# Your Rights Under Section 504

**[Insert District Name or Logo]**

*You have the right to be informed by the school district of your rights under Section 504. This is a notice of you and your child's rights under Section 504 and the rights you have if you disagree with the school district's decisions.*

**WHAT IS SECTION 504?**

Section 504 of the Rehabilitation Act of 1973, commonly called "Section 504," is a federal law that protects students from discrimination based on disability. Section 504 assures that students with disabilities have educational opportunities and benefits equal to those provided to students without disabilities. To be eligible, a student must have a physical or mental impairment that substantially limits one or more major life activity.

## YOUR CHILD'S EDUCATION

Your child has the right to:

- Receive a free and appropriate public education.
- Participate in and benefit from the district's educational programs without discrimination.
- Be provided an equal opportunity to participate in the district's nonacademic and extracurricular activities.
- Be educated with students who do not have disabilities to the maximum extent appropriate.
- Be educated in facilities and receive services that are comparable to those provided to students without disabilities.
- Receive accommodations and/or related aids and services to allow your child an equal opportunity to participate in school activities.
- Receive educational and related aids and services without cost, except for those fees imposed on the parents of children without disabilities.
- Receive special education services if needed.

## YOUR CHILD'S EDUCATIONAL RECORDS

You have the right to:

- Review your child's educational records and to receive copies at a reasonable cost. You will not be charged if the cost would keep you from reviewing the records.
- Ask the district to change your child's education records if you believe that they are wrong, misleading, or are otherwise in violation of your child's privacy rights. If the district refuses this request, you have the right to challenge the refusal by requesting an impartial hearing.
- A response to your reasonable requests for explanations and interpretations of your child's education records.

## THE SECTION 504 PROCESS

Your child has the right to an evaluation before the school determines if he or she is eligible under Section 504. You have the right to:

- Receive notice before the district takes any action regarding the identification, evaluation, and placement of your child.
- Have evaluation and placement decisions made by a group of persons, often called a "504 team", including persons who know your child, the meaning of the evaluation information, and the placement options available.
- Have evaluation decisions based on a variety of sources, such as aptitude and achievement tests, teacher recommendations, physical conditions, medical records, and parental observations.
- Refuse consent for the initial evaluation and initial placement of your child.

If your child is eligible under Section 504, your child has a right to periodic re-evaluations, including re-evaluations before any significant change is made in your child's placement.

## IF YOU DISAGREE WITH THE DISTRICT'S DECISION

If you disagree with the district's decisions regarding your child's identification, evaluation, educational program, or placement under Section 504, you may request mediation or an impartial due process hearing. You and your child have the right to take part in the hearing and have an attorney represent you. Hearing requests and other concerns can be made to your district's Section 504 Coordinator:

[Insert Section 504 Coordinator's Name]
[Address]
[City, State, Zip]
[Phone], [E-mail]

You have the right to file a complaint of discrimination with the U.S. Department of Education's Office for Civil Rights (OCR), or to file a complaint in federal court. Generally, an OCR complaint may be filed within 180 calendar days of the act that you believe was discriminatory. The regional office is located at 915 Second Ave, Room 3310, Seattle, WA 98174-1099.
Phone: 206-607-1600/TDD: 206-607-1647
Website: www.ed.gov/OCR.

# Health Services Prior Written Notice
# and/or
# Action/Consent
# for
# 504 / Individual Health Plan (IHP)

**Purpose**: As a parent/guardian of a student potentially needing a 504/IHP, the school district is required to provide you with prior written notice whenever it proposes or refuses to initiate these services for your child. The notice should be given to you in a reasonable amount of time before the district takes action. By signing this form and the 504/IHP for your child, you are giving your consent for the 504 evaluation and accommodations. You will be provided with a copy of the *Notice of Parent/Guardian and Your Rights Under Section 504.* Please review these rights and consult with your school nurse if you have questions.

**To:** _____ **Date:** _____

**Student's Name:** _____ **Date of Birth:** _____

The purpose of this prior written notice is to inform you and receive your consent to take the following action:

___ Evaluate your child for eligibility under Section 504
___ Initiate and implement the attached 504/IHP
___ Not initiate a 504/IHP plan because your child is ineligible
___ Implement a change to your child's 504 plan
___ Re-evaluate your child for eligibility under Section 504
___ Terminate your child's 504/IHP plan
___ Other: _____

The reason we are proposing to take this action: _____

_____

A description of each procedure, test, record, or report we used or plan to use as the basis for taking this action is as follows: health history; relevant information from Health Care Provider/parent/student as appropriate; medication orders; other information or documents:

_____

_____

Any other factors that are relevant to this action (parent input, student's academic schedule, other):

_____

_____

The action will be initiated on: _____

☐ Rights explained and provided to parents. *Your child has procedural protections under IDEA.

_____ _____ _____ _____

Parent/Guardian Signature Date School Nurse Signature Date

_____ SCHOOL DISTRICT

**HISTORY/QUESTIONNAIRE FOR STUDENTS WITH DIABETES**

Name _____ Birthdate _____ Grade _____
Last First MI Legal name (if different)

1. At what age was your child diagnosed with diabetes? _____ ☐ Type 1 ☐ Type 2 ☐ Other_____
2. Has your child been hospitalized for diabetes? ☐ No ☐ Yes If yes, when: _____
3. Does your child have other health concerns or take other medications? ☐ Yes ☐ No
   If yes, please list: _____
4. What insulin method of delivery does your child use? ☐ Vial/syringe ☐ Pen (type)_____ ☐ Pump (type) _____
   - Insulin administration: ☐ Requires assistance ☐ Requires supervision ☐ Independent
5. What form of glucagon is prescribed for your child? ☐ Injectable (type)_____ ☐ Intranasal
   - Has glucagon ever been given for severe low blood sugar? ☐ No ☐ Yes If yes, when: _____
6. What glucose monitoring device does your child use? ☐ meter ☐ CGM (brand/model) _____
   - Blood glucose monitoring: ☐ Requires assistance ☐ Requires supervision ☐ Independent
   - Ability to recognize signs of low and high blood sugar: ☐ Requires assistance ☐ Independent
7. How often does your child typically experience **low** blood sugar?
   ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____
8. My child typically experiences low blood sugar:
   ☐ Morning ☐ Before lunch ☐ Afternoon ☐ Evening ☐ After Exercise ☐ Other_____
9. My child's symptoms of low blood sugar are: _____
   _____
10. How often does your child typically experience **high** blood sugar?
    ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____
11. My child typically experiences high blood sugar:
    ☐ Morning ☐ Before lunch ☐ Afternoon ☐ Evening ☐ After Exercise ☐ Other_____
12. My child's symptoms of high blood sugar are: _____
    _____
13. Do you have concerns about your child being in school related to diabetes?_____
    _____
14. Does your child have concerns about being in school related to diabetes? _____
    _____
15. Will your child eat school meals? ☐ Breakfast ☐ Lunch ☐ no, meals will be provided from home
    - Carbohydrate counting: ☐ Requires assistance ☐ Requires supervision ☐ Independent
16. Any other information do you want us to know to best help your child in school?_____
    _____
17. How would your child prefer to share information about diabetes with classmates?_____
    _____

_____
Parent signature Phone Date

# SCHOOL DISTRICT

## AUTHORIZATION FOR *EXCHANGE* OF HEALTH CARE INFORMATION

---

Patient/Student Name _____ Birthdate _____

I hereby authorize the exchange of health and education information:

**Between School District Staff (listed below)** **and:**

School Nurse _____ Phone _____ Name of Agency/Individual _____ Phone _____

Health Coordinator _____ Phone _____ Address _____

Other _____ Phone _____ City, State, Zip Code _____

**Specific nature of information to be disclosed:**

_____

_____

_____

**Purpose for which disclosure is being made:**

_____

_____

I hereby authorize the exchange of health care information as described above. I recognize that this information, once received by the school district, may no longer be protected by the HIPAA Privacy Rule and become educational records protected by the Family Education Rights and Privacy Act (FERPA), but will be handled in compliance with applicable state and federal laws and school district policies and procedures.

This authorization expires with end of the school year or _____, whichever is sooner. I may terminate this authorization in writing at any time. I have a right to a copy of the authorization and may inspect and receive a copy of the disclosed or used information.

Parent Signature _____ Date _____ Student Signature * _____ Date _____

* If the student is a minor but is authorized to consent to health care without parental consent under federal and state laws, only the student shall sign this form.

| | |
|---|---|
| HIV/AIDS, STDs status, diagnosis, treatment | 14 years of age |
| Family Planning/Abortion | No age limit |
| Alcohol/Drug Treatment | 13 years of age |
| Mental Health Services | 13 years of age |

(Envelope shall be marked "**CONFIDENTIAL**")

Washington Office of Superintendent of
# PUBLIC INSTRUCTION

## REQUEST FOR SPECIAL DIETARY ACCOMODATIONS

| | |
|---|---|
| Student / Participant Name | Date of Birth |
| Parent / Guardian Name | Phone |
| Mailing Address | City/State/Zip |
| School / Center / Site | Grade / Classroom |
| Signature of Parent/Guardian | Date |

### Diet Order

Federal law and USDA regulation require nutrition programs to make reasonable modifications to accommodate children with disabilities. Under the law, a disability is an impairment which substantially limits a major life activity or bodily function, which can include allergies and digestive conditions, but does not include personal diet preferences.

1. **Describe how the impairment affects the child** (i.e., how the ingestion/contact with the food impacts the child):

2. **Explain what must be done to accommodate the child's diet** (i.e., specific food(s) to be omitted/avoided from the child's diet):

3. **List food(s) and/or beverages to be substituted, provided, or modified:**

| | |
|---|---|
| Signature of State-Recognized Medical Authority* | Date |
| Clinic Name | |

# SCHOOL DIABETES ORDERS - MDI (Multiple Daily Injection)

NAME: _____ GRADE: _____ SCHOOL: _____

Start date: _____ for the current school year. *Licensed Healthcare Provider (LHP) to Complete Annually*

**LOW GLUCOSE (BG) MANAGEMENT**

1. If BG is below 70 or SG < 80 with a downward arrow or student having symptoms, give _____grams fast-acting carbohydrates per 504.
2. Recheck BG in 15 minutes and repeat carbohydrate treatment if BG still < 80 or if student continues to be symptomatic.
3. Once BG is > 80, may follow with 5-15 gram carb snack, or meal if time. Do not include low treatment in meal carbs.

**If unconscious, unresponsive, difficulty swallowing, or evidence of seizure: Phone 911 immediately. Do NOT give anything by mouth.**

☐ **If nurse or PDA is available, administer Glucagon ____ mg SQ or IM -or- ☐ Baqsimi 3mg/nasal spray by nurse/designee.**

**HIGH GLUCOSE (BG) MANAGEMENT**

1. Correction with Insulin
   - ☐ If glucose is over target range _____for _____hours after last bolus or carbohydrate intake, student should receive correction dose of insulin per orders, but only cover with carb ratio at the next meal time.
   - ☐ Never correct for high glucose levels other than at mealtime, unless consultation with student's LHP (Licensed Healthcare Provider) or as set up by 504 plan.
2. Ketones: Test urine/blood ketones if ☐ Glucose > 300 X 2hrs, or ☐ Never. Call guardian if having moderate or large ketones.
3. No exercise if having nausea or abdominal pain, or if ketones are tested and found positive (moderate or large).
4. Encourage student to drink plenty of water and provide rest if needed.

**BLOOD GLUCOSE (BG) TESTING / SENSOR GLUCOSE (SG) VIA CONTINUOUS GLUCOSE MONITOR (CGM)**

**Use of SG allowed for extra testing.**

Glucose to be tested: ☐ Before meals and for symptoms of low or high glucose, or as set up by the 504 plan.

Extra glucose testing: ☐ before PE, ☐ before going home unless pick up by guardian.

**Glucose at which guardian should be notified:** Low < 70 mg/dL after 2 treatments, or High >300 mg/dL X 2 hours.

Notify guardian if repeated hypoglycemia, abdominal pain, nausea/vomiting, fever, hypoglycemic before going home, or if there is a refusal of care by the student. Hyperglycemia alone is not medically justified for sending student home in absence of symptoms.

**INSULIN ADMINISTRATION at *Mealtime/Snacks*** ☐ Apidra ☐ Humalog ☐ Novolog ☐ Fiasp ☐ Lyumjev

| | |
|---|---|
| **Insulin to Carb Ratio:** 1 unit per _____grams Carb<br>**Glucose Correction Factor:** 1 unit per_____mg/dL > ____ | Insulin injection to be given: ☐ before, or ☐ after meal<br>☐ after meal injection when before meal glucose < 80 mg/dL |
| ☐ Guardian authorized to adjust insulin for carbs, glucose level, activity | |
| ☐ Licensed medical personnel authorized to adjust the insulin dose by +/- 0 to 5 units after consultation with guardian | |

**STUDENT'S SELF-CARE**

| | | | |
|---|---|---|---|
| **1.** Independent Diabetes Management - Student will perform all diabetes task independent of adult supervision. Guardian will work together with student to make dose adjustments as needed. | ☐ | **2.** Student Needs Supervision - Specific supervision plan subject to parent, student, nurse and HCP approval and/or assessment, with ongoing re-evaluation, as identified in the IHP and 504 plan. | ☐ |

| | |
|---|---|
| If patient wears **Dexcom or FreeStyle Libre** CGM insulin dose per orders based on SG reading per FDA. Test BG if no number, no arrow trend, or if symptoms/expectations do not correlate with SG reading. | If patient wears **Medtronic Guardian Connect** CGM; Insulin per orders based on BG reading only per FDA. |

**DISASTER PLAN ORDERS**

**Guardian is responsible for providing and maintaining "disaster kit" and to notify school nurse.** In case of disaster:
Use above glucose correction scale + carb ratio coverage for disaster insulin dosing every 3-4 hrs as indicated by BG levels and carbs.

Electronically signed by: Fax: 509-474-2241 Phone: 509-474-2880

I authorize the exchange of medical information about my child's diabetes management between the LHP and the school nurse.

Parent Signature:_____ Print Name:_____ Date:

School Nurse Signature:_____ Print Name:_____ Date: _____

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# SCHOOL DIABETES ORDERS – Pump:

NAME : GRADE: SCHOOL:

Start date: _____for the current school year. *Licensed Healthcare Provider (LHP) to Complete Annually*

**LOW GLUCOSE (BG) MANAGEMENT**

1. If BG is below 70 or SG < 80 with a downward arrow or student having symptoms, give _____grams fast-acting carbohydrates per 504.
2. Recheck BG in 15 minutes and repeat carbohydrate treatment if BG still < 80 or if student continues to be symptomatic.
3. Once BG is > 80, may follow with 5-15 gram carb snack, or meal if time. Do not include low treatment in meal carbs.

**If unconscious, unresponsive, difficulty swallowing, or evidence of seizure: Phone 911 immediately. Do NOT give anything by mouth.**

☐ **If nurse or PDA is available, administer Glucagon mg SQ or IM -or- ☐ Baqsimi 3mg/nasal spray by nurse/designee.**

**HIGH GLUCOSE (BG) MANAGEMENT**

1. Correction with Insulin
   - ☐ If glucose is over 200 for 2 hours after last bolus or carbohydrate intake, student should receive correction bolus of insulin per insulin orders; pump will account for insulin on board (IOB).
   - ☐ Never correct for high blood glucose other than at mealtime, unless consultation with student's LHP (Licensed Healthcare Provider) or as set up by 504 plan.
2. Ketones: Test urine/blood ketones if ☐ Glucose > 300 X 2hrs, or ☐ Never. Call guardian if having moderate/large ketones.
3. No exercise if having nausea or abdominal pain, or if ketones are tested and found positive (moderate or large).
4. Encourage student to drink plenty of water and provide rest if needed.

**BLOOD GLUCOSE (BG) TESTING / SENSOR GLUCOSE (SG) VIA CONTINUOUS GLUCOSE MONITOR (CGM)**

**Use of sensor Glucose allowed for extra testing.**

Glucose to be tested: ☐ Before meals and for symptoms of low or high glucose, or as set up by the 504 plan.

Extra glucose testing: ☐ before PE ☐ before going home unless pick up by guardian.

**Glucose at which guardian should be notified**: Low < 70 mg/dL after 2 treatments, or High >300 mg/dL X 2 hours.

Notify guardian if repeated hypoglycemia, abdominal pain, nausea/vomiting, fever, hypoglycemic before going home, or if there is a refusal of care by the student. Hyperglycemia alone is not medically justified for sending student home in absence of symptoms.

**INSULIN ADMINISTRATION at *Mealtime/Snacks*** ☐ Apidra ☐ Humalog ☐ Novolog ☐ Fiasp ☐ Lyumjev

**Insulin to Carb Ratio:** 1 unit per _____ grams Carb
**Glucose Correction Factor:** 1 unit per_____mg/dL > _____

☐ Guardian authorized to adjust insulin for carbs, glucose level, activity

Insulin bolusing to be given: ☐ before, or ☐ after meal

☐ Insulin injection should be used for pump malfunction

☐ after meal bolusing when before meal BG < 80 mg/dL

☐ Licensed medical personnel authorized to adjust the insulin dose by +/- 0 to 5 units after consultation with guardian

**STUDENT'S SELF-CARE**

| | | | | | |
|---|---|---|---|---|---|
| **1.** | Independent Diabetes Management - Student will perform all diabetes task independent of adult supervision. Guardian will work together with student to make dose adjustments as needed. | ☐ | **2.** | Student Needs Supervision - Specific supervision plan subject to parent, student, nurse and HCP approval and/or assessment, with ongoing re-evaluation, as identified in the IHP and 504 plan. | ☐ |

| | |
|---|---|
| If patient wears **Dexcom or FreeStyle Libre** CGM insulin dose per orders based on SG reading per FDA. Test BG if no number, no arrow trend, or if symptoms/expectations do not correlate with SG reading. | If patient wears **Medtronic** CGM; Insulin per orders based on BG reading only per FDA. |

**DISASTER PLAN & ORDERS**

**Guardian is responsible for providing and maintaining "disaster kit" and to notify school nurse.** In case of disaster:
Use above glucose correction scale + carb ratio coverage for disaster insulin dosing every 3hrs as indicated by BG levels and carbs.

Electronically signed by: Fax: 509-474-2241 Phone: 509-474-2880

I authorize the exchange of medical information about my child's diabetes management between the LHP and the school nurse.

Parent Signature:_____Print Name:_____Date: _____

School Nurse Signature:_____Print Name:_____Date:_____

# DIABETES INDIVIDUALIZED HEALTHCARE PLAN AND 504 ACCOMMODATION PLAN

*Parent/Guardian and School Nurse to Complete Annually Together*

Name _____ Birthdate _____ Grade ____
Last First MI Legal name (if different)

Start Date: _____ End Date: ☐ Last day of school ☐ other: _____

**Brief History**

| | |
|---|---|
| Age of onset: | Results and date of Hemoglobin A1C test: |
| Date(s) of recent hospitalizations: | Related social/emotional factors: |
| Concurrent illness or disability (including medications): | |

**Substantial limitation in major life activities**

All students with diabetes are substantially limited in the function of their endocrine system. Additional major life activities affected:

☐ Eating ☐ Caring for oneself ☐ Thinking ☐ Communicating ☐ Learning ☐ Other: _____

**ACCOMMODATIONS**

**Daily Diabetes Routine**

Daily snacks (time): _____

Blood glucose testing: Time/s: _____
Location/s: _____

Breakfast eaten at ☐ home ☐ school (time): _____

Lunch eaten at (time): _____ Location/s: _____

Recess times: _____

Insulin dosing: Time/s: _____
Location/s: _____

PE days/times: _____

**District food services department** will provide carbohydrate content information for meals provided by the district. Meals will never be withheld because of nonpayment of fees or disciplinary action.

**Student will be allowed** unrestricted access to water, meal/snack, and use of the restroom.

**Classroom work and tests**

Educators working with the student will be informed when the student has a blood glucose level (less than ____ or over____) that may affect their cognitive and/or physical ability by: ☐ Written note ☐ Student verbally ☐ Other (specify) _____

- If the student is affected by high or low blood glucose levels at the time of regular testing, the student will be permitted to take the test at another time without penalty.
- If the student needs to take breaks to use the water fountain or bathroom, check blood glucose, or to treat hypoglycemia or hyperglycemia during a test or other activity, the student will be given extra time to finish the test or other activity without penalty.
- The student shall be given instruction to help him/her make up any classroom instruction missed due to diabetes care without penalty.
- The student shall not be penalized for absences required for medical appointments and/or for illness. The parent will provide documentation from the treating health care professional if otherwise required by school policy

**Communication**

- The school nurse, and other staff will keep the student's diabetes confidential, except to the extent that the student decides to openly communicate about it with others.
- Encouragement is essential. The student be treated in a way that encourages the student to eat snacks on time and to progress toward self-care with their diabetes management skills.
- The teacher, school nurse, or other school staff will provide reasonable notice to parent/guardian when there will be a change in planned activities such as exercise, playground time, field trips, parties, or lunch schedule, so that the lunch, snack plan, and insulin dosage can be adjusted accordingly.
- Each substitute teacher and substitute school nurse will be provided with written instructions regarding the student's diabetes care and a list of all school nurses and trained staff at the school.
- Communication from staff members to parents will be completed by: ☐ Written note ☐ Student verbally ☐ Other (specify): _____

**Classroom parties:** Food treats will be handled as follows:

☐ Student will eat treat ☐ Replace with parent/guardian supplied alternative ☐ Other _____

☐ Schedule extra insulin per prearranged plan.

**Parent Designated Adult (PDA)**: Is a PDA present for your child? ☐ Yes *(If Yes, PDA Documentation Required)* ☐ No

**After-school activities/school-sponsored events:** _____

Note: Student will be permitted to participate in all school-sponsored activities without restriction and with all accommodations and modifications indicated in this plan.

**Field trips**: All diabetes supplies are taken and care is provided by: ☐ Licensed nurse ☐ PDA ☐ Other_____

Note: In the unplanned event where these options are unavailable, the student may remain at school and be provided a comparable experience or stay home when applicable.

**Transportation**: ☐ Takes the bus (Bus #_____) ☐ Walks ☐ Transported by parent/guardian

On-bus care is provided by: ☐ Licensed nurse ☐ PDA ☐ Other_____

Student will not be transported on school bus with BG < ____ or > ____ within 15 minutes of departure. Parent/guardian will be called to transport the student.

**Additional accommodations**:

Student uses and carries electronic device(s) for diabetic management: ☐ Yes ☐ No

If yes, please describe what is used: _____

_____

_____

_____

_____

_____

**EXTRA SUPPLIES (PROVIDED BY PARENT/GUARDIAN) AND LOCATION KEPT** (including disaster supplies):

| |
|---|
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |
| 6. |

**CONTACT INFORMATION**

| **Parent/Guardian 1** | **Parent/Guardian 2** |
|---|---|
| Name: | Name: |
| Home Phone: | Home Phone: |
| Work Phone: | Work Phone: |
| Other: | Other: |

**ADDITIONAL EMERGENCY CONTACTS:**

| | | |
|---|---|---|
| 1. | Relationship: | Phone: |
| 2. | Relationship: | Phone: |

**LICENSED HEALTHCARE PROVIDER:**

| | | |
|---|---|---|
| Name: | Phone: | Fax: |
| Location/Address: | | |

**SIGNATURES:**

| | |
|---|---|
| Parent/Guardian: | Date: |
| Student: | Date: |
| School Nurse: | Date: |

# DIABETES EMERGENCY CARE PLAN

**An adult must stay with any student suspected of having low blood glucose!**

Place student picture here

| **STUDENT NAME** | | | | **Birthdate** | |
|---|---|---|---|---|---|
| **Grade** | **School** | ☐ **Bus #** | ☐ **Walk** ☐ **Drive** | **Weight:** | **Height:** |

**Brief medical history:**

## HYPOGLYCEMIA (LOW BLOOD SUGAR)

**Signs of Low Blood Glucose (BG)**

*Circle Student Specific Symptoms*

- Headache
- Sweating, pale
- Shakiness, dizziness
- Poor coordination
- Tired, falling asleep in class
- Inability to concentrate
- Student states they don't feel "right" or feel "funny"
- Weakness
- Anxiety
- Irritability
- Hunger
- Behavior Change
- Confusion
- Blurry Vision
- Slurred Speech
- Other: _____

1. If BG is below ___ or having symptoms, give__ grams of fast-acting carbohydrates (i.e., __ glucose tabs, __ oz juice)

   Location: ☐ Office ☐ Backpack ☐ On person

   ☐ Other_____
2. Recheck BG in 15 minutes and repeat carbohydrate treatment if BG still < 80 or if student continues to be symptomatic.
3. Once BG is > 80, *may* follow with _____ grams carbs.

   Do not include treatment carbs in insulin dosing calculation. Student may return to activity.

**If unconscious, unresponsive, having difficulty swallowing, or evidence of seizure:**

**Call 911 immediately**

**Do NOT give anything by mouth.**

**If nurse or trained PDA is available, administer:**

☐ Glucagon (___ mg SQ or IM)

**If nurse, PDA, or UAP is available, administer:**

☐ Baqsimi 3mg/nasal spray

Location: ☐ Office ☐ Backpack ☐ On person

☐ Other_____

☐ STOP Insulin Pump

☐ Keep student on the left side in the recovery position.

☐ Call School Nurse and Parent/Guardian

## HYPERGLYCEMIA (HIGH BLOOD SUGAR)

**Signs of High Blood Glucose (BG)**

*Circle Student Specific Symptoms*

- Headache
- Nausea
- Tired
- Increased thirst
- Frequent urination
- Tired
- Blurred vision
- Other: _____
- Flushed Skin
- Increased Hunger
- Lack of concentration
- Sweet breath
- Stomach pain
- Dry mouth

Insulin Correction:

☐ Pump

If BG is over target range _____ for _____ hours after last bolus or carbohydrate intake, student should receive correction dose of insulin per orders; the pump will account for insulin on board (IOB).

☐ Injection

If BG is over target range _____ for _____ hours after last bolus or carbohydrate intake, student should receive correction dose of insulin per orders, but only cover with carb ratio at the next meal time.

☐ Never correct for high blood sugars other than at mealtime, unless consultation with student's LHP (Licensed Healthcare Provider) or as set up by the 504 plan.

Test urine ketones:

☐ if BG > 300 X 2hrs

☐ Never

Call parent if child is having moderate or large ketones.

No exercise if having nausea or abdominal pain, or if ketones are tested and found positive (moderate or large).

Encourage student to drink plenty of water and provide rest if needed.

**If changes in mental status and labored breathing are present.**

**Call 911 immediately**

**Contact Parent/Guardian and School Nurse**

Notify the parent/guardian of repeated hypoglycemia, abdominal pain, nausea/vomiting, fever, if hypoglycemic before going home, or if there is a refusal of care by the child. Hyperglycemia is not medically justified for sending home the student, in the absence of symptoms.

## EMERGENCY CONTACT INFORMATION

| Parent/ Guardian | Name | Parent/ Guardian | Name |
|---|---|---|---|
| | Primary # | | Primary # |
| | Other # | | Other # |

| School Nurse Signature: | Date: |
|---|---|

# DESIGNATION OF A PARENT DESIGNATED ADULT FOR DIABETIC CARE

Washington State requires public school districts to address the medical needs of students with diabetes. Pursuant to RCW 28A.210.330-350, the school district uses this document to allow the parent/guardian to designate a parent designated adult (PDA) who can provide care for a student with diabetes.

For the purpose of this form, a PDA means, a volunteer who may be a school district employee, who receives additional training from a health care professional or expert in diabetic care selected by the parent/guardian, who provides care for the child consistent with their individual health plan. The additional training is for care that would otherwise be performed by a health care professional licensed under RCW 18.79.

## INFORMATION

Name of child _____ Birthdate _____

Address _____ Phone _____

School _____ School Year _____

Name of PDA _____

Phone _____ Alternative Phone _____

## GRANT OF PERMISSION

As a parent/guardian of _____, a child with diabetes, I acknowledge
(Child's Name)
that I have read and understand this form.

I authorize _____, to be a PDA for my child. I empower them
(PDA's name)
to provide diabetes-related health care for my child.

I agree that this PDA will receive training by the school nurse in the proper procedures for the care of students with diabetes, or if this person is not an employee of the district, they will receive training comparable to the district-provided training. This PDA will also receive training to my child's individual health plan by the school nurse.

I agree that this PDA will receive additional training from a healthcare professional or expert in diabetic care selected by me, to provide training for tasks consistent with my child's individual healthcare plan. This additional training is for the care that would otherwise be performed by a healthcare professional licensed under RCW 18.79.

I agree that pursuant to RCW 28A.210. 350, the school district, school district employee, agent, or PDA, acting in good faith, and in substantial compliance with my child's individual health plan, and the instructions of my child's licensed health care professional, provides assistance or services under RCW 28A.210.330, shall not be liable in any criminal action or for civil damages, as a result of the services provided for my child with diabetes.

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Parent/guardian signature | Date | Work phone | Home phone |