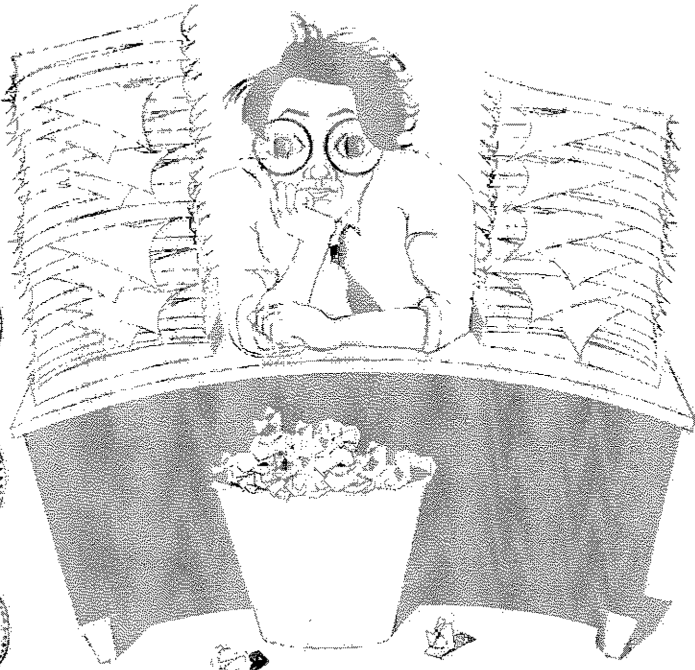
REPORTS & FORMS



Snowflake Taylor Public Schools

IS MY CHILD WELL ENOUGH TO GO TO SCHOOL?

Sometimes children are too sick to be at school. Putting other students and staff at risk for becoming ill. Here are some guidelines for keeping your child home, and for how long.

Fever 100.0 degrees or higher: Child should stay home until they are fever free for 24 hours or longer, **without** fever reducing medication.
Coughing: Severe/Persistent coughing or coughing with other signs of illness, such as fever/chills/muscle aches/colored discharge from mouth or nose, child should stay home until symptoms subside, and fever free for 24 hours.
Vomiting or Diarrhea: Child should stay home until it has been 24 hours or longer since their last episode of vomiting or diarrhea.
Rashes: Check with your doctor or your school heath staff **before** sending a child, with a rash, to school.
Strep Throat: In cases of suspected or diagnosed strep throat, the child should be kept out of school until the diagnosis has been made and/or treatment has been underway for at least 24 hours.
Chicken Pox: A child with chicken pox must be kept out of school for at least 5 days following the appearance of blisters. Child may return to school after all blisters are scabbed over/dry, and individual is fever free for 24 hours.
Head Lice: A child with head lice must receive adequate treatment and all nits (eggs) removed from hair before returning to school.
Conjunctivitis (Pink Eye): Child should stay home until signs and symptoms are gone, or until 24 hours after appropriate treatment has been started, **and** signs and symptoms are greatly reduced.

All these illnesses are easily spread, both at school and in the family. Frequent hand washing is the single most important thing we can do to help prevent the spread of infection. Please encourage your children to wash their hands often.

Thank you for following these guidelines, and helping us provide a safe and healthy environment for our students and staff.

Sincerely,
Health Staff

682 School Bus Lane, Snowflake, Arizona 85937
Phone (928) 536-4156 Fax: (928) 536-2634

WHEN TO CALL THE DISTRICT NURSE SUPERVISOR

-911 calls – IMMEDIATELY

-Possible BROKEN ARMS

-UNKNOWN RASHES, COMMUNICABLE DISEASE (pinkeye, scabies, lice, etc.)

-INJURY or ILLNESS (if serious enough the parent might take to a doctor)

-POSSIBLE STITCHES

-All new PARENT LETTERS from Health Services

-Possible CHILD ABUSE, SUICIDE, MUTILATION

-IMMUNIZATION DISPUTES

- MAD PARENTS

-NEW NURSING PROCEDURES

-SEVERE MEDICAL CONDITIONS

-IEP'S INVOLVING STUDENTS WITH MEDICAL A MEDICAL DIAGNOSIS OR PROCEDURE, OR STUDENTS WITH VISION /HEARING LOSSES

-NEW MEDICATIONS

-NURSING MEDICAL QUESTIONS

- PREGNANCIES

-MEDICAL CONCERNS that are going to the Principal

Blood Pressure Tracking Chart

Date	Time	Systolic	Diastolic	Date	Time	Systolic	Diastolic	Date	Time	Systolic	Diastolic
/ /				/ /				/ /			
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/ /				/ /				/ /			
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www.FreePrintableMedicalForms.com

SNOWFLAKE UNIFIED SCHOOL DISTRICT
ACCIDENT REPORT FORM

Student Name/Address

Last ______ First ______ MI ______

Street Address ______

City ______

Parents/Guardian Name

Last ______ First ______ MI ______

Street Address ______

City ______

Date of Injury ______

Date of Birth ______

Time of Injury ______

Grade ____ School HS ☐ JH ☐ S. INT. ☐ T. INT. ☐ HP ☐ TE ☐

Date Reported ______

ACTION TAKEN

- ☐ first aid administered
- ☐ parent /guardian notified
- ☐ unable to contact parent/guardian
- ☐ remained in/returned to class
- ☐ sent/taken home
- ☐ checked by health staff
- ☐ checked by ems
- ☐ taken to physician
- ☐ taken to emergency facility
- ☐ other ______

SURFACE WHERE INJURY OCCURED

☐ black top ☐ concrete ☐ lawn/grass ☐ gravel ☐ dirt
☐ carpet/mat ☐ sand ☐ wood ☐ tile
☐ other ______

EQUIPMENT THAT WAS INVOLVED

☐ slide ☐ swing ☐ balance beam ☐ bars
☐ other ______

INCIDENT LOCATION

- ☐ athletic field
- ☐ auditorium/multi
- ☐ basketball court
- ☐ bathroom/shower
- ☐ bus loading area
- ☐ classroom
- ☐ lockers/hallway
- ☐ gymnasium
- ☐ lunchroom
- ☐ home ec.
- ☐ shop/industrial
- ☐ parking area
- ☐ playground
- ☐ school bus
- ☐ pool
- ☐ lab
- ☐ other ______

TYPE OF INJURY

- ☐ scrape/abrasion
- ☐ cut/laceration
- ☐ amputation
- ☐ concussion
- ☐ sprain/strain
- ☐ dislocation
- ☐ possible fracture
- ☐ poison
- ☐ puncture wound
- ☐ teeth lost
- ☐ teeth chipped
- ☐ bite/sting
- ☐ burn
- ☐ pain
- ☐ other ______

SUPERVISION

none ___ instructor ___ aide ___ driver ___ parent ___ other ___

name ______

if none, explain ______

INJURY SITE

- ☐ head
- ☐ ears/eyes/nose
- ☐ mouth/lips
- ☐ teeth
- ☐ gums
- ☐ face
- ☐ jaw
- ☐ chin
- ☐ neck
- ☐ chest/rib
- ☐ shoulder
- ☐ arm
- ☐ elbow
- ☐ wrist
- ☐ hand
- ☐ finger
- ☐ thumb
- ☐ back
- ☐ abdomen
- ☐ genitals
- ☐ pelvis/hip
- ☐ leg/knee
- ☐ ankle
- ☐ foot/toe
- ☐ other ______

WITNESSES:

1. ______

2. ______

COMMENTS: ______

______

SIGNATURE OF PERSON MAKING REPORT ______

DATE

Distribution
White - District Office Canary - Supervisor Pink - Health Services

a:\files\forms\accident

J-6281 © JLF-E

EXHIBIT EXHIBIT

REPORTING CHILD ABUSE / CHILD PROTECTION

(Suspected Abuse, Physical Injury, Child Abuse, Reportable Offense or Neglect)

To: **Child Protective Services, D.E.S. (or law enforcement agency)**

Student's name ______________________ Birth date __________ Sex ___

Address ______________________________________

Names of parents/guardians ______________________________

School ______________ Grade ___ Teacher ______________

Description of suspected present or prior abuse, child abuse, physical injury, or neglect (use additional page if necessary) ______________________

____

____

____

Symbols: *Severity:*

Symbol		Meaning	Severity		
A	=	Abrasion	(1)	=	Mild
Bl	=	Blister	(2)	=	Moderate
Bu	=	Burn	(3)	=	Severe
Br	=	Bruise			
La	=	Laceration			
Le	=	Lesions			
S	=	Scar			
R	=	Rash			
V	=	Vermin			
O	=	Other (describe)			

______________________________________ ______________

Signature and Title of Person Making the Report Date

Oral Report to: Name ______________________________

CHILD PROTECTIVE SERVICES (CPS)

Call Toll-Free Child Abuse Hotline **1-888-SOS-CHILD**
(1-888-767-2445)

Snowflake Unified School District #5
School Health Department
682 School Bus Lane, Snowflake, AZ 85937
(928)536-4156 EXT. 7212

PARENT NOTIFICATION OF POSSIBLE INJURIES TO THE HEAD

Date: ________________

Dear Parent:

____________________________, received a bump or blow on his/her head
on the____ (exact area)
by____________________________________ (describe the fall or accident)
at____ (time) today.

We had him/her rest in the Health Office after the accident and we observed him/her for signs of a concussion during that time, and again before leaving school.

At the time there were:
___ No obvious signs of head injury
___ Signs of possible head injury

Your child had:

_______ Slight headache
_______ Minor abrasion/cut
_______ Paleness or flushing
_______ Weakness or paralysis
_______ Nausea-vomiting
_______ Vision changes-doubled or blurred
_______ Bruising
_______ Bump
_______ Loss of consciousness
_______ Loss of memory
_______ Dizziness

Disposition:

_______ Student felt well and returned to class
_______ Parent called
_______ Parent unavailable
_______ Student sent home with parent or Alternate Emergency Contact

*All head injures should be watched closely for at least 24 hours. I URGE YOU TO CONTACT YOUR FAMILY PHYSIAN IMMEDIATELY IF YOUR CHILD HAS ANY OF THE FOLLOWING SYMPTOMS:

1. Loss of consciousness or extreme sleepiness
2. Has weakness or paralysis of face or limbs
3. Nausea or vomiting; continuous headache in same place
4. Has clear or bloody drainage from ear or nose
5. Has severe swelling at injury site or stiffness of neck
6. Has twitching movements of the body or convulsions
7. Complains of dizziness; has blurred or double vision
8. Doesn't respond or act as he/she usually does; loss of memory or confusion

A few children will get sick from a head injury 7 or 10 days after the accident. Please keep this slip and show it to your doctor if any of the above symptoms appear in your child at any time during the next 10 days.

Sincerely ____
Name Title Phone Ext.

SNOW FLAKE UNIFIED SCHOOL DISTRICT #5
SCHOOL HEALTH DEPARTMENT - 682 SCHOOL BUS LANE
SNOWFLAKE, AZ 85937
(928) 536-4156 EXT. 7520

PARENT NOTIFICATION OF ILLNESS/INJURY

Date: ______________________ Time: __________

Dear Parent:

______________________ was in the Health Room today for treatment that was given, if indicated:

____

____

Recommendations: ____

____

( ) We were unable to reach you at the time of concern: ______

Treated By: ______________________ at ______________________ Ext. #: ______
Name/Position Phone #

( ) Please contact me at your earliest convenience. (If checked)

14009

MEDICAL CERTIFICATION OF STUDENTS WITH CHRONIC HEALTH CONDITIONS

Student Name: ______________________________ Grade Level: _____

Date of Birth: ___/____/_____ School: ____________________

Parent Name: ______________________________ Phone #: (_____)______________

Medical diagnosis and prognosis:

____

Physical limitations affecting physical education classes or other high activity classes:

____

Physical limitations that may affect academic classes:

____

Anticipated absences due solely to illness, injury, pregnancy, or an accident of a student that may interfere with school or class participation during the school year:

______________ Months ______________ Days

Physician Name: ______________________________ (please print)

Physician Signature: ______________________________ Date: ____________

Snowflake Unified School District

Student Health History

Student Name____
Legal Last Name First Name Middle Name

Does your child have any of the following medical conditions? Please circle yes (Y) or no (N) for each condition.

Y N	ADD or ADHD	Y N	Epilepsy/Seizures
Y N	Allergic to bee stings __Mild __Moderate __Severe	Y N	Heart Condition
Y N	Gastrointestinal (stomach) disorders	Y N	Migraine Headaches
Y N	Asthma __Mild __Moderate __Severe	Y N	Psychiatric Disorders
Y N	Chicken Pox Month____ Year____	Y N	Urinary conditions
Y N	Diabetes	Y N	Skin Disorders

If any yes answers, please explain____

Please list any known allergies____
Is your child on any medications at home? If yes, please list_______________________
Is your child currently under a doctor's care? If yes, please give reason_______________

Occasionally your child may need acetaminophen or a cough drop at school. Please check yes or no:
☐Yes ☐No My child may be given an age-appropriate dose of acetaminophen (Tylenol) at school.
☐Yes ☐No My child may be given a cough drop at school.

Family Doctor_______________________________ Insurance_____________________

EMERGENCY CONTACTS (other than parent)

Name	Relationship	Phone Number

Emergency Contacts - Parental approval for the student to be picked up from school, for any reason, by someone other than the parent/guardian **must be given**. The school will not release the student to any one not listed on this form.

If emergency medical action or treatment is required and a parent/guardian cannot be contacted, I hereby consent for my student to be given medical care and if necessary, transported by ambulance to the hospital or doctor's office.

____
Parent/Guardian Signature Date

SIBLINGS LIVING IN THE HOME

Name	School Attending

Snowflake Unified School District No. 5

Grade____________

Student's Last Name	First	Address	City	Home Phone
Father/Guardian Name	First	Employer Name	City	Business Phone
Mother/Guardian Name	First	Employer Name	City	Business Phone

IN CASE OF EMERGENCY: Name of persons who could assume temporary responsibility.

Local friend or relative ______________________________ Phone ____________

Local friend or relative ______________________________ Phone ____________

Local Doctor ______________________________ Phone ____________

1. Specify health problems: ALLERGIES ☐ SEIZURES ☐ DIABETIC ☐ OTHER HEALTH PROBLEMS (please list below) ☐

____

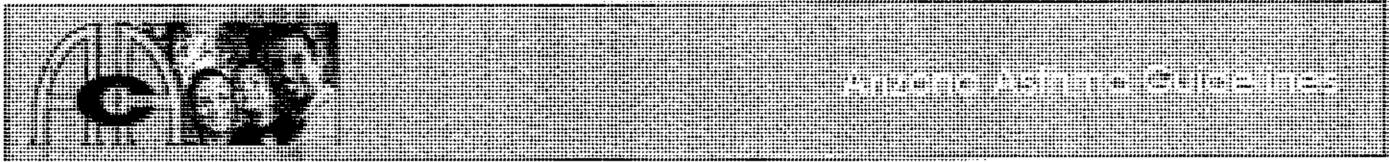
2. Is your child on daily medication? Yes _____ No _____ Specify _____
3. Recent surgery, accident or illness (past year) ______________________

I, the undersigned parent/guardian, hereby give my consent for the above named child to be released to the friend/relative I have designated and/or to be taken to the nearest hospital in case of emergency. Permission for High School students to be given Tylenol as needed for illness/injury at the discretion of health staff.

Yes ☐ No ☐

Signature of Parent/Guardian ______________________________

A&L/list/nurse/emotice



Individualized Student Treatment Plan 2

Emergency Asthma Plan: School Year_____________	ACME Unified School District Student Individualized Health Care Plan
Asthma: An intermittent obstruction (blockage) of lung airways (passages) that is at least partially reversible either spontaneously or with mediation.	

Student Name		Emergency Contact 1	
Teacher/Grade		Phone number(s)	
Parent Name:		Emergency Contact 2	
Parent Phone #		Phone number(s)	
Parent Name		Physician's Name	
Parent Phone #		Phone number(s)	

Prescribed Treatment: ____

____

____

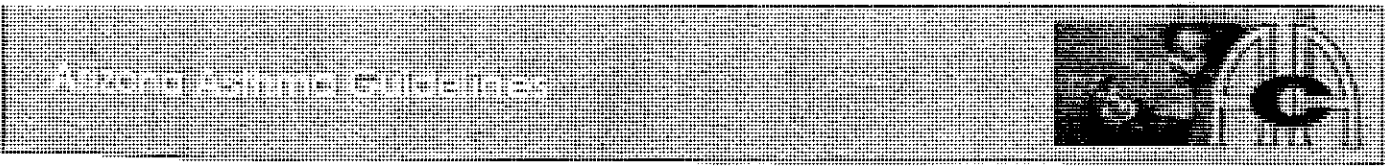
Name of Medication Dosage Frequency (when to use)

1. ____

2. ____

3. ____

GENERAL SYMPTOMS	SIGNS OF A MODERATE ASTHMA EVENT	SIGNS OF A SEVERE ASTHMA EVENT **(Call 911 for one or more signs below)**
Chest tightness Shortness of breath Wheezing Coughing Other ________ ____________ ____________	**Breathing:** coughing, shortness of breath, breathing through mouth **Verbal Complaints:** chest tightness, chest "hurts", hard to breath, headache, dry mouth **Facial Expression:** pale, sweating, red **Mood:** anything that is different from child's usual behavior	Can't speak, cry, or utter more than 2-3 words at a time Pale discoloration or blueness around mouth Movement, sucking in of, chest, neck, or rib muscles, body is hunched over Medication does not reduce or improve symptoms within 10-15 minutes



TREATMENT FOR SEVERE ASTHMA

1. CALL 911
2. Administer prescribed rescue inhaler/medications
3. Other (as prescribed by physician) ______________________________

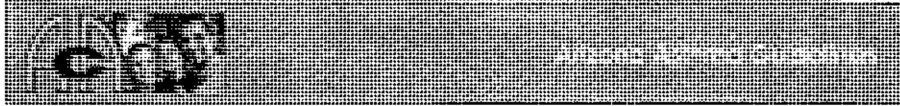
TREATMENT FOR MILD-MODERATE ASTHMA:

1. Have student relax; "whistle" breath or purse lips to encourage diaphragmatic breathing.
2. Give prescribed rescue medication (oral or inhaled) as per physician's instructions.
3. Have student sip room temperature water.
4. Have student use their "peak flow meter", if ordered by physician.
5. Reassure student.
6. Return student to class if/when symptoms resolve
7. If symptoms do not improve within 10-15 minutes of prescribed treatment, **CALL 911** and then parent(s).

Physician Signature ______________________________ Date __________

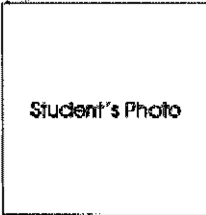
Parent/Guardian Signature ______________________________ Date __________

School Nurse Signature ______________________________ Date __________



Appendix A

Individualized Student Asthma Treatment Plan 1



STUDENT INFORMATION

Name ______________________________

DOB ______________________________

School ______________________________

Teacher ______________________________

Grade ______________________________

P.E. Days/Times ______________________________

Recess Days/Times ______________________________

IN CASE OF EMERGENCY CONTACT (in order)

NAME/RELATION	PHONE	CELL PHONE
1. ____________	____________	____________
2. ____________	____________	____________
3. ____________	____________	____________

EMERGENCY INFORMATION

Home Phone ______________________________

Parent/Guardian Cell Phone ______________________________

Mother: Work Phone ______________________________

Father: Work Phone ______________________________

Physician ____________________ Address: ____________

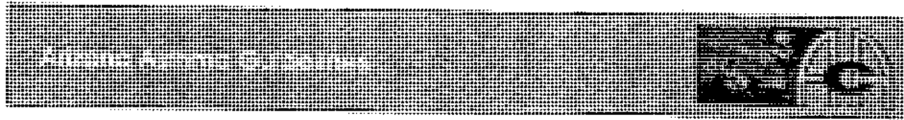
Physician Phone ______________________________

KNOWN TRIGGERS (circle)

Smoke | Dust | Mold | Animals (fur/feathered)
Cockroaches | Odor/fumes | Pollen | Cold Air
Exercise | Respiratory Infections | Other: ____________

Arizona Resource Guide 19

Appendix A



INSTRUCTIONS for ACUTE ASTHMA EPISODE: (to be completed by physician)

1) Check peak flow (health care provider must order) Yes ____ No ____ (if no, go to step 2)

2) Give medication as listed below. Student should improve within 15-20 minutes.

3) Seek emergency medical care **(911)** for any of the following:

- Continuous coughing
- Shortness of breath with walking, talking, or sitting
- Blue or gray discoloration of lips or fingernails
- No improvement 15-20 minutes after initial medication treatment
- Peak Flow of (specific to student)
- Other ______________________________

4) Notify parents/guardian and or emergency contacts (see list above)

MEDICATIONS

Name of Medication	Dosage	Frequency (when to use)
1.		
2.		
3.		

Physician Signature ______________________ Date ________

Parent/Guardian Signature ______________________ Date ________

School Nurse Signature ______________________ Date ________

INSTRUCTIONS for ACUTE ASTHMA EPISODE: (To be completed by physician)

Food Allergy Action Plan

Emergency Care Plan

Place Student's Picture Here

Name: ______________________ D.O.B.: __/__/__

Allergy to: ______________________

Weight: ______ lbs. **Asthma:** ☐ Yes (higher risk for a severe reaction) ☐ No

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.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:
LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body

Or **combination** of symptoms from different body areas:
SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Vomiting, diarrhea, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   - Antihistamine
   - Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): ______________________
Antihistamine (brand and dose): ______________________
Other (e.g., inhaler-bronchodilator if asthmatic): ______________________

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

______________________ ________ ______________________ ________
Parent/Guardian Signature Date Physician/Healthcare Provider Signature Date

TURN FORM OVER

Form provided courtesy of the Food Allergy & Anaphylaxis Network (www.foodallergy.org) 9/2011

Place Child's Picture Here

Appendix C
Emergency Action Plan

Student's Name:________________________ D.O.B:__________ Teacher:________________

ALLERGY TO:____

Asthmatic Yes* No *Higher risk for severe reaction

STEP 1: TREATMENT

Symptoms:		Give Checked Medication**: **(To be determined by physician authorizing treatment)	
• If a food allergen has been ingested, but *no symptoms*:		☐ Epinephrine	☐ Antihistamine
• Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
• Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
• Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
• Throat†	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
• Lung†	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
• Heart†	Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
• Other†	______________________	☐ Epinephrine	☐ Antihistamine
• If reaction is progressing (several of the above areas affected), give:______________________		☐ Epinephrine	☐ Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg (see reverse side for instructions)

Antihistamine: give____
medication/dose/route

Other: give____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

STEP 2: EMERGENCY CALLS

1. Call 911 (or Rescue Squad: ____________). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. ______________________________ Phone Number: ______________________

3. Parent______________________________ Phone Number(s) ______________________

4. Emergency contacts:

Name/Relationship	Phone Number(s)
a. ______________________________	1.)____________________ 2.)________
b. ______________________________	1.)____________________ 2.)________

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature____ Date________

Doctor's Signature (required)____ Date________

TRAINED STAFF MEMBERS

1. ____ Room ________

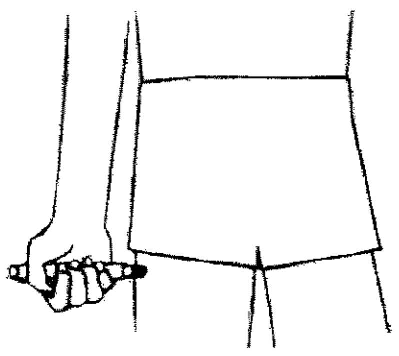
2. ____ Room ________

3. ____ Room ________

EpiPen® and EpiPen® Jr. Directions

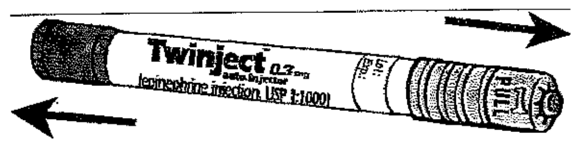
- Pull off gray activation cap.

- Hold black tip near outer thigh (always apply to thigh).



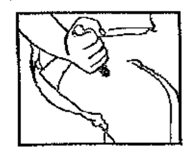
- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Twinject™ 0.3 mg and Twinject™ 0.15 mg Directions

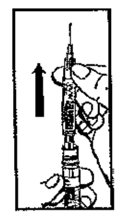


- Pull off green end cap, then red end cap.

- Put gray cap against outer thigh, press down firmly until needle penetrates. Hold for 10 seconds, then remove.

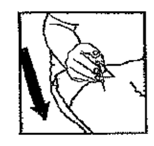


SECOND DOSE ADMINISTRATION: If symptoms don't improve after 10 minutes, administer second dose:



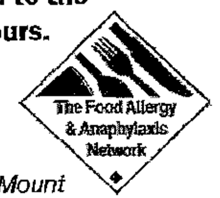
- Unscrew gray cap and pull syringe from barrel by holding blue collar at needle base.

- Slide yellow or orange collar off plunger.



- Put needle into thigh through skin, push plunger down all the way, and remove.

Once EpiPen® or Twinject™ is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.



For children with multiple food allergies, consider providing separate Action Plans for different foods.

***Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission*

Nov. 2006

National Diabetes Education Program

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 skill

☐ 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

EASTERN HIGHLANDS REGIONAL COOPERATIVE

[illegible] Navajo Blvd. • Holbrook, AZ [illegible] • [illegible] • [illegible] fax

REQUEST FOR ASSISTANCE - HI

PLEASE PRINT

Student's Legal Name (as appears on birth certificate): ______________________ Grade: ______

DOB: __________ Gender: M / F State of Birth: ______________ SAIS # ______________

Parents/Legal Guardians: ______________________ Home Language: ______________

Home address: ______________________ City/State: ____________ Zip: ________

Phone #: (hm) ______________ (wk) ______________ (cell) ______________

School District: ______________ School of attendance: ____________ School phone: ________

School Address: ______________________ City/State: ____________ Zip: ________

Teacher: ______________________ Teacher phone #: ______________________

Referral Source: ____

Name Title Phone email address

SERVICE REQUESTED:

- ☐ Audiological Evaluation (hard to test student or student must have failed two hearing screenings within current school year)
- ☐ Assistance with Determination of Services (Student w/current audiogram, but no current evaluations)
- ☐ Assistance with Record Review/Placement (Transfer Student with a current IEP and HI Eligibility)

Is this student currently receiving special services? Y / N If yes, under what eligibility category? __________

Does this student have any additional handicapping conditions? Y / N If yes, please explain: ______________________

____

____

Has this child failed at least two school screenings? Y / N If yes, please attach results.

Does this child have a current (within the past year) audiogram? Y / N If yes, please attach results.

Information provided by Parent/Guardian:

- Has your child had ear surgery? Y / N
  If yes, what type of surgery: ______________________ Date of surgery: ________
- I will inform EHRC Audiology Department of future ear surgeries

Parent/Guardian Permission for Hearing Evaluation:

- It is recommended that your child be seen for a current Audiological Evaluation. There will be no charge to you for this evaluation.
- You may be contacted to set up the hearing evaluation at an EHRC testing site.
- Based on the results and recommendations from the Audiologist, a Teacher of the Hearing Impaired MAY screen and/or observe your child in his or her classroom to determine impact of possible hearing difficulties on learning.

______________________ ______________

Parent/Guardian Signature Date

Revised: 12/2010

SNOWFLAKE UNIFIED SCHOOL DISTRICT #5
HEALTH SERVICES

MASS SCREENING AND VERIFIED CASES FOR PEDICULOSIS
SCHOOL ______________ YEAR ________

Date	Classroom Teacher	#Screened	Verified Positive Student Name	Class Note Sent Home	Returned Box Top	Treatment Date	Recheck	
							1	2