



**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.	
<input type="checkbox"/> Received in error	<input type="checkbox"/> Student’s medical condition does not require medication and/or emergency planning

Student Name: \_\_\_\_\_

Comments: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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: \_\_\_\_\_ Policy/Group # \_\_\_\_\_  
 (optional) (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.*

<b>SNACK</b>	Times snacks are to be eaten: _____ Snacks = _____ gm. carbs
<b>MEAL PLAN</b>	1. Diet prescribed by physician: _____ grams of carbohydrates per meal. 2. Copy of diet orders to cafeteria? <input type="checkbox"/> YES <input type="checkbox"/> NO (Check one)
<b>BLOOD GLUCOSE (BG) TESTING</b>	1. Blood glucose target range: _____ mg./dl to _____ mg./dl 2. Check blood glucose: (Check all that apply) _____ before meals _____ when he/she feels "low" or "ill" _____ before snacks _____ before extracurricular activity _____ before getting on bus (BG 80-350) _____ during extracurricular activity _____ 1-2 hours after lunch _____ before driving home must report BG to staff member _____ before P. E. _____ 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)
<b>INSULIN</b>	1. Student receives insulin by: (Check one) <input type="checkbox"/> Injection <input type="checkbox"/> Insulin pump 2. Insulin type: _____ 3. Insulin dose based on "carb counting"? <input type="checkbox"/> YES <input type="checkbox"/> 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. Basal rate: _____ 9. Insulin taken at home: Type: _____ Dose: _____ Time: _____
<b>KETONES</b>	1. When should student check ketones? 2. Limitations when ketones present? <input type="checkbox"/> YES <input type="checkbox"/> 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 any health concerns 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 <b>hypoglycemia</b> : (Low blood sugar): <b>Shakiness, irritability, sweating, drowsiness, headache, or slightly confused.</b>  Other:	<ol style="list-style-type: none"> <li>1. Check blood glucose (BG)</li> <li>2. If blood glucose &lt; _____ mg/dl, student will eat a _____ gram carb snack</li> <li>3. Observe student for 15 minutes</li> <li>4. If &gt; 30 minutes to mealtime and/or there is no improvement, repeat above and call Parent/Guardian/Emergency Contact</li> </ol>
Student is confused and / or unable to respond appropriately to questions	<ol style="list-style-type: none"> <li>1. Check blood glucose if not checked previously</li> <li>2. Administer glucose paste or cake icing to inside of cheeks</li> </ol>
Student becomes unconscious  Life threatening (Diabetic Emergency)	<ol style="list-style-type: none"> <li>1. Check blood glucose if not previously checked</li> <li>2. Suspend or disconnect insulin pump, if applicable <input type="checkbox"/> YES <input type="checkbox"/> NO (Check one)</li> <li>3. Glucagon ordered? <input type="checkbox"/> YES <input type="checkbox"/> NO (Check one) If student "self-carries" medication, a "back-up" medication may be kept in clinic? <input type="checkbox"/> YES <input type="checkbox"/> NO (Check one)</li> <li>4. If ordered, administer <b>Glucagon IM/SQ Dose</b>, place student side-lying <b>0.5 mg or 1 mg</b> (circle one)</li> <li>5. Glucagon not ordered, place student side-lying put glucose paste or cake icing inside cheeks, rub, call 911</li> <li>5. Call Parent/Guardian/Emergency Contact</li> <li>6. Report to 911 personnel</li> </ol>
Student exhibiting signs of <b>hyperglycemia</b> (High blood sugar): thirsty, headache, confused, drowsy, nauseated Other:	<ol style="list-style-type: none"> <li>1. Check blood glucose</li> <li>2. Administer insulin <i>if ordered by physician.</i></li> <li>3. Have student drink at least 16 ounces of water</li> <li>4. If blood glucose is &gt; _____ ml/dl, student will check urine for ketones</li> <li>5. Recheck blood glucose in _____ min</li> <li>6. Never leave student alone</li> </ol>
Blood glucose remains elevated at time of re-check and urine <b>ketones are NOT</b> present	<ol style="list-style-type: none"> <li>1. Call Parent/Guardian/Emergency Contact</li> <li>2. Encourage student to continue to drink water</li> <li>3. Encourage student to do mild exercise such as "hall-walking" with supervision</li> </ol>
If blood glucose > _____ and <b>ketones ARE</b> present:	<ol style="list-style-type: none"> <li>1. Restrict student from P.E. and Recess</li> <li>2. Encourage fluid intake (water)</li> <li>3. Call Parent/Guardian/Emergency Contact</li> <li>4. <b>Student needs to be picked up from school</b></li> </ol>
If blood glucose > _____ and ketones > _____	<ol style="list-style-type: none"> <li>4. <b>Student needs to be picked up from school</b></li> </ol>
Student begins to vomit or have diarrhea with or without ketones present	<ol style="list-style-type: none"> <li>1. Call Parent/Guardian/Emergency Contact to pick up student</li> </ol>

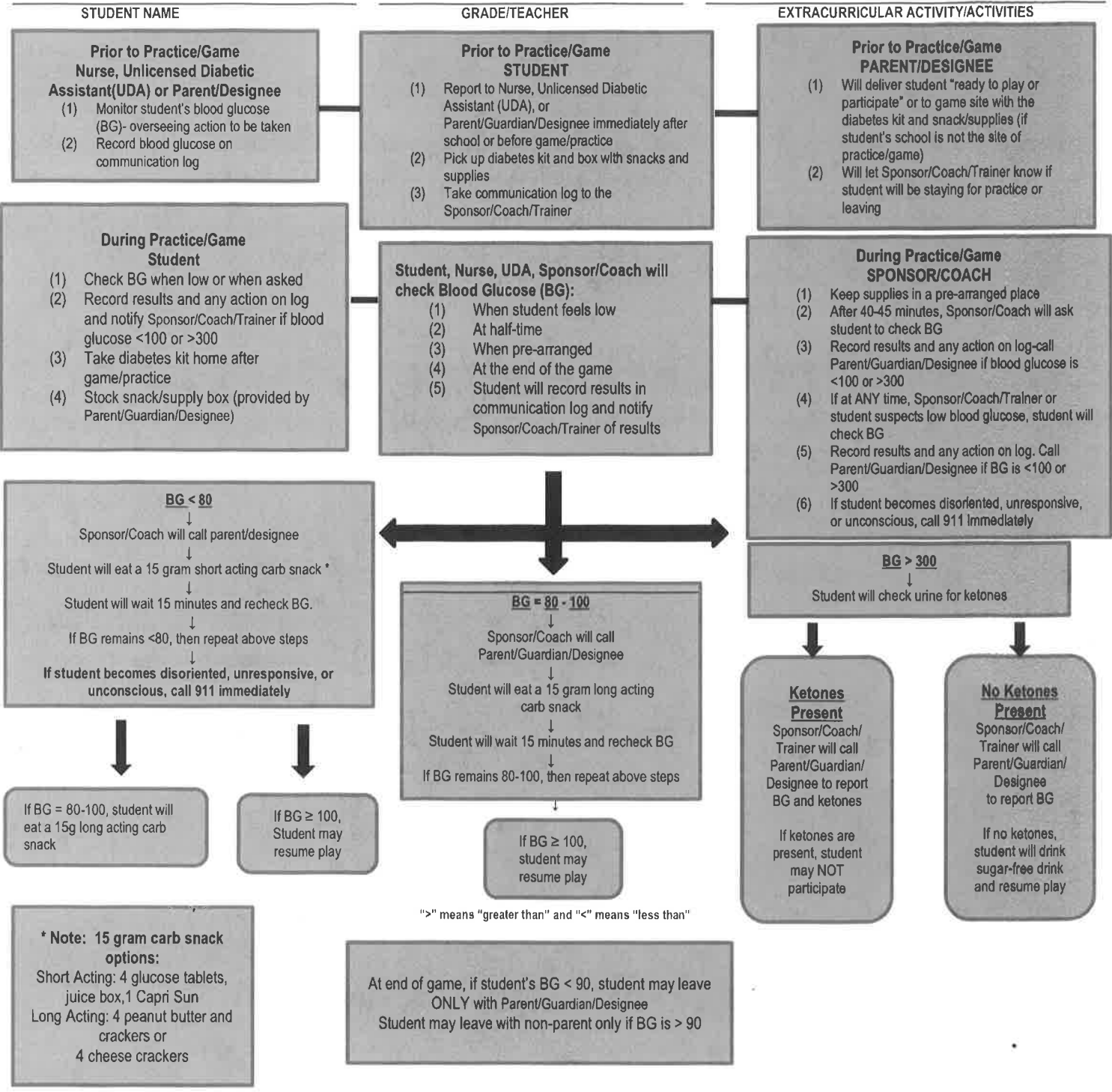
**DIABETES BUS PLAN – SCHOOL TRANSPORTATION AND FIELD TRIPS**

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...
<b>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.</b>	<ol style="list-style-type: none"> <li>1. Student will check blood glucose prior to boarding bus and report number to Nurse or Unlicensed Diabetic Assistant (UDA)</li> </ol>
<b>Hypoglycemia</b>	<ol style="list-style-type: none"> <li>2. Treat until within target range for hypoglycemia</li> </ol>
<b>Hyperglycemia</b>	<ol style="list-style-type: none"> <li>3. Do not allow to board bus if large ketones or symptomatic</li> <li>4. If ordered by MD, student should carry meter and snack on bus as needed</li> </ol>
<b>Confusion, Seizure, or Unresponsive- Life-Threatening (Diabetic Emergency)</b>	<ol style="list-style-type: none"> <li>5. Pull over and call 911; give juice if student is responsive and able to swallow</li> </ol>
<b>If awakens and can swallow</b>	<ol style="list-style-type: none"> <li>6. Turn student onto side</li> <li>7. Give juice</li> </ol>

**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.

**DIABETIC FLOW CHART EXTRACURRICULAR MANAGEMENT PLAN**



**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: ( ) \_\_\_\_\_ - \_\_\_\_\_