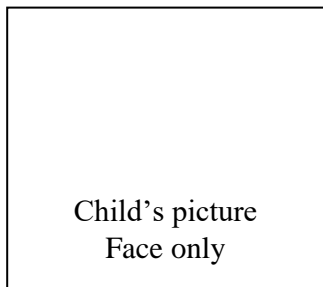


Student Name _____ Attachment D

**Madison District Public Schools
Diabetes Medical Action Plan (MAP)**



Student's Name _____
 Date of Birth _____ School _____
 Age _____ Grade _____ Teacher _____

Page one of this MAP is to be completed, signed and dated by a parent/guardian.
 Page two of this MAP is to be completed, signed and dated by a physician/licensed prescriber.
 Without signatures this MAP is not valid. The parent/guardian is responsible for supplying all
 needed medications and any other supplies/equipment necessary to the school.

CONTACT INFORMATION

	<u>Call First</u>		<u>Try Second</u>
Parent/	Name: _____	Name: _____	
Guardian:	Relationship: _____	Relationship: _____	
Phone:	Home: _____	Home: _____	
	Cell: _____	Cell: _____	
	Work: _____	Work: _____	

Call Third (If a parent /guardian cannot be reached)

Name: _____ Relationship: _____
 Address: _____ Phone: _____

HISTORY and MANAGEMENT

Age when diabetes was diagnosed _____ Type I Diabetes ☐ YES ☐ NO Type II Diabetes ☐ YES ☐ NO

Can student perform their own blood glucose (BG) testing ☐ YES ☐ NO Please monitor/help ☐ YES ☐ NO

Will student have a glucometer for school use only ☐ YES ☐ NO

Routinely test BG: ☐ Before Snack ☐ Before Lunch ☐ Before Exercise ☐ After Exercise ☐ Other _____

Target BG range _____ to _____

Insulin will be given at school ☐ YES ☐ NO **If YES, please circle: Syringe/vial Insulin pen Pump**

Can student give their own insulin or insulin bolus, if on pump ☐ YES ☐ NO Please monitor/help ☐ YES ☐ NO

Please send a copy home of all BS readings, carbohydrate counts, and insulin given at school ☐ YES ☐ NO

If YES, please circle how often: Weekly Monthly Other _____

Accommodations as needed are allowed. A more detailed medical plan may be needed to manage your child's diabetes at school.

Use the plan you and your medical provider feel is best for daily management and keep the school informed of any changes.

☐ YES ☐ NO I have read the attached information regarding section 504 eligibility

☐ YES ☐ NO I wish to be contacted regarding a 504 evaluation

Other considerations/instructions: _____

I agree to have the information in this two page emergency plan shared with staff needing to know. I understand that my child's name may appear on a list with other students to better identify medical concerns. I give permission to use my child's picture on this plan (if I did not supply a photo.) I give permission for trained staff to help administer and/or monitor all the medication or testing required for control of blood sugar and to contact the ordering prescriber for clarification if needed.

Date _____ Parent/Guardian _____
 _____ Signature

Location(s) of Glucagon in the school for emergency use _____

Bus # _____ Driver: _____ Transportation Office Use ONLY if needed
 Route # _____ Medical File _____

Signs of Hypoglycemia or Low Blood Sugar (BS)

- Hunger or dizzy
- Shakiness or weakness
- Sweating or pale
- Personality or behavior change
- Other _____
- Blood sugar under 65 or 80 with symptoms



Common Causes (can happen quickly)

- Too much insulin
- Missed or delayed food
- Intense Exercise

ACTION

- Stay with the student. **Never send alone anywhere.**
- Check blood sugar (BS) if possible. **If not, treat for a low BS.**
- Give 15 grams of fast acting carbohydrate (4oz juice, or chew 3-4 glucose tablets, or consume other sugar source.)
- Wait 15 minutes & re-check BS.
- Repeat treatment of 15 grams of carbohydrate if BS is under 65 or _____
- If more than one hour before the next meal or snack, give a snack of carbohydrate and protein now (i.e. cheese & crackers.)
- Notify parent/guardian. **Be sure student feels okay before returning to normal activity.**
- Other _____

Signs of EMERGENCY

- Loss of consciousness
- Seizure
- Inability to swallow



ACTION

- **Call 911; Do Not give anything by mouth**
- Trained person to give **Glucagon** (if ordered)
- **Position on side** (if possible); **Stay with child**
- **Notify parent/guardian**

Signs of Hyperglycemia or High Blood Sugar (BS)

- Thirst or Hunger
- Frequent urination
- Fatigue or Sleepiness
- Dry warm skin
- Blurred vision or Poor concentration
- Other _____
- Blood sugar over 300



Common Causes (happens slowly, hours to days)

- Too little insulin
- Too much food
- Decreased activity
- Illness or stress (hormones)

ACTION

Check urine for ketones:

- ✓ Ketones Moderate or Large (see **EMERGENCY** below)
- ✓ Ketones Negative, Trace or Small, **go to next bullet**
- Give water or sugar free drink (8 oz every hour)
- For **Small** ketones, recheck after one hour or at next urination
- **Notify parent/guardian**
- **No exercise if ketones are present**
- If unable to test for ketones **and** student has no symptoms (feels ok but BS is >300) Offer water & **call family**
- May Return to class or rest per student's desires
- Recheck BS in one hour if unable to reach family
- If unable to test for ketones **and** student is having symptoms (feels bad with BS>300) Encourage water, rest and continue to monitor until parents can be reached.

Signs of EMERGENCY

- Moderate to Large Ketones
- Nausea or Vomiting or Abdominal pain
- Sweet, fruity breath
- Labored breathing
- Confused or Unconscious



ACTION

- **Call 911** if student is unresponsive
- Call parent/guardian and encourage water
- **Call 911** if abdominal pain, nausea, vomiting or lethargic **AND** parent/guardian can't be reached
- No water if vomiting
- No exercise

Authorized Physician Order/Licensed Prescriber & Agreement with Protocol in this 2 page plan (see page 1)

Insulin _____ **Carb ratio** _____ **Correction factor** _____

Target Blood Sugar _____ **Changes in insulin calculation to be determined by parent/guardian** ☐ YES ☐ NO

Glucagon ☐ YES ☐ NO (please circle correct dose) **Dose** 1mg (entire vial) or **Dose** ½ mg (half of vial)

Give as injection (mix first) into leg or arm muscle for severe hypoglycemia **with** unconsciousness or inability to swallow. Refer to package directions if needed for further help.

Other instructions/orders _____

Physician/Licensed Prescriber _____ **Phone** _____ **FAX** _____

Signature _____ **Date** _____

NOTICE OF SECTION 504 PROCEDURAL SAFEGUARDS

FORM C

The following is a brief summary description of the rights provided by Section 504 of the Rehabilitation Act of 1973 to students with disabilities, or suspected disabilities, and some related rights provided by Title VI of the Civil Rights Act of 1964 and the Family Educational Rights and Privacy Act. The intent of the law is to keep you fully informed about decisions concerning your child and to inform you of your rights in the event you disagree with any decisions concerning your child. You have the right to:

1. have the District advise you of your rights under federal law;
2. receive notice with respect to Section 504 identification, evaluation, and/or placement of your child
3. have an evaluation and placement decision for your child based upon information from a variety of sources and which is made by a team of persons knowledgeable about the student, the meaning of evaluation data, and placement options;
4. have your child receive a free appropriate public education, which is the provision of regular or special education and related aids and services that are designed to meet individual educational needs of your child as adequately as the needs of students without disabilities are met, if the child is Section 504 eligible;
5. have your child be educated with non-disabled students to the maximum extent appropriate, if the child is Section 504 eligible;
6. have your child take part in and receive benefits from the District without discrimination on the basis of disability;
7. have your child educated in facilities and receive services comparable to those provided to non-disabled students;
8. examine all relevant records of your child, including those relating to decisions about your child's Section 504 identification, evaluation, educational program, and placement; and obtain copies of those records at a reasonable cost, unless the fee would effectively deny you access to the records;
9. receive information in your native language and primary mode of communication;
10. have a periodic re-evaluation of your child, including an evaluation before any significant change of placement;
11. have your child given an equal opportunity to participate in nonacademic and extracurricular activities offered by the District;
12. request and participate in an impartial due process hearing regarding the identification, evaluation, or placement of your child, including a right to be represented by counsel in that process and to appeal an adverse decision;
13. file a complaint in accordance with the District's grievance procedures or with the U.S. Department of Education, Office for Civil Rights.