**Holy Family Regional School** 2300 Beasley Avenue, Huntsville, Al 35816
Phone: 256-539-5221 Fax: 256-533-0747

**Instructions for the School Medication Prescriber/Parent Authorization Form (PPA) & Management Plan, (IHP) Individualized Healthcare Plan, (EAP) Emergency Action Plan, and (CAP) Classroom Action Plan for DIABETES**

1. **(IHP) Individualized Healthcare Plan/(EAP) Emergency Action Plan/(CAP) Classroom Action Plan**
   - Section I – Parent/Guardian must complete.
   - Section II – Physician, Physician's Assistant, or Nurse Practitioner must complete.
   - Signatures - Parent/Guardian, Physician, Physician's Assistant, and/or Nurse Practitioner must sign and date.

**_Alabama Board of Nursing requires the following to be completed on all (PPAs) for each Med/Dose_*

2. **School Medication Prescriber/Parent Authorization Form (PPA)**
   - **Prescriber Authorization Section: (Prescription & Over-the-Counter Medications)**
     - **Every blank must be completed** to include: med, dosage, time, route, start and stop dates, reason, special instructions, sign and date,
     - Med(s) will not be accepted or administrated with an incomplete and/or incorrect PPA,
     - Complete one PPA for each med & each dose,
     - Start Date and Stop Date - Please list specific dates,
     - Use as Directed instructions will not be accepted - must be specific,
     - Frequency/Time(s) to be given – "as needed", please include time parameters (example: every 4 hours as needed), and
     - Self-Administer/Self-Carry - Only med(s) to prevent &/or treat medical emergencies are acceptable.
   - **Parent/Guardian Section**
     - **Student Information Section**- Parent/Guardian must complete every question including: allergies, weight and birth date,
     - **Parent Authorization Section**- Parent/Guardian must sign and date, and
     - **Self-Administration Authorization Section**- Parent/Guardian must sign and date to allow student to self-medicate and/or self-carry approved med at school.

Parent/Guardian must bring in PPA(s), medication(s), and management plan(s) directly to the school nurse or designated medication assistant. Students, unless prescribed to 'Self-Administer/Self-Carry', may not bring in their own medication(s). All medications (to include over-the-counter & prescription) must be counted and logged-in each time.

**Expired Medication(s)**: Please be aware of medication expiration dates. You will be notified when your child's med expires.

**End of School Year**: All medication(s) must be signed out at the end of the school year. Medication(s) left in the clinic after that time will be discarded according to federal and state guidelines.

Sincerely,

School Nurse

If you have received this packet in error, or if your student's medical condition does not require emergency planning, please sign below and return this form to your child's teacher or school nurse.

☐ Received in error ☐ Student's medical condition does not require medication and/or emergency planning

Student Name: ______________________

Comments: ______________________

Parent/Guardian Signature: ______________________ Date: __________


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HCS School: ______ School Year: ______ School Hours: ______

Stop Date: Extracurricular Hours: ______

# MANAGEMENT PLAN: DIABETES

**Individualized Health Plan (IHP) / Emergency Action Plan (EAP) / Classroom Plan (CAP) / Extracurricular Plan / Bus Plan**

Student Name: ______ DOB: ______ Teacher/Grade: ______

Known Allergies/Triggers: ______ Wt. ______

Medications Taken at Home: ______

Bus Transportation to and from school: Bus # a.m. ______ Bus # p.m. ______

Emergency Contact: ______ Name ______ Cell # ______ Home # ______ Work #

Emergency Contact: ______ Name ______ Cell # ______ Home # ______ Work #

Physician: ______ Phone #: ______

Preferred Hospital in Case of Emergency: ______

Insurance Provider: ______ (optional) Policy/Group # ______ (optional)

**Section II - Physician:** ***School Medication Prescriber/Parent Authorization form (PPA) required for each medication***

| | |
|---|---|
| SNACK | Times snacks are to be eaten: ______ Snacks = ______ gm. carbs |
| MEAL PLAN | 1. Diet prescribed by physician: ______ grams of carbohydrates per meal.<br>2. Copy of diet orders to cafeteria? YES ☐ NO ☐ (Check one) |
| BLOOD GLUCOSE TESTING | 1. Blood glucose target range: ______ mg./dl to ______ mg./dl<br>2. Check blood glucose: (Check all that apply)<br>____ before meals<br>____ before snacks<br>____ before getting on bus (B/S 80-350)<br>____ 1-2 hours after lunch<br>____ before P. E.<br>____ when he/she feels "low" or "ill"<br>____ before extracurricular activity<br>____ during extracurricular activity<br>____ before driving home must report B/S to staff member<br>3. Student will complete blood glucose testing: (Check one)<br>____ independently<br>____ independently with adult supervision<br>____ with assistance from an adult<br>4. Glucometer will be kept: ______ (location) |
| INSULIN<br><br>School ***Prescriber/Parent Authorization Form*** (PPA) required for each medication | 1. Student receives insulin by: Injection ☐ Insulin pump ☐ (Check one)<br>2. Insulin type: ______<br>3. Insulin dose based on "carb counting"? YES ☐ NO ☐ (Check one)<br>4. If so, give for Breakfast: 1 unit of insulin for every _____gram carbohydrates eaten<br>Lunch: 1 unit of insulin for every _____grams of carbohydrates eaten<br>Snack: 1 unit of insulin for every _____gram carbohydrates eaten<br>Correction: (Blood glucose - ____) /___<br>5. If not, insulin order is as follows: ______<br>6. Insulin bolus dosage calculation:<br>____ Student calculates dose independently<br>____ Student calculates dose independently with adult supervision<br>____ Dose calculated with assistance of or by an adult<br>7. Insulin administration:<br>____ Student administers insulin independently<br>____ Student administers insulin independently with adult supervision<br>____ Insulin administered with assistance of or by an adult<br>8. Student has a(n) ______ (brand) insulin pump. Basil rate: ______<br>9. Insulin taken at home: Type: ______ Dose: ______ Time: ______ |
| KETONES | 1. When should student check ketones?<br>2. Limitations when ketones present? YES ☐ NO ☐ (Check one)<br>3. If limitations, please list: ______ |

| Medication | Self Carry? | Self Administer? | Expiration | Location of Medication |
|---|---|---|---|---|
| | | | | |
| | | | | |

Student Name: ______________________ HCS School: ______________________

## DIABETES – EMERGENCY PLAN

***Note:** In cases of __any__ health concern regarding diabetic students, please observe the following precautions: (1) Notify nurse to come to classroom, (2) Have __adult__ accompany student to clinic or nurse's office, (3) Notify nurse that student is being sent to clinic/office*

| IF YOU SEE THIS… | DO THIS… |
|---|---|
| Student exhibiting signs of **hypoglycemia**: (Low blood sugar): **Shakiness, irritability, sweating, drowsiness, headache, or slightly confused.** Other: | 1. Check blood glucose (BG)<br>2. If blood glucose < ________ mg/dl, student will eat a ________ gram carb snack<br>3. Observe student for 15 minutes<br>4. If > 30 minutes to mealtime and/or there is no improvement, repeat above and call parent |
| Student is confused and / or unable to respond appropriately to questions | 1. Check blood glucose if not checked previously<br>2. Administer glucose paste or cake icing to inside of cheeks |
| Student becomes unconscious<br><br>Life threating (Diabetic Emergency) | 1. Check blood glucose if not previously checked<br>2. Suspend insulin pump (if applicable)<br>3. Glucagon ordered? Yes ☐ No ☐ (Check. one.) If student 'self-carries" medication, a 'back-up" medication may be kept in clinic? Yes ☐ No ☐ (Check one)<br>4. If ordered, administer **Glucagon IM Dose 0.5 mg. or 1 mg** (circle one)<br>5. Glucagon not ordered, place student side - lying put glucose paste or cake icing inside cheeks, rub, call 911<br>5. Call parent / guardian / emergency contact<br>6. Report to 911 personnel |
| Student exhibiting signs of **hyperglycemia** (High blood sugar): thirsty, headache, confused, drowsy, nauseated Other: | 1. Check blood glucose<br>2. Administer insulin *if ordered by physician.*<br>3. Have student drink at least 16 ounces of water<br>4. If blood glucose is > ________ ml/dl, student will check urine for ketones<br>5. Recheck blood glucose in ___ min<br>6. Never leave student alone |
| Blood glucose remains elevated at time of re-check and urine **ketones are NOT** present | 1. Call parent / guardian / emergency contact<br>2. Encourage student to continue to drink water<br>3. Encourage student to do mild exercise such as "hall-walking" with supervision |
| If blood glucose > ________ and **ketones ARE** present:<br><br>If blood glucose > and ketones > | 1. Restrict student from P.E. and Recess<br>2. Encourage fluid intake (water)<br>3. Call parent / guardian / emergency contact<br>4. **Student needs to be picked up from school** |
| Student begins to vomit or have diarrhea with or without ketones present | 1. Call parents / guardian / emergency contact to pick up student |

## DIABETES BUS PLAN – SCHOOL TRANSPORTATION AND FIELD TRIPS

**Nurse, Unlicensed Diabetic Assistant (UDA), or parent/designee may not be available on bus/car transport to and from school, fieldtrips or extracurricular activities; therefore, Glucagon will not be available for administration in the absence of Nurse, Unlicensed Diabetic Assistant (UDA), or parent/guardian/designee. Call 911 for student confusion, seizure, or unconscious.**

| IF YOU SEE THIS… Student is to ride bus… | DO THIS… |
|---|---|
| **Routine Blood Glucose check prior to boarding bus or at any time student displays symptoms as follows: nausea, shakiness, irritability, sweating, thirst, drowsiness, headache, or confusion.** | 1. Student will check blood glucose prior to boarding bus and report number to Nurse or Unlicensed Diabetic Assistant (UDA) |
| **Hypoglycemia** | 2. Treat until within target range for hypoglycemia |
| **Hyperglycemia** | 3. Do not allow to board bus if large ketones or symptomatic |
| | 4. If ordered by MD, student should carry meter and snack on bus as needed |
| **Confusion, Seizure, or Unresponsive- Life-Threatening (Diabetic Emergency)** | 5. Pull over and call 911; give juice if student is responsive and able to swallow |
| | 6. Turn student onto side |
| **If awakens and can swallow** | 7. Give juice |

**PLEASE NOTE:** Parents are responsible for providing all diabetic supplies and snacks for use at school, during bus transportation, and during sporting events, practices and extracurricular activities. Students will not be allowed to participate in practices, sporting events, or extracurricular activities if supplies and snacks are not available.


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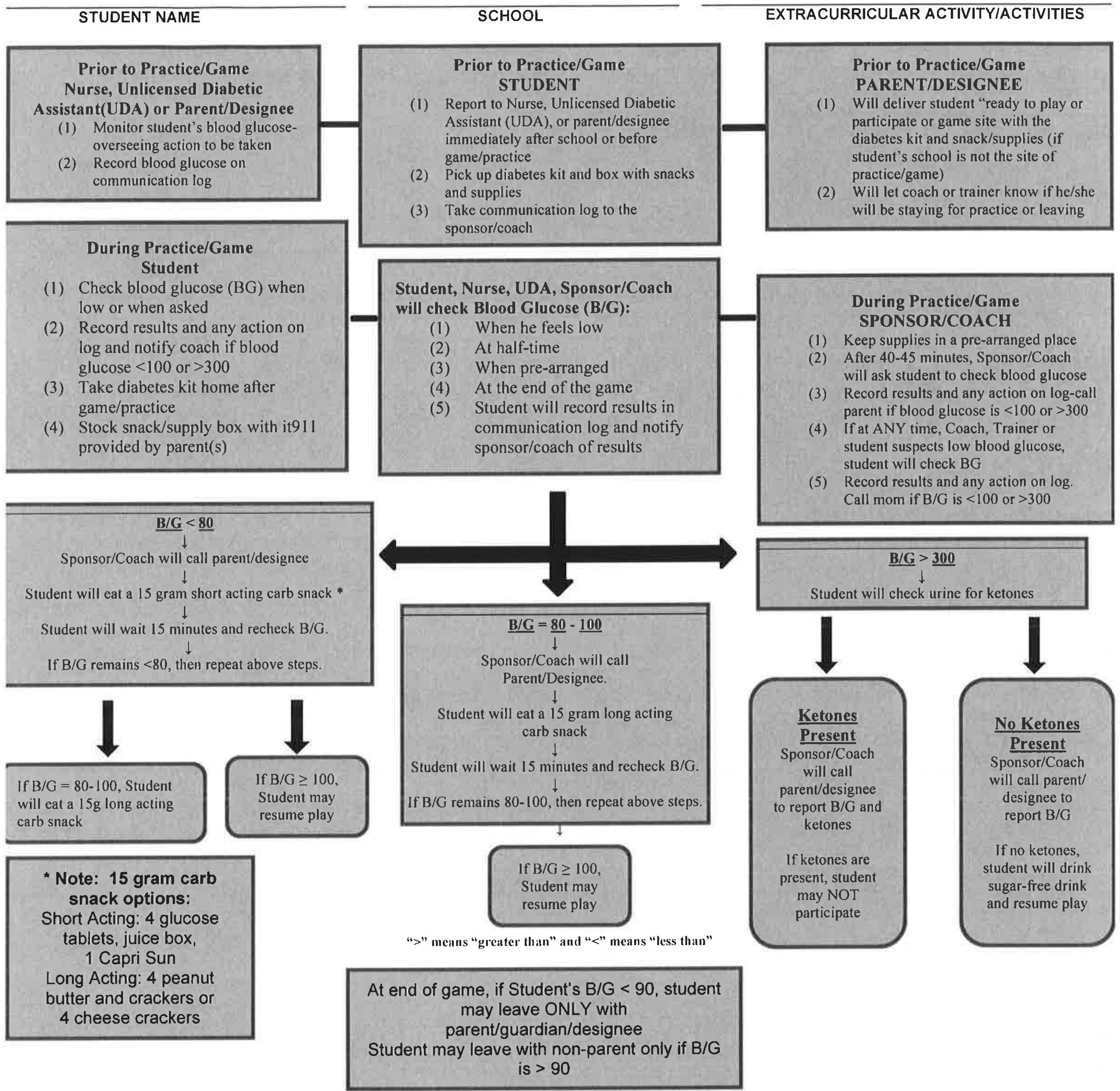
# DIABETIC FLOW CHART EXTRACURRICULAR MANAGEMENT PLAN

STUDENT NAME

SCHOOL

EXTRACURRICULAR ACTIVITY/ACTIVITIES



**Prior to Practice/Game**
**Nurse, Unlicensed Diabetic Assistant(UDA) or Parent/Designee**

(1) Monitor student's blood glucose- overseeing action to be taken
(2) Record blood glucose on communication log

**Prior to Practice/Game**
**STUDENT**

(1) Report to Nurse, Unlicensed Diabetic Assistant (UDA), or parent/designee immediately after school or before game/practice
(2) Pick up diabetes kit and box with snacks and supplies
(3) Take communication log to the sponsor/coach

**Prior to Practice/Game**
**PARENT/DESIGNEE**

(1) Will deliver student "ready to play or participate or game site with the diabetes kit and snack/supplies (if student's school is not the site of practice/game)
(2) Will let coach or trainer know if he/she will be staying for practice or leaving

**During Practice/Game**
**Student**

(1) Check blood glucose (BG) when low or when asked
(2) Record results and any action on log and notify coach if blood glucose <100 or >300
(3) Take diabetes kit home after game/practice
(4) Stock snack/supply box with it911 provided by parent(s)

**Student, Nurse, UDA, Sponsor/Coach will check Blood Glucose (B/G):**

(1) When he feels low
(2) At half-time
(3) When pre-arranged
(4) At the end of the game
(5) Student will record results in communication log and notify sponsor/coach of results

**During Practice/Game**
**SPONSOR/COACH**

(1) Keep supplies in a pre-arranged place
(2) After 40-45 minutes, Sponsor/Coach will ask student to check blood glucose
(3) Record results and any action on log-call parent if blood glucose is <100 or >300
(4) If at ANY time, Coach, Trainer or student suspects low blood glucose, student will check BG
(5) Record results and any action on log. Call mom if B/G is <100 or >300

**<u>B/G</u> < <u>80</u>**
↓
Sponsor/Coach will call parent/designee
↓
Student will eat a 15 gram short acting carb snack *
↓
Student will wait 15 minutes and recheck B/G.
↓
If B/G remains <80, then repeat above steps.

If B/G = 80-100, Student will eat a 15g long acting carb snack

If B/G ≥ 100, Student may resume play

**<u>B/G</u> = <u>80</u> - <u>100</u>**
↓
Sponsor/Coach will call Parent/Designee.
↓
Student will eat a 15 gram long acting carb snack
↓
Student will wait 15 minutes and recheck B/G.
↓
If B/G remains 80-100, then repeat above steps.
↓
If B/G ≥ 100, Student may resume play

**<u>B/G</u> > <u>300</u>**
↓
Student will check urine for ketones

**<u>Ketones Present</u>**
Sponsor/Coach will call parent/designee to report B/G and ketones

If ketones are present, student may NOT participate

**<u>No Ketones Present</u>**
Sponsor/Coach will call parent/ designee to report B/G

If no ketones, student will drink sugar-free drink and resume play

*** Note: 15 gram carb snack options:**
Short Acting: 4 glucose tablets, juice box, 1 Capri Sun
Long Acting: 4 peanut butter and crackers or 4 cheese crackers

">" means "greater than" and "<" means "less than"

At end of game, if Student's B/G < 90, student may leave ONLY with parent/guardian/designee
Student may leave with non-parent only if B/G is > 90

**I UNDERSTAND AND AGREE WITH THIS MANAGEMENT PLAN:**

I give permission for my child to be transported to the hospital indicated on this form, in the event of an emergency and for the release of my child's medical information to be shared with appropriate persons on an as-needed basis to insure the health and safety of my child. A nurse will not be present on the school bus, private car, or extracurricular activity.

| Physician Signature | Date | Nurse Signature | Date | Parent Signature | Date |
|---|---|---|---|---|---|
| Student Signature | Date | Sponsor/Coach Signature | Date | Sponsor/Coach Signature | Date |



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**ALABAMA STATE DEPARTMENT OF EDUCATION**

# SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

**School Year: ________-__________**

## STUDENT INFORMATION

**Student's Name:** ______________________________ **School:** __________________________________

**Date of Birth:** ____/____/_____ Age: _________ Grade: ______ Teacher: ______________________

❑ **No known drug allergies---if drug allergies list:** _______________________ Weight: ________pounds

## PRESCRIBER AUTHORIZATION (To be completed by licensed healthcare provider)

**Medication Name:** ____________________________ **Dosage:** ______________**Route:** ______________

**Frequency/Time(s) to be given:** __________________ **Start Date:** ___/___/___ **Stop Date:** ___/___/___

Reason for taking medication: ______________________________

Potential side effects/contraindications/adverse reactions: ______________________________

Treatment order in the event of an adverse reaction: ______________________________

**SPECIAL INSTRUCTIONS:**

Is the medication a controlled substance? Yes ❑ No ❑

Is self- medication permitted and recommended? Yes ❑ No ❑

If "yes" I hereby affirm this student has been instructed
On proper self-administration of the prescribe medication.

Do you recommend this medication be kept "on person" by student? Yes ❑ No ❑

**Printed Name of Licensed Healthcare Provider:** __________________**Phone:** ( ) ______-______ **Fax:** _____-______

**Signature of Licensed Healthcare Provider:** ________________________________________ **Date:** __________________

## PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up with the medication.

**Prescription Medication** must be registered with School Nurse or trained Medication Assistants. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

**Over the Counter Medication** must be registered with the School Nurse or Trained Medication Assistant, OTC's in the original, unopened and sealed container. Local Education Agency Policy for OTC medication to be followed:

**Parent's/Guardian's Signature:** ___________________________**Date:** ___/___/___ **Phone:** ( ) _______-_______

## SELF-ADMINISTRATION AUTHORIZATION

**(To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider.)**

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

**Signature of Parent:** ___________________________________ **Date:** ____/____/_____ **Phone:** ( ) _______-_______