



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**
 - o Sección I – Padre/Tutor debe completar.
 - o Sección II – Médico, Asistente del Médico, o Enfermera(o) calificada(o) debe firmar y escribir la fecha.
 - o 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).**
 - o **Sección de Autorización del Médico que Receta: (Medicamentos con y/o sin Receta)**
 - Cada espacio vacío debe ser llenado para incluir: 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 dosis.
 - 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 – Únicamente será permitido para tratar y/o prevenir emergencias.
 - o **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: _____ WT _____ HT _____
Known Allergies/Triggers: _____
 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.

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? <input type="checkbox"/> YES <input type="checkbox"/> 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 _____ 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)
INSULIN	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: _____
KETONES	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 hypoglycemia : (Low blood sugar): Shakiness, irritability, sweating, drowsiness, headache, or slightly confused. Other:	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 1. Check blood glucose if not checked previously 2. Administer glucose paste or cake icing to inside of cheeks
Student becomes unconscious Life threatening (Diabetic Emergency)	<ol style="list-style-type: none"> 1. Check blood glucose if not previously checked 2. Suspend or disconnect insulin pump, if applicable <input type="checkbox"/> YES <input type="checkbox"/> NO (Check one) 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) 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:	<ol style="list-style-type: none"> 1. Check blood glucose 2. Administer insulin <i>if ordered by physician.</i> 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	<ol style="list-style-type: none"> 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:	<ol style="list-style-type: none"> 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
If blood glucose > _____ and ketones > _____	<ol style="list-style-type: none"> 4. Student needs to be picked up from school
Student begins to vomit or have diarrhea with or without ketones present	<ol style="list-style-type: none"> 1. Call Parent/Guardian/Emergency Contact to pick up student

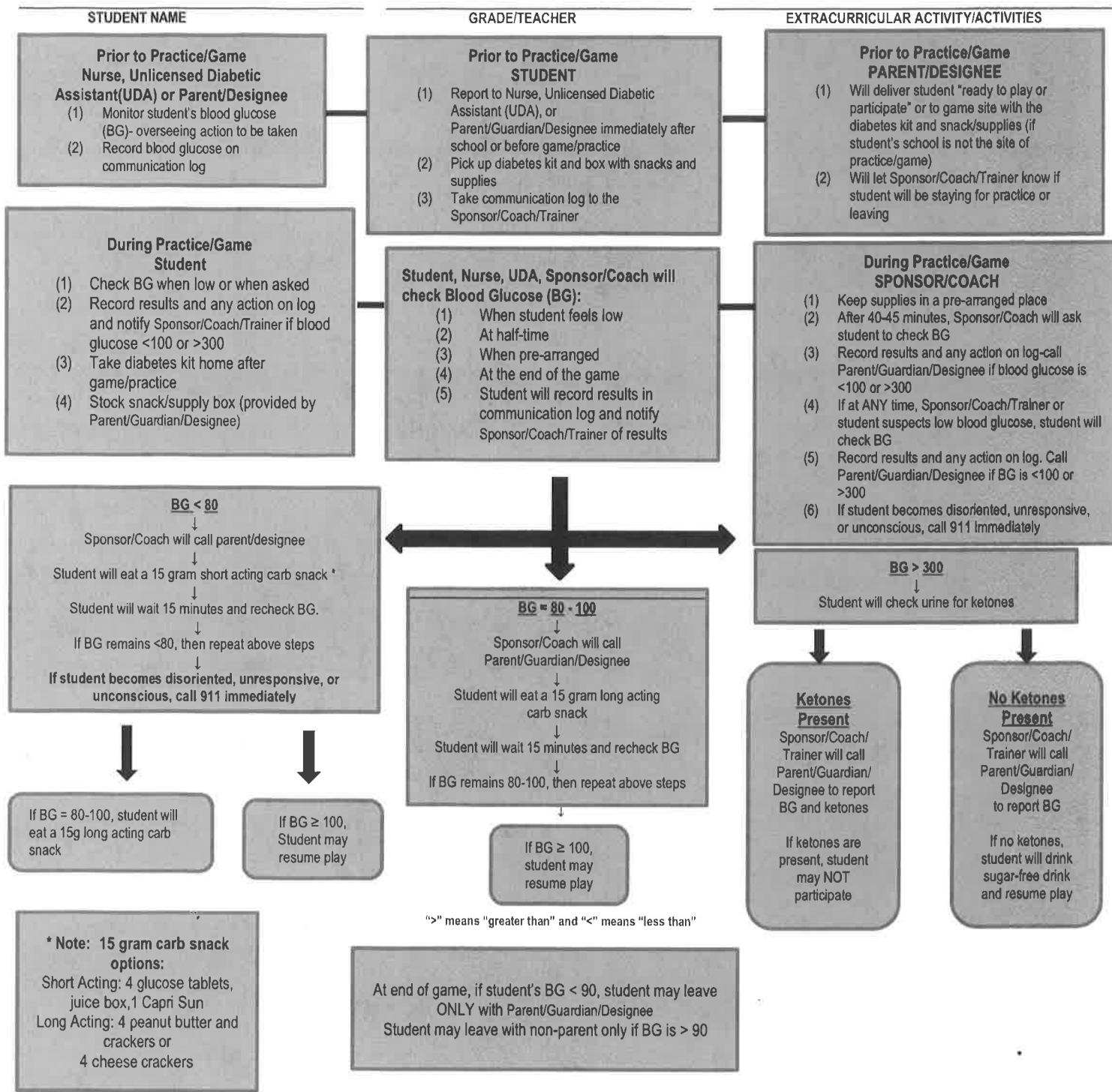
DIABETES BUS PLAN – SCHOOL TRANSPORTATION AND FIELD TRIPS

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.	<ol style="list-style-type: none"> 1. Student will check blood glucose prior to boarding bus and report number to Nurse or Unlicensed Diabetic Assistant (UDA)
Hypoglycemia	<ol style="list-style-type: none"> 2. Treat until within target range for hypoglycemia
Hyperglycemia	<ol style="list-style-type: none"> 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)	<ol style="list-style-type: none"> 5. Pull over and call 911; give juice if student is responsive and able to swallow
If awakens and can swallow	<ol style="list-style-type: none"> 6. Turn student onto side 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.

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 _____

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: () _____ - _____