Frankfort

COMMUNITY CONSOLIDATED SCHOOL DISTRICT 157-C

DIABETIC ACTION PLAN

You have indicated during registration your child is diabetic. It is important to develop a diabetic management plan to provide an optimal learning environment for your child. This packet contains several forms which need to be completed by you and your child's physician. When the forms are completed, please return them to the nurse in your child's school. The information will be used to develop an Individual Health Care Plan, which will be shared with the school staff working with your child during the academic year.

Important points to remember:

- **Diabetes Medical Management Plan:** Please provide a signed copy from your doctor.
- **Medication Authorization Form:** This must be completed by the student's parent/guardian and the prescribing physician for all prescription and non-prescription medications administered at school. If you child's physician wants the insulin given at school, the form must include specific directions regarding covering blood glucose levels and carbohydrate intake.
- **School Procedure Authorization Form:** This form must be completed by your physician, and signed by the parent if glucose testing or ketone testing will be done while the student is in school. One form required for each procedure.
- **Medication:** All medication must be brought to school by the parent/guardian in the original or duplicate bottle with the correct prescription label on the container including student name, medication name, dosage, route, prescriber name, and pharmacy information.
- **Supplies:** All glucose testing supplies, food products to treat hypoglycemia, insulin and syringes, and ketone test strips must be supplied by parents as needed. Please include extra batteries for the glucometer and supplies for the insulin pump if one is being used.
- **Ketones:** If your physician orders ketone testing, the School Procedure Authorization Form will be followed.
- **School Actions:** All personnel involved with a diabetic student will receive information on diabetes and a written copy of the Individual Health Care Plan. If a diabetic reaction is suspected, the student will be escorted to the nurse's office and the treatment plan provided by the doctor will be implemented. Emergency diabetic supplies will be located in the nurse's office, child's classroom, gym, and will go on all field trips for students attending Grand Prairie and Chelsea Schools. Hickory Creek students should carry emergency supplies with them at all times in a pencil bag or purse. Emergency supplies will also be located in the nurse's office at Hickory Creek.
- **911:** 911 will be called if the following situations occur: vomiting, seizure, loss of consciousness, inability to increase the blood sugar to within the doctor's prescribed limits. Parents will be notified when EMS has been called.
- **Glucagon:** If your child's physician prescribes Glucagon to be administered in the event of a hypoglycemic reaction combined with unresponsiveness, please be aware if a nurse is not present in the building, **the medication *will not* be administered**. However, 911 will be called and you will be contacted.

I HAVE READ AND UNDERSTAND THE ABOVE AND AGREE WITH THE PROPOSED PLAN OF ACTION.

Parent Signature _____ Date _____

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SCHOOL PROCEDURE AUTHORIZATION FORM

Student Name: _____ Birth Date: _____

Address: _____

Home Phone: _____ Emergency Phone: _____

School: _____ Grade: _____

*** TO BE COMPLETED BY STUDENT'S PHYSICIAN ***

The above student is under my medical care for: _____

and is required to have the following procedure administered during school hours:

_____

_____

Equipment Needed: _____

Time/Frequency of Procedure: _____

Side Effects/Precautions: _____

Discontinuation Date: _____

To what degree can child participate in procedure? (Please circle)

Independent Needs Assistance Unable to Assist

He/she understands the need for the procedure and the necessity to report to school personnel any unusual side effects or problems.

_____ _____

Printed Name of Physician Physician's Signature

_____ _____

Address Phone Number

*** TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN ***

I, _____, give permission for my child to receive the above procedure as directed by the physician. I will provide all supplies needed to do the procedure. I will notify the school in writing if the treatment discontinued.

_____ _____

Parent's Signature Date

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School Medication Authorization Form – Page 1 of 2

**** WE REQUIRE ONE FORM FOR EACH MEDICATION KEPT AT SCHOOL ****

Student's Name: _____ Birth Date: _____

Address: _____

Home Phone: _____ Emergency Phone: _____

School: _____ Grade: _____ Teacher: _____

*** TO BE COMPLETED BY STUDENT'S PHYSICIAN (UNLESS IT IS FOR AN INHALER) ***

Physician's Printed Name: _____

Office Address: _____

Office Phone: _____ Emergency Phone: _____

Name of Medication: _____

Dosage: _____ Frequency: _____ Route: _____

Date of Order: _____ Time/Given in School: _____

Discontinuation Date: _____ Date of Prescription: _____

Diagnosis requiring medication: _____

Is it necessary for this medication to administered during the school day? Yes ☐ No ☐

Expected side effects, if any: _____

Other medication(s) student is receiving:

_____

_____

*Allergies: _____

He/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

_____ _____

Physician's Signature Date

Asthma Inhalers

Parent(s)/Guardian(s) please attach prescription label here:

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School Medication Authorization Form – Page 2 of 2

For only parents/guardians of students who need to carry asthma medication or an epinephrine auto-injector:
I authorize the School District and its employees and agents, to allow my child or ward to carry and self-administer his or her asthma inhaler and/or use his or her epinephrine auto-injector: (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property. Illinois law requires the School District to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration of medication or epinephrine auto-injector (105 ILCS 5/22-30). **If you choose to have your child carry their inhaler/epinephrine, we recommend that you provide an additional inhaler/epinephrine to be kept at school in the health office in the event that your child forgets or loses his/her medication.**

If you agree please initial: _____

For all parents/guardians:
I confirm that I am primarily responsible for administering medication to my child. However, in the vent that I am unable to do so or in the event of a medical emergency, I hereby authorize Frankfort School District 157-C and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child (or allow my child to self-administer, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. **I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICATIONS TO MY CHILD TO BE PERFORMED BY AN INDIVIDUAL OTHER THAN A SCHOOL NURSE, AND SPECIFICALLY CONSENT TO SUCH PRACTICES.** I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian Printed Name

Phone: _____ Emergency Phone: _____

Address (if different from Student's address): _____