +/- \_\_\_\_\_ units of insulin.

### Student's self-care insulin administration skills:

- Independently calculates and gives own injections.
- May calculate/give own injections with supervision.
- Requires school nurse or trained diabetes personnel to calculate dose and student can give own injection with supervision.
- Requires school nurse or trained diabetes personnel to calculate dose and give the injection.

## Additional information for student with insulin pump

**Brand/model of pump:** \_\_\_\_\_ **Type of insulin in pump:** \_\_\_\_\_

**Basal rates during school:** Time: \_\_\_\_\_ Basal rate: \_\_\_\_\_ Time: \_\_\_\_\_ Basal rate: \_\_\_\_\_  
Time: \_\_\_\_\_ Basal rate: \_\_\_\_\_ Time: \_\_\_\_\_ Basal rate: \_\_\_\_\_  
Time: \_\_\_\_\_ Basal rate: \_\_\_\_\_

**Other pump instructions:** \_\_\_\_\_

**Type of infusion set:** \_\_\_\_\_

**Appropriate infusion site(s):** \_\_\_\_\_

- For blood glucose greater than \_\_\_\_\_ mg/dL that has not decreased within \_\_\_\_\_ hours after correction, consider pump failure or infusion site failure. Notify parents/guardians.
- For infusion site failure: Insert new infusion set and/or replace reservoir, or give insulin by syringe or pen.
- For suspected pump failure: Suspend or remove pump and give insulin by syringe or pen.

### Physical Activity

- May disconnect from pump for sports activities:  Yes, for \_\_\_\_\_ hours  No
- Set a temporary basal rate:  Yes, \_\_\_\_\_ % temporary basal for \_\_\_\_\_ hours  No
- Suspend pump use:  Yes, for \_\_\_\_\_ hours  No

## Additional information for student with insulin pump (continued)

Student's Self-care Pump Skills	Independent?	
Counts carbohydrates	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculates correct amount of insulin for carbohydrates consumed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Administers correction bolus	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculates and sets basal profiles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculates and sets temporary basal rate	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Changes batteries	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Disconnects pump	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reconnects pump to infusion set	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prepares reservoir, pod, and/or tubing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Inserts infusion set	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Troubleshoots alarms and malfunctions	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## Other diabetes medications

Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Times given: \_\_\_\_\_

Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Times given: \_\_\_\_\_

## Meal plan

Meal/Snack	Time	Carbohydrate Content (grams)
Breakfast		____ to ____
Mid-morning snack		____ to ____
Lunch		____ to ____
Mid-afternoon snack		____ to ____

Other times to give snacks and content/amount: \_\_\_\_\_

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event): \_\_\_\_\_

Special event/party food permitted:  Parents'/Guardians' discretion  Student discretion

### Student's self-care nutrition skills:

- Independently counts carbohydrates
- May count carbohydrates with supervision
- Requires school nurse/trained diabetes personnel to count carbohydrates

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## Physical activity and sports

A quick-acting source of glucose such as  glucose tabs and/or  sugar-containing juice must be available at the site of physical education activities and sports.

Student should eat  15 grams  30 grams of carbohydrate  other: \_\_\_\_\_

before  every 30 minutes during  every 60 minutes during  after vigorous physical activity  other: \_\_\_\_\_

If most recent blood glucose is less than \_\_\_\_\_ mg/dL, student can participate in physical activity when blood glucose is corrected and above \_\_\_\_\_ mg/dL.

Avoid physical activity when blood glucose is greater than \_\_\_\_\_ mg/dL or if urine/blood ketones are moderate to large.

(See **Administer Insulin** for additional information for students on insulin pumps.)

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## Disaster plan

To prepare for an unplanned disaster or emergency (72 hours), obtain emergency supply kit from parents/guardians.

Continue to follow orders contained in this DMMP.

Additional insulin orders as follows (e.g., dinner and nighttime): \_\_\_\_\_

\_\_\_\_\_

Other: \_\_\_\_\_

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## Signatures

This Diabetes Medical Management Plan has been approved by:

\_\_\_\_\_  
Student's Physician/Health Care Provider

\_\_\_\_\_  
Date

I, (parent/guardian) \_\_\_\_\_, give permission to the school nurse or another qualified health care professional or trained diabetes personnel of (school) \_\_\_\_\_ to perform and carry out the diabetes care tasks as outlined in (student) \_\_\_\_\_ Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified health care professional to contact my child's physician/health care provider.

Acknowledged and received by:

\_\_\_\_\_  
Student's Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student's Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
School Nurse/Other Qualified Health Care Personnel

\_\_\_\_\_  
Date

# SEIZURE ACTION PLAN (SAP)



Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact/Relationship \_\_\_\_\_ Phone: \_\_\_\_\_

## Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

### How to respond to a seizure (check all that apply)

- First aid – **Stay. Safe. Side.**
- Give rescue therapy according to SAP
- Notify emergency contact
- Notify emergency contact at \_\_\_\_\_
- Call 911 for transport to \_\_\_\_\_
- Other \_\_\_\_\_

### First aid for any seizure

- STAY** calm, keep calm, **begin timing seizure**
- Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- STAY** until recovered from seizure
- Swipe magnet for VNS
- Write down what happens \_\_\_\_\_
- Other \_\_\_\_\_

### When to call 911

- Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- Difficulty breathing after seizure
- Serious injury occurs or suspected, seizure in water

### When to call your provider first

- Change in seizure type, number or pattern
- Person does not return to usual behavior (i.e., confused for a long period)
- First time seizure that stops on its' own
- Other medical problems or pregnancy need to be checked

### When rescue therapy may be needed:

#### WHEN AND WHAT TO DO

If seizure (cluster, # or length) \_\_\_\_\_

Name of Med/Rx \_\_\_\_\_ How much to give (dose) \_\_\_\_\_

How to give \_\_\_\_\_

If seizure (cluster, # or length) \_\_\_\_\_

Name of Med/Rx \_\_\_\_\_ How much to give (dose) \_\_\_\_\_

How to give \_\_\_\_\_

If seizure (cluster, # or length) \_\_\_\_\_

Name of Med/Rx \_\_\_\_\_ How much to give (dose) \_\_\_\_\_

How to give \_\_\_\_\_

## Care after seizure

What type of help is needed? (describe) \_\_\_\_\_

When is person able to resume usual activity? \_\_\_\_\_

## Special instructions

First Responders: \_\_\_\_\_

Emergency Department: \_\_\_\_\_

## Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

## Other information

Triggers: \_\_\_\_\_

Important Medical History \_\_\_\_\_

Allergies \_\_\_\_\_

Epilepsy Surgery (type, date, side effects) \_\_\_\_\_

Device:  VNS  RNS  DBS Date Implanted \_\_\_\_\_

Diet Therapy  Ketogenic  Low Glycemic  Modified Atkins  Other (describe) \_\_\_\_\_

Special Instructions: \_\_\_\_\_

## Health care contacts

Epilepsy Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

My signature \_\_\_\_\_ Date \_\_\_\_\_

Provider signature \_\_\_\_\_ Date \_\_\_\_\_