LEGACY
CHRISTIAN ACADEMY

Dear Parent(s),

In reviewing your student's health records, I see that your student has been diagnosed with diabetes. In order to properly care for your student, please complete the enclosed forms and return them to the clinic.

- The Diabetes Medical Management Plan- This form is for me, and necessary staff, to direct us in how to best care for your child. This form will be sent with LCA staff members on field trips. A physician signature is required. You may also use a plan provided by your Physician.

- Medication form- This form is for non-prescription and prescription medications and must be completed in its entirety. Each medication, and child, requires a separate form. All medication is to be stored in the clinic. Medications must be unexpired, unopened, and in the original container; and have a pharmacy label if it's a prescription medication. Please remember that all prescription medications must have a physician signature on the medication form. The clinic will not accept any medication unless accompanied with this completed form, and with the appropriate signatures.

Please have this paperwork completed over the summer, as it can take several weeks for physicians to complete them and prepare any required prescriptions. If you have any questions, please contact me.

Jamie Hartsell, RN, BSN
School Nurse
1101 Wesley Ave.
Xenia, OH 45385
937- 352-1655 (ph)
937-352-1641 (fax)
nurse@legacyknights.org

American Diabetes Association.
Cure • Care • Commitment®

DREDF
Advocating for disability civil rights since 1979
DISABILITY RIGHTS EDUCATION & DEFENSE FUND

**Date of Plan: _____**

# Diabetes Medical Management Plan

*This plan should be completed by the student's personal health care team and parents/guardian. It should be reviewed with relevant school staff and copies should be kept in a place that is easily accessed by the school nurse, trained diabetes personnel, and other authorized personnel.*

Effective Dates: _____

Student's Name: _____

Date of Birth: _____ Date of Diabetes Diagnosis: _____

Grade: _____ Homeroom Teacher: _____

Physical Condition: ☐ Diabetes type 1 ☐ Diabetes type 2

**Contact Information**

Mother/Guardian: _____

Address: _____

_____

Telephone: Home _____ Work _____ Cell_____

Father/Guardian: _____

Address: _____

_____

Telephone: Home _____ Work _____ Cell _____

Student's Doctor/Health Care Provider:

Name: _____

Address: _____

Telephone: _____ Emergency Number: _____

Other Emergency Contacts:

Name: _____

Relationship: _____

Telephone: Home _____ Work _____ Cell _____

Notify parents/guardian or emergency contact in the following situations: _____

_____

_____

**Blood Glucose Monitoring**

Target range for blood glucose is ☐ 70-150 ☐ 70-180 ☐ Other _____

Usual times to check blood glucose _____

Times to do extra blood glucose checks (*check all that apply*)

☐ before exercise

☐ after exercise

☐ when student exhibits symptoms of hyperglycemia

☐ when student exhibits symptoms of hypoglycemia

☐ other (explain): _____

Can student perform own blood glucose checks? ☐ Yes ☐ No

Exceptions: _____

_____

Type of blood glucose meter student uses: _____

_____

**Insulin**

**Usual Lunchtime Dose**

Base dose of Humalog/Novolog /Regular insulin at lunch (circle type of rapid-/short-acting insulin used) is _____ units or does flexible dosing using _____ units/ _____ grams carbohydrate.

Use of other insulin at lunch: (circle type of insulin used): intermediate/NPH/lente _____ units or basal/Lantus/Ultralente _____ units.

**Insulin Correction Doses**

Parental authorization should be obtained before administering a correction dose for high blood glucose levels. ☐ Yes ☐ No

_____ units if blood glucose is _____ to _____ mg/dl

_____ units if blood glucose is _____ to _____ mg/dl

_____ units if blood glucose is _____ to _____ mg/dl

_____ units if blood glucose is _____ to _____ mg/dl

_____ units if blood glucose is _____ to _____ mg/dl

Can student give own injections? ☐ Yes ☐ No

Can student determine correct amount of insulin? ☐ Yes ☐ No

Can student draw correct dose of insulin? ☐ Yes ☐ No

_____ Parents are authorized to adjust the insulin dosage under the following circumstances:

_____

_____

**For Students with Insulin Pumps**

Type of pump: _____ Basal rates: _____ 12 am to _____

_____ _____ to _____

_____ _____ to _____

Type of insulin in pump: _____

Type of infusion set: _____

Insulin/carbohydrate ratio: _____ Correction factor: _____

| *Student Pump Abilities/Skills:* | *Needs Assistance* | |
|---|---|---|
| Count carbohydrates | ☐ Yes | ☐ No |
| Bolus correct amount for carbohydrates consumed | ☐ Yes | ☐ No |
| Calculate and administer corrective bolus | ☐ Yes | ☐ No |
| Calculate and set basal profiles | ☐ Yes | ☐ No |
| Calculate and set temporary basal rate | ☐ Yes | ☐ No |
| Disconnect pump | ☐ Yes | ☐ No |
| Reconnect pump at infusion set | ☐ Yes | ☐ No |
| Prepare reservoir and tubing | ☐ Yes | ☐ No |
| Insert infusion set | ☐ Yes | ☐ No |
| Troubleshoot alarms and malfunctions | ☐ Yes | ☐ No |

**For Students Taking Oral Diabetes Medications**

Type of medication: _____ Timing: _____

Other medications: _____ Timing: _____

**Meals and Snacks Eaten at School**

Is student independent in carbohydrate calculations and management? ☐ Yes ☐ No

| *Meal/Snack* | *Time* | *Food content/amount* |
|---|---|---|
| Breakfast | _____ | _____ |
| Mid-morning snack | _____ | _____ |
| Lunch | _____ | _____ |
| Mid-afternoon snack | _____ | _____ |
| Dinner | _____ | _____ |

Snack before exercise? ☐ Yes ☐ No

Snack after exercise? ☐ Yes ☐ No

Other times to give snacks and content/amount:

_____

Preferred snack foods:

_____

Foods to avoid, if any:

_____

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event): _____

_____

**Exercise and Sports**

A fast-acting carbohydrate such as _____ should be available at the site of exercise or sports.

Restrictions on activity, if any: _____ student should not exercise if blood glucose level is below _____ mg/dl or above _____ mg/dl or if moderate to large urine ketones are present.

**Hypoglycemia (Low Blood Sugar)**

Usual symptoms of hypoglycemia: _____

_____

Treatment of hypoglycemia:_____

_____

Glucagon should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow.

Route _____, Dosage _____, site for glucagon injection: _____arm, _____thigh, _____other.

If glucagon is required, administer it promptly. Then, call 911 (or other emergency assistance) and the parents/guardian.

**Hyperglycemia (High Blood Sugar)**

Usual symptoms of hyperglycemia: _____

_____

Treatment of hyperglycemia: _____

_____

Urine should be checked for ketones when blood glucose levels are above _____ mg/dl.

Treatment for ketones: _____

_____

**Supplies to be Kept at School**

_____Blood glucose meter, blood glucose test strips, batteries for meter

_____ Lancet device, lancets, gloves, etc.

_____Urine ketone strips

_____Insulin pump and supplies

_____Insulin pen, pen needles, insulin cartridges

_____Fast-acting source of glucose

_____Carbohydrate containing snack

_____Glucagon emergency kit

**Signatures**

**This Diabetes Medical Management Plan has been approved by:**

_____ _____

Student's Physician/Health Care Provider Date

I give permission to the school nurse, trained diabetes personnel, and other designated staff members of _____ school to perform and carry out the diabetes care tasks as outlined by _____'s Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

**Acknowledged and received by:**

_____ _____

Student's Parent/Guardian Date

_____ _____

Student's Parent/Guardian Date

# Legacy Christian Academy
# School Medication Administration Authorization Form
# Prescription or Non-Prescription Medication

**Legacy Christian Academy Clinic**
1101 Wesley Ave., Xenia OH 45385
Phone: 937-352-1655
Fax: 937-352-1641

| | | |
|---|---|---|
| Student's Name: *** Only one student name per form*** | | Grade: |
| Address: | | Phone |
| City: | State: | Zip: |

| | |
|---|---|
| **Medication Name: *Only list one medication per form*** | **Dosage:** |
| **Time/Frequency of administration:** | **Special instructions for administration or storage:** |
| **Date administration is to begin:** | **Date to cease:** |
| Severe adverse reactions that should be reported to the physician: | |

***Required for prescription medications only***

**Physician's name and address:**

**One or more of physician's phone number:**

| | | |
|---|---|---|
| **Phone:** | **Phone:** | **Fax:** |
| **Physician's signature:** | | **Date:** |

**This form must be completed entirely in order for medication to be administered.**
**All medications must be in the original container with label intact.**
All prescription medications need to have the dosing information completed and signed by a physician.
Any changes to prescription medication dosage or administration need to be signed by a physician.

**Emergency Medication Self Carry/Administration Authorization/Approval**

Self carry/administration of emergency medication may be authorized by the prescriber and must be approved by the school nurse according to the State Medication Policy.

**Prescriber authorization for self carry/administration of emergency medication**:_____
**School Nurse approval for self carry/self administration of emergency medication**: _____

**Parent/Guardian Authorization**

I/We request designated school personnel to administer the prescription medication as prescribed by the above prescriber. I/We request the designated school personnel or volunteer nurse to administer the non-prescription medication as directed above. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We authorize the school nurse to communicate with the health care provider if needed.

Parent/Guardian Signature_____Date:_____
Home Phone #:_____Cell Phone #_____Work Phone #_____