Holy Family Regional School 2300 Beasley Avenue, Huntsville, Al 35816
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Formulario de Autorización, Instrucciones y Plan de Manejo del Medicamento Otorgado por el Médico/Padre de Familia a la Escuela (PPA), Plan Individual de Cuidados de Salud (IHP), Plan de Acción de Emergencia (EAP), y Plan de Acción para el Salón de Clases (CAP) por DIABETES

1. **(IHP) Plan Individual de Cuidados de Salud/(EAP) Plan de Acción de Emergencia/(CAP) Plan de Acción para el Salón de Clases**
   - Sección I – Padre/Tutor debe completar.
   - Sección II – Médico, Asistente del Médico, o Enfermera(o) calificada(o) debe firmar y escribir la fecha.
   - Firmas – Padre de Familia/Tutor, Médico, Asistente del Médico, y/o Enfermera(o) Calificada(o) debe firmar y escribir la fecha.

**El Consejo de Enfermería de Alabama exige que lo siguiente sea llenado en su totalidad para cada (PPAs) Medicamento/Dosis.*

2. **Formulario de Autorización Otorgado a la Escuela por el Médico/Padre de Familia (PPA).**
   - **Sección de Autorización del Médico que Receta: (Medicamentos con y/o sin Receta)**
     - **Cada espacio vacío debe ser llenado** para incluír: medicamento, dosis, horario, vía de suministro (oral, nasal, etc.) fechas de comienzo y terminación, razón, instrucciones especiales, firma y fecha.
     - Ningún Medicamento será aceptado ni suministrado si el formulario (PPA) está incompleto y/o incorrecto.
     - Llene un Formulario (PPA) para cada medicamento y para cada dósis.
     - Fecha de Comienzo y Fecha de Terminación – Por favor mencione las fechas específicas.
     - Eso de *"Usarse de acuerdo a las instrucciones"*, no será aceptado – debe ser específico.
     - Horario de suministro – *"como sea necesario"*, por favor incluya parámetros de tiempo (por ejemplo: cada 4 horas si es necesario, etc.), y
     - El Auto suministro/hecho de llevar consigo medicamentos – Unicamente será permitido para tratar y/o prevenir emergencias.
   - **Sección del Padre/Tutor.**
     - **Sección de Información del Estudiante –** El Padre/Tutor debe contestar por escrito cada pregunta incluyendo: alergias, peso y fecha de nacimiento,
     - **Sección de Autorización del Padre –** El Padre/Tutor debe firmar, poner la fecha y
     - **Sección de Autorización para el Auto suministro de medicamentos –** El Padre/Tutor debe firmar y poner la fecha donde autoriza a su hijo/a, el auto suministro y/o el hecho de llevar consigo el medicamento a la escuela.

El Padre /Tutor debe traer (directamente a la enfermera de la escuela ó a la persona asignada para suministrar medicamentos), un Formulario de Autorización del Médico y/o del Padre de Familia (PPA(s)); medicamento(s), e instrucciones de suministro. Los Estudiantes, no deben, a menos que estén autorizados para auto suministrarse y/o llevar consigo, su(s) propio(s) medicamento(s). Todo medicamento (incluyendo recetado y no recetado) debe ser contado y registrado cada vez.

Medicamentos vencidos: Por favor esté pendiente de las fechas de vencimiento de sus medicamentos. Usted será notificado(a) cuando el medicamento de su hijo(a) se venza.

Fin del Año Escolar: Todo medicamento debe ser recogido y firmar de recogido, al final del año escolar. Después de este tiempo, todo medicamento dejado u olvidado en la clínica de la escuela será desechado de acuerdo al reglamento estatal y federal.

Sinceramente,

Enfermera de la Escuela

Si usted ha recibido este paquete por equivocación, o si la condición médica de su estudiante no necesita de un plan de emergencia, por favor, firme y regrese este formato a la maestra de su hijo(a) o a la enfermera de la escuela.

☐ Recibido por equivocación ☐ La condición médica del estudiante no necesita ni medicamento, ni plan de emergencia.

Nombre del Estudiante: _____

Comentarios: _____

Firma del Padre/Tutor: _____ Fecha: _____

School: _____ School District: _____ School Hours: _____
School Nurse _____ Start Date: _____ Extracurricular Hours: _____
Nurse Phone# _____ Stop Date: _____ Extracurricular Activity: _____

MANAGEMENT PLAN: DIABETES

SECTION I –PARENT (Please, Print) **IEP?** ❑ YES ❑ NO **504 PLAN?** ❑ YES ❑ NO

Student Name: _____ DOB: _____ Teacher/Grade: _____
Student Home Address: _____
Known Allergies/Triggers: _____ WT _____ HT _____
Medications Taken at Home: _____
Potential Side-Effects of Home Meds: _____
Bus Transportation ❑ YES ❑ NO Bus # a.m. _____ Bus # p.m. _____ Fieldtrip/Extracurricular Bus Transportation ❑ YES ❑ NO

Parent/Guardian Contact: _____ (Name) _____ (Cell #) _____ (Home #) _____ (Work #)
Parent/Guardian Contact: _____ (Name) _____ (Cell #) _____ (Home #) _____ (Work #)
Emergency Contact: _____ (Name) _____ (Cell #) _____ (Home #) _____ (Work #)

Physician: _____ Phone#: _____ Fax#: _____
Physician Address: _____ Preferred Hospital: _____
Insurance Provider: _____ (optional) Policy/Group # _____ (optional)

SECTION II –PHYSICIAN (Please, Print) **EMERGENCY ACTION PLAN (EAP)**

A signed medication PRESCRIBER/PARENT AUTHORIZATION (PPA) FORM is required for each medication

Is a medication PRESCRIBER/PARENT AUTHORIZATION (PPA) on file for this student? ❑ YES ❑ NO

If student "self-carries" medication, a "back up" medication may be kept in clinic? ❑ YES ❑ NO

The severity of symptoms can change quickly and potentially progress to a life threatening situation.

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

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

HCS School: _____ **School District:** _____ **School Hours:** _____
Onsite Nurse Name _____ **Start Date:** _____ **Extracurricular Hours:** _____
Onsite Nurse Phone# _____ **Stop Date:** _____ **Extracurricular Activity:** _____

Student Name: _____ **Grade/Teacher:** _____

DIABETES – EMERGENCY ACTION PLAN (EAP)

Note: In cases of <u>any</u> health concerns regarding diabetic students, please observe the following precautions: (1) Notify nurse to come to classroom, (2) Have <u>adult</u> 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) 2. If blood glucose < _____ mg/dl, student will eat a _____ gram carb snack 3. Observe student for 15 minutes 4. If > 30 minutes to mealtime and/or there is no improvement, repeat above and call Parent/Guardian/Emergency Contact
Student is confused and / or unable to respond appropriately to questions	1. Check blood glucose if not checked previously 2. Administer glucose paste or cake icing to inside of cheeks
Student becomes unconscious Life threating (Diabetic Emergency)	1. Check blood glucose if not previously checked 2. Suspend or disconnect insulin pump, if applicable ❑ YES ❑ NO (Check one) 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) 4. If ordered, administer **Glucagon IM/SQ Dose,** place student side-lying **0.5 mg or 1 mg** (circle one) 5. Glucagon not ordered, place student side-lying put glucose paste or cake icing inside cheeks, rub, call 911 5. Call Parent/Guardian/Emergency Contact 6. Report to 911 personnel
Student exhibiting signs of **hyperglycemia** (High blood sugar): thirsty, headache, confused, drowsy, nauseated Other:	1. Check blood glucose 2. Administer insulin *if ordered by physician.* 3. Have student drink at least 16 ounces of water 4. If blood glucose is > _____ ml/dl, student will check urine for ketones 5. Recheck blood glucose in _____ min 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 2. Encourage student to continue to drink water 3. Encourage student to do mild exercise such as "hall-walking" with supervision
If blood glucose > _____ and **ketones ARE** present: If blood glucose > _____ and ketones >	1. Restrict student from P.E. and Recess 2. Encourage fluid intake (water) 3. Call Parent/Guardian/Emergency Contact 4. **Student needs to be picked up from school**
Student begins to vomit or have diarrhea with or without ketones present	1. Call Parent/Guardian/Emergency Contact to pick up student

DIABETES BUS PLAN – SCHOOL TRANSPORTATION AND FIELD TRIPS

Nurse, Unlicensed Diabetic Assistant (UDA), or Parent/Guardian/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.

HCS School: _____ School District: _____ School Hours: _____
Onsite Nurse Name _____ Start Date: _____ Extracurricular Hours: _____
Onsite Nurse Phone# _____ Stop Date: _____ Extracurricular Activity: _____

DIABETIC FLOW CHART EXTRACURRICULAR MANAGEMENT PLAN

STUDENT NAME _____ GRADE/TEACHER _____ EXTRACURRICULAR ACTIVITY/ACTIVITIES _____

Prior to Practice/Game
Nurse, Unlicensed Diabetic Assistant(UDA) or Parent/Designee
(1) Monitor student's blood glucose (BG)- 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/Guardian/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/Trainer

Prior to Practice/Game
PARENT/DESIGNEE
(1) Will deliver student "ready to play or participate" or to game site with the diabetes kit and snack/supplies (if student's school is not the site of practice/game)
(2) Will let Sponsor/Coach/Trainer know if student will be staying for practice or leaving

During Practice/Game
Student
(1) Check BG when low or when asked
(2) Record results and any action on log and notify Sponsor/Coach/Trainer if blood glucose <100 or >300
(3) Take diabetes kit home after game/practice
(4) Stock snack/supply box (provided by Parent/Guardian/Designee)

Student, Nurse, UDA, Sponsor/Coach will check Blood Glucose (BG):
(1) When student 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/Trainer 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 BG
(3) Record results and any action on log-call Parent/Guardian/Designee if blood glucose is <100 or >300
(4) If at ANY time, Sponsor/Coach/Trainer or student suspects low blood glucose, student will check BG
(5) Record results and any action on log. Call Parent/Guardian/Designee if BG is <100 or >300
(6) If student becomes disoriented, unresponsive, or unconscious, call 911 immediately

BG < 80
↓
Sponsor/Coach will call parent/designee
↓
Student will eat a 15 gram short acting carb snack *
↓
Student will wait 15 minutes and recheck BG.
↓
If BG remains <80, then repeat above steps
↓
If student becomes disoriented, unresponsive, or unconscious, call 911 immediately

If BG = 80-100, student will eat a 15g long acting carb snack

If BG ≥ 100, Student may resume play

BG = 80 - 100
↓
Sponsor/Coach will call Parent/Guardian/Designee
↓
Student will eat a 15 gram long acting carb snack
↓
Student will wait 15 minutes and recheck BG
↓
If BG remains 80-100, then repeat above steps
↓
If BG ≥ 100, student may resume play

BG > 300
↓
Student will check urine for ketones

Ketones Present
Sponsor/Coach/ Trainer will call Parent/Guardian/ Designee to report BG and ketones

If ketones are present, student may NOT participate

No Ketones Present
Sponsor/Coach/ Trainer will call Parent/Guardian/ Designee to report BG

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

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

*** 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

At end of game, if student's BG < 90, student may leave ONLY with Parent/Guardian/Designee
Student may leave with non-parent only if BG is > 90

I UNDERSTAND AND AGREE WITH THIS MANAGEMENT PLAN:

I give permission for my child to be transported to the hospital, 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 & safety of my child. A nurse will not be present on the school bus, private car, or extracurricular activity.

Physician Signature	Date	Parent Signature	Date	Student Signature	Date	Nurse Signature	Date

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:** ( )_____-_____