Please Print these Forms and Bring to Your Doctor- Action Plans are at the End.

Dear Siena Families,

Please read the requirements for handling student medication administration at The Siena School, in order to comply with State health requirements for schools,. the requirements are as follows:

We must have a signed physician's authorization before we can administer any medication during the school day or during the after-school program. A physician's authorization is also required in order for us to allow a student to self-carry emergency medication (such as an EpiPen and inhalers).

Please read the Information and Procedures section on the reverse side of the medication authorization form. As described, any medication the school may need to administer must be delivered by the parent/guardian (or under special circumstances, by an adult designated by the parent/guardian). Under NO circumstances may a student deliver the medication to be administered.

All prescription medication must be provided in a container with the pharmacist's label affixed. Over-the-counter medications must be in an unopened manufacturer's packaging with the student's name on the outer package material. Physician samples must be appropriately labeled by the physician. **If student is to receive more than one prescription or OTC medication during the school day, a separate form must be completed for each medication.**

We have a Delegating Nurse to oversee the medication administration procedures and have designated specific Siena staff to become Certified Medicine Technicians. Only such licensed staff are allowed to administer medications to students during the school day. Medications without accompanying physician's orders and parental consent will not be administered by the Certified Medicine Technician/Delegating Nurse.

If you will need your child to receive medication at school, please complete the medication authorization form and have your physician sign off on the form. Submit on line the completed form to Magnus/Siena as soon as possible. All forms must be reviewed and approved by the Delegating Nurse before medication may be administered.

Thank you.

The Siena School

Parents or Guardians:
In order for your child to enter The Siena School for the first time and to participate in athletics, the following are **required:**

• **A physical examination by a physician or certified nurse practitioner must be completed no more than nine months before or six months after enrollment.** A physical examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene must be used to meet this requirement. (see below)
• **Evidence of complete primary immunizations against certain childhood communicable diseases is required for all students in preschool through the twelfth grade**. A Maryland Immunization Certification form for **newly** enrolling students may be obtained from the local Department of Health and Human Services or from school personnel. The form and the required immunizations must be completed before a child may attend school. Exemptions from a physical examination and immunizations are permitted if they are contrary to a student's or families religious beliefs. Students may also be exempted from immunization requirements if a physician/nurse practitioner or health department official certifies that there is a medical reason not to receive a vaccine.

The health information on this form will be available only to those health and education personnel who have a legitimate educational interest in your child.

A physician or nurse practitioner, must complete and sign off on this medical form.

Students must have an annual medical evaluation by a physician or nurse practitioner in order to participate in physical education and interscholastic athletics. A letter from a physician or nurse practitioner giving an athlete permission to participate in interscholastic athletics is required when he/she has experienced a significant injury, illness, or surgery since the last medical evaluation.

THE Siena SCHOOL®

HEALTH and PHYSICAL EVALUATION

CHILD'S NAME _____

HEALTH and PHYSICAL EVALUATION
– To be completed by physician/nurse practitioner –

1. Does this child have a health condition(s) which may require EMERGENCY ACTION while he/she is at school (e.g., seizures, asthma insect sting allergy, bleeding problem, diabetes, heart problem)? If "Yes", please describe.
☐ No ☐ Yes _____
_____

2. Is there any evidence for concern in the areas listed below? Indicate the results of your examination by placing a check (✓) in the appropriate box.

CONCERN							
Health Area	Yes	No	Not Evaluated	**Health Area**	Yes	No	Not Evaluated
Vision	☐	☐	☐	Adjustment	☐	☐	☐
Hearing	☐	☐	☐	Nutrition	☐	☐	☐
Development	☐	☐	☐	Physical/Illness/Impairment	☐	☐	☐

Please explain all yes answers. Include recommendations for referral and treatment.-
_____
_____
_____
_____

3. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.
☐No ☐Yes _____
_____

4. Medical evaluation of students for participation in interscholastic athletics. May this student participate in supervised activities? ☐No ☐Yes

Student Name (Type/print)_____ has had a complete history and physical examination at our office and has no evident health problem except as noted above.

_____ _____ _____
Physician/Nurse Practitioner (Print) Original Signature, Physician/Nurse Practitioner Date

_____
Phone Number

How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella.**

2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.

3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).

4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.

5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the MDH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:
(1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
(2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
(3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and MDH COMAR 10.06.04.03 are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the **"Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs"** guideline chart are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

CHILD'S NAME_____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE_____/_____/_____

COUNTY _____ SCHOOL_____ GRADE_____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP_____

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr
4										_____	_____	_____	_____
5										_____	_____	_____	_____
										_____			

To the best of my knowledge, the vaccines listed above were administered as indicated.

Clinic / Office Name
Office Address/ Phone Number

1. _____
Signature Title Date
(Medical provider, local health department official, school official, or child care provider only)

2. _____
Signature Title Date

3. _____
Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: ☐ Permanent condition OR ☐ Temporary condition until _____/_____/_____
Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, _____

Signed: _____ Date _____
Medical Provider / LHD Official

RELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

Vaccine Requirements For Children
Enrolled in Preschool Programs and in Schools — Per DHMH COMAR 10.06.04.03
Maryland School Year 2023 - 2024 (Valid 9/1/23 - 8/31/24)

Required cumulative number of doses for each vaccine for PRESCHOOL aged children enrolled in educational programs

Vaccine / Child's Current Age	DTaP/DTP/DT[1]	Polio[2]	Hib[3]	Measles,[2,4] Mumps, Rubella	Varicella[2,4,5] (Chickenpox)	Hepatitis B[2]	PCV[3] (Prevnar™)
Less than 2 months	0	0	0	0	0	1	0
2 - 3 months	1	1	1	0	0	1	1
4 - 5 months	2	2	2	0	0	2	2
6 - 11 months	3	3	2	0	0	3	2
12 - 14 months	3	3	At least 1 dose given after 12 months of age	1	1	3	2
15 - 23 months	4	3	At least 1 dose given after 12 months of age	1	1	3	2
24—59 months	4	3	At least 1 dose given after 12 months of age	1	1	3	1
60 - 71 months	4	3	0	2	1	3	0

Required cumulative number of doses for each vaccine for children enrolled in KINDERGARTEN - 12th grade

Grade Level / Grade	(Ungraded)	DTaP/DTP/Tdap/ DT/Td[1,6]	Tdap[6]	Polio[2]	Measles,[2,4] Mumps, Rubella	Varicella[2,4,5] (Chickenpox)	Hepatitis B[2]	Meningococcal (MCV4)
Kindergarten, Grade 1, 2, 3, 4 5 & 6	(5 –11 yrs)	3 or 4	0	3	2	2	3	0
Grades 7, 8 & 9	(11 -13 yrs)	3 or 4	1	3	2	2	3	1
Grades 10, 11 & 12	(13 - 18yrs)	3 or 4	1	3	2	1 or 2	3	1

*** See footnotes on back for 2023-24 school immunization requirements.**

Vaccine Requirements For Children
Enrolled in Preschool Programs and in Schools
Maryland School Year 2023 – 2024 (Valid 9/1/23 - 8/31/24)

FOOTNOTES

Requirements for the 2023-24 school year are:

- **2 doses of Varicella vaccine for entry into Kindergarten, 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th AND 9th grades**

Instructions: On the chart locate the student's age or grade and read from left to right on the chart to determine the NUMBER of required vaccinations by age or grade. Dosing or spacing intervals should not be considered when determining if the requirement is met, only count the number of doses needed. MMR and Varicella vaccination dates should be evaluated (See footnote #4).

1. If DT vaccine is given in place of DTP or DTaP, a physician documented medical contraindication is required.
2. Proof of immunity by positive blood test is acceptable in lieu of vaccine history for hepatitis B, polio and measles, mumps, rubella and varicella, **but revaccination may be more expedient.**
3. Hib and PCV (Prevnar™) are not required for children older than 59 months (5 years) of age.
4. All doses of measles, mumps, rubella and varicella vaccines should be given on or after the first birthday. However, upon record review for students in preschool through 12th grade, a preschool or school may count as valid vaccine doses administered less than or equal to four (4) days before the first birthday.
5. Two doses of varicella vaccine are required for students entering Kindergarten, 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th and 9th grades and for previously unvaccinated students 13 years of age or older. Medical diagnosis of varicella disease is acceptable in lieu of vaccination. Medical diagnosis is documented history of disease provided by a health care provider. Documentation must include month and year.
6. Four (4) doses of DTP/DTaP are required for children less than 7 years old. Three (3) doses of tetanus and diphtheria containing vaccine (any combination of the following — DTP, DTaP, Tdap, DT or Td) are required for children 7 years of age and older. One dose of Tdap vaccine received prior to entering 7th grade is acceptable and should be counted as a dose that fulfills the Tdap requirement.
7. Polio vaccine is not required for persons 18 years of age and older.

THE Siena SCHOOL®

Montgomery County DHHS Authorization Form for Schools to Administer Medications, Release and Indemnification Agreement

Part I – To Be Completed by the Parent/Guardian

I hereby request and authorize the school personnel to administer prescribed and/or Over The Counter (OTC) medication as directed by the physician (Part II below). I agree to release, indemnify, and hold harmless the school and any of their officers, staff members, or agents such as nurse delegates from lawsuit, claim, demand, or action against them for administering prescribed medication to this student, provided the school staff are following the physician's order as written in Part II below. I have read the procedures outlined on the back (or as page 2) of this form and assume the responsibilities as required.

Student: _____ **Birth date:** _____

Prescription: ____Renewal _____ New If new, the first full day's dosage was given at home on: _____

Allergies _____

List all medication(s) the student is taking, including over-the-counter medication(s): _____

_____

_____ _____ _____

Parent/Guardian Signature **Phone Number** **Date**

Part II – To Be Completed by the Physician for Prescriptions or Over The Counter (OTC) Medications

The Montgomery County DHHS and the School discourages the administration of medication to students in school during the school day. Any necessary medication that possibly can be administered before or after school should be so prescribed. Only non-parenteral medications are administered except in specific emergency situations. School personnel will, when it is absolutely necessary, administer medication to students during the school day and while participating in outdoor education programs and overnight field trips, according to the procedures outlined on the back of this form or as the 2nd page of this form. Please do not use abbreviations.

****I have read the above parent/guardian information and assume the responsibilities as required.**

*****MUST USE A SEPARATE FORM FOR EACH PRESCRIPTION OR OTC MEDICATION*****

Name of Medication: _____ **Diagnosis (write out):** _____

Dosage: _____**Frequency (write out):**_____ **Time(s) to be given at school:** _____

Route of Administration: _____**Effective Dates: From:**_____**To:**_____

Side Effects: _____

If PRN, must specify indication (signs/symptoms): _____

_____ _____

****Physician's Name (Print/Type)** ****Physician Signature** **Phone Number** **Date**

MD Address or stamp: _____**Fax :** _____

SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self-carry/self-administration of Emergency med. such as inhalers and EpiPens® must be authorized by the prescriber and school nurse according State medication policy.

****MD Prescriber's authorization** _____**School RN approval** _____

Signature **Date** **Signature** **Date**

Part III – To Be Completed By the School Nurse

_____Parts I and II above are completed, including signatures. **_____Medication is properly labeled by pharmacist.**

_____Medication label and physician order are consistent. **_____OTC Medication is in manufacturer labeled container.**

School Nurse Signature and Date_____

Information and Procedures

1. No medication will be administered in school or during school-sponsored activities without the parent's/guardian's written authorization and a written physician order. This includes both prescription and over-the-counter (OTC) medications.

2. The parent/guardian is responsible for completing Part I and obtaining the physician's statement on Part II. This is required every school year for each new or continuing order or if there is a change in dosage or time of administration during the school year. (A physician may use office stationery or prescription pad in lieu of completing Part II.) Information necessary includes: child's name, diagnosis, medication name, dosage, time of administration, duration of medication, side effects, physician signature, and date.

3. The medication must be delivered to the school by the parent/guardian or, under special circumstances, an adult designated by the parent/guardian. Under no circumstances will the School administer medication brought to school by a child.

4. All prescription medication must be provided in a container with the pharmacist's label attached. Non-prescription OTC medication must be in the container with the manufacturer's original label. Physician samples must be appropriately labeled by the physician.

5. The first day's dosage of any new medication must have been given at home before it can be administered at school.

6. The parent/guardian is responsible for collecting any unused portion of a medication within one week after expiration of the physician's order or at the end of the school year. Medication not claimed within that time period will be destroyed.

7. Self-administered and/or non-medically prescribed medications are entirely the responsibility of the parent/guardian and not that of The Siena School. Medications without accompanying physician's orders and parental consent will not be stored in the health room.

8. Students may not self-administer controlled substances.

9. A physician's order and parental permission are necessary for self-carry/self-administered emergency medications such as inhalers for asthma and EpiPens® for anaphylaxis. The school nurse must evaluate and approve the student's ability and capability to self-administer medication. It is imperative the student understands the necessity for reporting to the health staff or other school staff that they have self-administered their inhaler without any improvement or have self-administered an EpiPen®, so that 911 may be called.

10. The school nurse will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

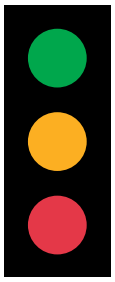
11. **This form applies to overnight trips provided there are no changes.**

ASTHMA ACTION PLAN

Asthma and Allergy Foundation of America
aafa.org

Name:	Date:
Doctor:	Medical Record #:
Doctor's Phone #: Day	Night/Weekend
Emergency Contact:	
Doctor's Signature:	

The colors of a traffic light will help you use your asthma medicines.



GREEN means Go Zone!
Use preventive medicine.

YELLOW means Caution Zone!
Add quick-relief medicine.

RED means Danger Zone!
Get help from a doctor.

Personal Best Peak Flow: _____

GO

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work & play

Peak flow:
from _____
to _____

Use these daily controller medicines:

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
For asthma with exercise, take:		

CAUTION

You have *any* of these:
- First signs of a cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night

Peak flow:
from _____
to _____

Continue with green zone medicine and add:

MEDICINE	HOW MUCH	HOW OFTEN/ WHEN

CALL YOUR ASTHMA CARE PROVIDER.

DANGER

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard & fast
- Nose opens wide
- Trouble speaking
- Ribs show (in children)

Peak flow:
reading below _____

Take these medicines and call your doctor now.

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

GET HELP FROM A DOCTOR NOW! Your doctor will want to see you right away. It's important!
If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT.
Make an appointment with your asthma care provider within two days of an ER visit or hospitalization.

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: [ ] **Yes (higher risk for a severe reaction)** [ ] **No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following foods: _____

THEREFORE:

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

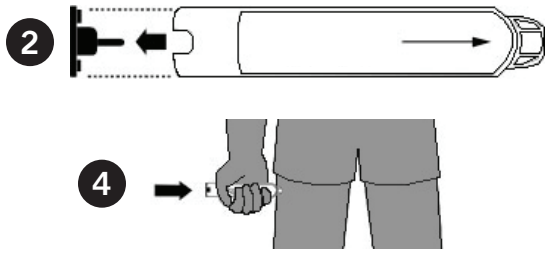
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

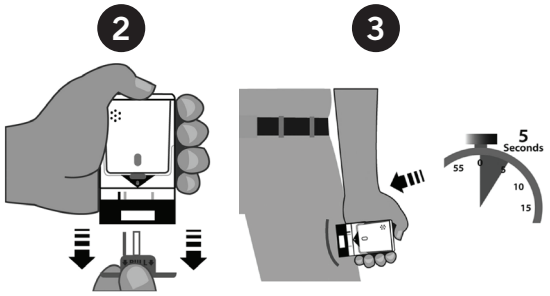
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled “1” and “2”.
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.)**:**

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014

Diabetes Medical Management Plan (DMMP)

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

Date of Plan: _____ This plan is valid for the current school year: _____ - ____

Student's Name: _____ Date of Birth: _____

Date of Diabetes Diagnosis: _____ ❑ type 1 ❑ type 2 ❑ Other_____

School: _____ School Phone Number: _____

Grade: _____ Homeroom Teacher: _____

School Nurse: _____ Phone:_____

CONTACT INFORMATION

Mother/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell: _____

Email Address: _____

Father/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell: _____

Email Address: _____

Student's Physician/Health Care Provider: _____

Address: _____

Telephone:_____

Email Address: _____ Emergency Number: _____

Other Emergency Contacts:

Name: _____ Relationship:_____

Telephone: Home _____ Work _____ Cell: _____

CHECKING BLOOD GLUCOSE

Target range of blood glucose: ☐ 70–130 mg/dL ☐ 70–180 mg/dL

☐ Other: _____

Check blood glucose level: ☐ Before lunch ☐ _____ Hours after lunch

☐ 2 hours after a correction dose ☐ Mid-morning ☐ Before PE ☐ After PE

☐ Before dismissal ☐ Other:_____

☐ As needed for signs/symptoms of low or high blood glucose

☐ As needed for signs/symptoms of illness

Preferred site of testing: ☐ Fingertip ☐ Forearm ☐ Thigh ☐ Other: _____

Brand/Model of blood glucose meter:_____

Note: The fingertip should always be used to check blood glucose level if hypoglycemia is suspected.

Student's self-care blood glucose checking skills:

☐ Independently checks own blood glucose

☐ May check blood glucose with supervision

☐ Requires school nurse or trained diabetes personnel to check blood glucose

Continuous Glucose Monitor (CGM): ☐ Yes ☐ No

Brand/Model: _____ Alarms set for: ☐ (low) and ☐ (high)

Note: Confirm CGM results with blood glucose meter check before taking action on sensor blood glucose level. If student has symptoms or signs of hypoglycemia, check fingertip blood glucose level regardless of CGM.

HYPOGLYCEMIA TREATMENT

Student's usual symptoms of hypoglycemia (list below):

_____

_____

If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than _____mg/dL, give a quick-acting glucose product equal to _____ grams of carbohydrate.

Recheck blood glucose in 10–15 minutes and repeat treatment if blood glucose level is less than _____ mg/dL.

Additional treatment: _____

HYPOGLYCEMIA TREATMENT (Continued)

Follow physical activity and sports orders (see page 7).

- If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movements), give:
- Glucagon: ❑ 1 mg ❑ 1/2 mg Route: ❑ SC ❑ IM
- Site for glucagon injection: ❑ arm ❑ thigh ❑ Other:_____
- Call 911 (Emergency Medical Services) and the student's parents/guardian.
- Contact student's health care provider.

HYPERGLYCEMIA TREATMENT

Student's usual symptoms of hyperglycemia (list below):

_____

_____

Check ❑ Urine ❑ Blood for ketones every _____hours when blood glucose levels are above _____mg/dL.

For blood glucose greater than _____mg/dL AND at least _____hours since last insulin dose, give correction dose of insulin (see orders below).

For insulin pump users: see additional information for student with insulin pump.

Give extra water and/or non-sugar-containing drinks (not fruit juices): _____ounces per hour.

Additional treatment for ketones: _____

Follow physical activity and sports orders (see page 7).

- Notify parents/guardian of onset of hyperglycemia.
- If the student has symptoms of a hyperglycemia emergency, including dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy, or depressed level of consciousness: Call 911 (Emergency Medical Services) and the student's parents/guardian.
- Contact student's health care provider.

INSULIN THERAPY

Insulin delivery device: ❑ syringe ❑ insulin pen ❑ insulin pump

Type of insulin therapy at school:

❑ Adjustable Insulin Therapy
❑ Fixed Insulin Therapy
❑ No insulin

Adjustable Insulin Therapy

- **Carbohydrate Coverage/Correction Dose:**
  Name of insulin: _____
- **Carbohydrate Coverage:**
  Insulin-to-Carbohydrate Ratio:
  Lunch: 1 unit of insulin per _____ grams of carbohydrate
  Snack: 1 unit of insulin per _____ grams of carbohydrate

Carbohydrate Dose Calculation Example

$$\frac{\textit{Grams of carbohydrate in meal}}{\textit{Insulin-to-carbohydrate ratio}} = \_\_\_\_\_ \text{ units of insulin}$$

- **Correction Dose:**

Blood Glucose Correction Factor/Insulin Sensitivity Factor = _____
Target blood glucose = _____ mg/dL

Correction Dose Calculation Example

$$\frac{\textit{Actual Blood Glucose–Target Blood Glucose}}{\textit{Blood Glucose Correction Factor/Insulin Sensitivity Factor}} = \_\_\_\_\_ \text{ units of insulin}$$

Correction dose scale (use instead of calculation above to determine insulin correction dose):

Blood glucose _____ to _____ mg/dL give _____units
Blood glucose _____ to _____ mg/dL give _____units
Blood glucose _____ to _____ mg/dL give _____units
Blood glucose _____ to _____ mg/dL give _____units

INSULIN THERAPY (Continued)

When to give insulin:

Lunch

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____mg/dL and ____ hours since last insulin dose.

☐ Other: _____

Snack

☐ No coverage for snack

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____mg/dL and ____ hours since last insulin dose.

☐ Other: _____

☐ Correction dose only:

For blood glucose greater than _____mg/dL AND at least _____ hours since last insulin dose.

☐ Other: _____

Fixed Insulin Therapy

Name of insulin: _____

☐ ____ Units of insulin given pre-lunch daily

☐ ____ Units of insulin given pre-snack daily

☐ Other: _____

Parental Authorization to Adjust Insulin Dose:

☐ Yes ☐ No Parents/guardian authorization should be obtained before administering a correction dose.

☐ Yes ☐ No Parents/guardian are authorized to increase or decrease correction dose scale within the following range: +/- _____ units of insulin.

☐ Yes ☐ No Parents/guardian are authorized to increase or decrease insulin-to-carbohydrate ratio within the following range: _____ units per prescribed grams of carbohydrate, +/- ___ grams of carbohydrate.

☐ Yes ☐ No Parents/guardian are authorized to increase or decrease fixed insulin dose within the following range: +/- _____ units of insulin.

INSULIN THERAPY (Continued)

Student's self-care insulin administration skills:

- ☐ Yes ☐ No Independently calculates and gives own injections
- ☐ Yes ☐ No May calculate/give own injections with supervision
- ☐ Yes ☐ No Requires school nurse or trained diabetes personnel to calculate/give injections

ADDITIONAL INFORMATION FOR STUDENT WITH INSULIN PUMP

Brand/Model of pump: _____ Type of insulin in pump: _____

Basal rates during school: _____

Type of infusion set: _____

☐ For blood glucose greater than _____ mg/dL that has not decreased within _____ hours after correction, consider pump failure or infusion site failure. Notify parents/guardian.

☐ For infusion site failure: Insert new infusion set and/or replace reservoir.

☐ For suspected pump failure: suspend or remove pump and give insulin by syringe or pen.

Physical Activity

May disconnect from pump for sports activities ☐ Yes ☐ No

Set a temporary basal rate ☐ Yes ☐ No _____% temporary basal for _____ hours

Suspend pump use ☐ Yes ☐ No

Student's self-care pump skills:	**Independent?**	
Count carbohydrates	☐ Yes	☐ No
Bolus correct amount for carbohydrates consumed	☐ Yes	☐ No
Calculate and administer correction bolus	☐ Yes	☐ No
Calculate and set basal profiles	☐ Yes	☐ No
Calculate and set temporary basal rate	☐ Yes	☐ No
Change batteries	☐ Yes	☐ No
Disconnect pump	☐ Yes	☐ No
Reconnect pump to infusion set	☐ Yes	☐ No
Prepare reservoir and tubing	☐ Yes	☐ No
Insert infusion set	☐ Yes	☐ No
Troubleshoot alarms and malfunctions	☐ Yes	☐ No

OTHER DIABETES MEDICATIONS

Name: _____ Dose: _____ Route: _____ Times given: ____
Name: _____ Dose: _____ Route: _____ Times given: ____

MEAL PLAN

Meal/Snack	Time	Carbohydrate Content (grams)
Breakfast	_____	_____ to_____
Mid-morning snack	_____	_____ to_____
Lunch	_____	_____ to_____
Mid-afternoon snack	_____	_____ to_____

Other times to give snacks and content/amount:_____

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

Special event/party food permitted: ☐ Parents/guardian discretion
☐ Student discretion

Student's self-care nutrition skills:

☐ Yes ☐ No Independently counts carbohydrates
☐ Yes ☐ No May count carbohydrates with supervision
☐ Yes ☐ No Requires school nurse/trained diabetes personnel to count carbohydrates

PHYSICAL ACTIVITY AND SPORTS

A quick-acting source of glucose such as ☐ glucose tabs and/or ☐ sugar-containing juice must be available at the site of physical education activities and sports.

Student should eat ☐ 15 grams ☐ 30 grams of carbohydrate ☐ other_____
☐ before ☐ every 30 minutes during ☐ after vigorous physical activity
☐ other _____

If most recent blood glucose is less than _____ mg/dL, student can participate in physical activity when blood glucose is corrected and above _____ mg/dL.

Avoid physical activity when blood glucose is greater than _____ mg/dL or if urine/blood ketones are moderate to large.

(Additional information for student on insulin pump is in the insulin section on page 6.)

DISASTER PLAN

To prepare for an unplanned disaster or emergency (72 HOURS), obtain emergency supply kit from parent/guardian.

☐ Continue to follow orders contained in this DMMP.

☐ Additional insulin orders as follows: _____

☐ Other: _____

SIGNATURES

This Diabetes Medical Management Plan has been approved by:

_____

Student's Physician/Health Care Provider Date

I, (parent/guardian:) _____ give permission to the school nurse or another qualified health care professional or trained diabetes personnel of (school:) _____ to perform and carry out the diabetes care tasks as outlined in (student:) _____'s Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified health care professional to contact my child's physician/health care provider.

_____

Acknowledged and received by:

_____

Student's Parent/Guardian Date

_____

Student's Parent/Guardian Date

_____

School Nurse/Other Qualified Health Care Personnel Date

EPILEPSY FOUNDATION®
Not another moment lost to seizures

Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name | Date of Birth

Parent/Guardian | Phone | Cell

Other Emergency Contact | Phone | Cell

Treating Physician | Phone

Significant Medical History

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ❒ Yes ❒ No

If YES, describe process for returning student to classroom:

Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol
(Check all that apply and clarify below)

- ❒ Contact school nurse at _____
- ❒ Call 911 for transport to _____
- ❒ Notify parent or emergency contact
- ❒ Administer emergency medications as indicated below
- ❒ Notify doctor
- ❒ Other _____

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ❒ Yes ❒ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

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