District School Board of Pasco County

Dear Parent/Guardian:

According to District School Board of Pasco County Policy 5335, students who receive medication or health procedures (e.g. Diabetes Management, Diastat, Asthma Inhaler, EpiPen, Pancreatic Enzyme Supplement) at school shall provide **annual** parental and healthcare provider authorization for the administration of medications and treatments.

If your child plans to carry his/her own supplies and/or perform any of the above medical procedures <u>independently and without supervision</u> during the next school year:

- Please return the *Authorization to Carry and Self Administer Diabetes Medication/Procedure, Asthma Inhaler, EpiPen, Pancreatic Enzyme Supplement* form (available on the district website) signed by physician, parent and student **on or before the first day of school.**

- Please make sure your child carries all necessary supplies (Diabetes equipment or medication, Inhaler, Epipen, and/or Pancreatic enzyme supplement) at all times.

If your child <u>may/will require assistance</u> with administration of medication and/or procedures at any time during the next school year:

- Depending on your child's condition, please return either the *Severe Allergy* ***or*** *Seizure* ***or*** *Diabetes Medical Management Plan* form (found below) completed and signed by physician and parent **on or before the first day of school.**

- Please return the *Authorization for Medication Administration* form (available on the district website) for any medication that will need to be administered for your child **on or before the first day of school.** This form should be completed and signed by parent.

- Please provide the school clinic with all necessary supplies. Remember that medication must be brought to school by the parent / guardian (e.g. Insulin, Glucagon, Diastat, Inhaler, Epipen, etc.).

Please feel free to call your child's School Nurse if you have any questions or would like to discuss your child's health status.

Thank you,

Pasco County School Health Services Program

District School Board of Pasco County

Severe Allergy Medical Management Plan

Student Name:	**D.O.B:**	**School Year:**
Diagnosis/Allergy to:	Asthmatic: _____Yes ***higher risk for severe reaction*** _____ No	

Symptoms of Allergic Reaction

Mild Reaction	**Severe Reaction**
Please indicate typical symptoms (if known): _____ **Mouth:** Itchy mouth _____ **Skin:** A few hives, mild itch _____ **GI**: Mild nausea/discomfort **Other symptoms**: _____ _____	Please indicate typical symptoms (if known): _____ **Lung:** Short of breath, repetitive coughing, and/or wheezing _____ **Mouth**: Itching and swelling of the lips, tongue or, mouth; obstructive swelling of tongue/lips _____ **Throat**: Trouble breathing/swallowing, tightness, hoarseness _____ **Skin:** Many hives over body, swelling and itching of the lips, face or extremities _____ **GI:** Abdominal cramps, vomiting and/or diarrhea _____ **Heart:** Pale, blue, faint, weak pulse, dizzy, confused **Other symptoms**: _____ _____

Emergency Medication Plan

Medication/Action for **Mild Reaction:**	Medication/Action for **Severe Reaction:**
Medication: _____ Dose: _____ Route: _____ _____ If checked, give epinephrine **immediately** if the allergen was **definitely** eaten, even if **NO** symptoms are noted. Comments: _____ _____	Medication: _____ Dose: _____ Route: _____ _____ Call 911/EMS after administration _____ If checked, give epinephrine **immediately** for **ANY** symptoms if the allergen was **likely** eaten. Comments: _____ _____

School Accommodations (for food allergies only)

Please list **any foods** that should be omitted from the student's diet and indicate substitute foods:

Please indicate any lunchroom/classroom accommodations? (i.e. hand washing /washing of tables)

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____

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Seizure Medical Management Plan

Student Name:	**D.O.B:**	**School Year:**
Diagnosis:		
Medication(s):		

Seizure Information

Indicate type of seizure disorder

_____ Tonic-Clonic _____ Myoclonic _____ Other
_____ Simple Partial _____ Atonic
_____ Partial Partial _____ Absence

Seizure History

Date of onset _____ Last Known Seizure _____

Seizure triggers: _____ TV/Video games _____ Computer monitor _____ Fire alarm/strobe light

Aura (if known)_____

Emergency Medication for Seizure

Administer medication as directed below for seizures lasting more than _____ minutes.

Medication: _____

Dose: _____

Route: _____

_____ **If seizure continues after giving emergency medication, call 911.**

Special Instructions: _____

List any Special Considerations or Precautions regarding sports, school activities and/or field trips:

_____

_____

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____

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Diabetes Medical Management Plan

Student Name:	**D.O.B:**	**School Year:**

Glucose Monitoring at School:
___Yes ___No
Testing performed:
____ Independent ____ With supervision
Testing supplies carried by student:
___Yes ___No
Testing location:
_____Clinic _____ Classroom _____ Other

Time to be performed:
_____Mid-morning _____Before Lunch
_____Mid-afternoon _____Before Dismissal
_____Before/After PE/Activity
_____ PRN for symptoms of low/high blood sugar
Time of Daily Classroom Snack:
_____ Morning _____ Afternoon

Insulin Therapy at School:
Insulin Dosage: _____

Insulin Delivery: __Syringe __Pen ___Pump
___Independent ____ With supervision

Student can:
Determine correct dose __Y __N Draw up correct dose __Y __N
Give own injection __Y __N Needs supervision __Y __N

Target Range/Number: _____
Insulin/Carb Ratio: _____ unit(s) per _____ grams
Correction Factor: _____ unit(s) per _____ mg/dl (points)
Sliding Scale Coverage: _____ _____
_____ _____
_____ _____

Classroom parties: _____ Student to eat same food as peers _____Student to eat snacks provided by parent

Hypoglycemia (Blood Glucose <_____Range)

Symptoms of Hypoglycemia:
All or some of the following symptoms may occur:
_____ Headache/dizziness/blurred vision
_____Weakness/shakiness/tremors
_____ Irritability/personality changes
_____ Drowsy /fatigue
_____ Loss of consciousness

Treatment of Hypoglycemia (indicate treatment choices):

_____ 15 grams of carbohydrates (i.e. 4-6 oz. Juice, 3 glucose tabs, glucose gel tube, syrup, cake icing tube)
_____ Wait 15 min after treatment w/ 15g carb & retest blood glucose
_____ If blood glucose is **< 70** repeat treatment w/15g of carbs. If **> 70** then return to regular activities w/ protein snack or meal

Emergency Glucagon

_____ Administer Glucagon if child is unconscious, having a seizure or unable to eat /drink fluids. **Call 911 and parent(s) immediately.**
_____ Call **911** immediately for severe low blood glucose/unconscious state when Glucagon is not available/ provided by parent.

Insulin Pump Only:
For Pump Site Failure: _____ Parent should be called _____ Student can change site independently

Hyperglycemia (Blood Glucose >_____Range)

Symptoms of Hyperglycemia:
_____ Increased thirst
_____ Tired/drowsy/less energy
_____ Blurred vision
_____ Warm, dry, or flushed skin
_____ Fruity breath (odor)
_____ Lack of concentration

Treatment of Hyperglycemia:
_____ Sugar free fluids
_____ May not need snack
_____ Frequent bathroom breaks
_____ Check urine for ketones if Blood Glucose >_____
_____ For abdominal pain /vomiting, positive ketones and/or blood glucose >_____, notify parent and follow insulin administration orders. Consider pump site failure.

Supplies /Field Trips/Emergency Drills: _____ All diabetic supplies are to be provided to the school by the parent and taken with the student for field trips and available during emergency drills.

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____