DIABETES MEDICAL MANAGEMENT PLAN

I. CONTACT AND PLAN INFORMATION

Student's Name: ___________________________ **Date of Birth:** ______/____/______
(Month) (Day) (Year)

Health Condition: ☐ Diabetes type 1 ☐ Diabetes type 2 (For t*his Plan "Health Condition" means diabetes)*

Mother/Guardian: ____

Address: ____

Telephone: Home _________________ Work ________________ Cell________________

Father/Guardian: ____

Address: ____

Telephone: Home ________________ Work _________________ Cell ________________

Student's Doctor/Health Care Provider:____

Address: ____

Telephone: ________________________ Emergency Number: _________________________

Other Emergency Contacts:____

Relationship: ____

Telephone: Home ________________ Work ________________ Cell _________________

II. PARENT OR GUARDIAN AUTHORIZATION, APPROVAL AND LIABILITY WAIVER

The parents or guardians (hereinafter "Parent") request that Raymond Central Public Schools allow the Student to self-manage the health condition and accept and agree to this Medical Management Plan. The Guidelines for Diabetes Medical Management Plan are incorporated into and are a part of this Plan.

Parents understand and agree that if the Student injures school personnel or another student as the result of the misuse of necessary diabetes medical supplies, Parents shall be responsible for any and all costs associated with such injury. Parents acknowledge that (a) the school and its employees and agents are not liable for any injury or death arising from the Student's self-management of the Student's Health Condition and Parents release same from any such claims and (b) Parents shall and do hereby agree to indemnify and hold harmless the school and its employees and agents against any claim arising from the Student's self-management of Student's Health Condition. This release, indemnification and hold harmless agreement shall take effect immediately and shall stay in effect for as long as the Student is provided permission to self-administer medication.

Parent/guardian signature: ___________________________________ Date: ______________

Parent/guardian signature: ___________________________________ Date: ______________

III. STUDENT AGREEMENT

I will use the prescription diabetes medication only as prescribed and as permitted by the Plan. I will not share the medication with others and I will not create an unnecessary distraction to others. I have been instructed how to self-administer this medication and understand the side effects of improper use and will follow the Guidelines. I understand that if I do not abide by these terms, I may be disciplined and that this Plan will be re-evaluated. I release the school and its employees of any liability any in way related to this Plan or my use of the medication.

Student signature: ____ Date: ____________

IV. MEDICAL MANAGEMENT PLAN

A. Health care services the Student may receive at school relating to Student's Health Condition: See Guidelines (Part V).

B. Evaluation of Student's understanding of and ability to self-manage Student's Health Condition.

The parents/guardians and the Physician certify that the Student has a sufficient level of understanding and ability to self-manage the Student's Health Condition as follows:

1. Access to Prescription Diabetes Medication

□ May have medication in Student's possession at any time.

□ May have medication in Student's possession when the health office is not accessible (for example, when the Student is out of the school on field trips or participating in extracurricular activities) but should otherwise be maintained in the health office.

□ May not have medication in Student's possession except for emergency use.

2. Self-Administration of Prescription Diabetes Medication

□ May self-administer independently and without supervision. The Student has had had training and is proficient in self-administering medication.

□ May self-administer when the health office or school staff authorized to administer medication are not readily accessible (for example, when the Student is out of the school on field trips or participating in extracurricular activities); but should otherwise have medication administered by the health office or authorized school staff.

□ May not self-administer except for emergency use.

C. It is agreed that this Plan permits regular monitoring of Student's self-management of Student's Health Condition by an appropriately credentialed health care professional.

D. Name, purpose and dosage of prescription diabetes medication prescribed for Student: See Student Diabetes Action Plan (Part IV(F)).

E. Procedures for storage and access to backup supplies of such prescription medication for Student's Health Condition:

1. The Student, when permitted to be in possession of medication, will only have the prescription medication that might be needed for the Student's own use.
2. The school will store any backup supply needed in accordance with its medication storage procedures.
3. The student may have access to the backup supply when necessary by requesting such from the health office.

F. Student Diabetes Action Plan

Student Name: ____________________________________ **Date of Birth:** _______/____/______
(Month) (Day) (Year)

EXERCISE PRECAUTION - Should not exercise (eg, gym class, recess) if blood glucose level is below_________mg/dl or if moderate to large urine ketones are present

SUPPLIES TO BE CARRIED BY THE STUDENT
"USE" DESCRIBES PURPOSE, WHEN TO USE & AS RELEVANT, DOSAGE

Use: ____

□ Blood glucose meter, blood glucose test strips, batteries for meter

Use: ____

□ Lancet device, lancets, gloves, etc.

Use: ____

□Urine ketone strips

Use: ____

□Insulin pump and supplies

Use: ____

□Insulin pen, pen needles, insulin cartridges

Use: ____

□Fast-acting source of glucose

Use: ____

□Carbohydrate containing snack

Use: ____

□Continuous Glucose Monitor

Use: ____

□ May carry and self-administer above medications and supplies per Part IV(B) of Medical Management Plan.

Possible adverse reactions to be reported to physician ____
____

Special instructions ____
____
____
____

I am the Student's Physician. Student has diabetes and has been prescribed the medication referenced above. Student has the ability to safely and responsibly self-manage Student's Health Condition in accordance with this Diabetes Medical Management Plan. I approve the Medical Management Plan and the Student Diabetes Action Plan and authorize Student to self-manage Student's Health Condition at school in accordance with the Plan.

Physician signature: ____ Date: ___________

V. GUIDELINES FOR DIABETES MEDICAL MANAGEMENT PLAN
Term of Plan: The plan is effective for the current school year. A new plan must be established each school year or more often if changes occur to the student's health or prescribed treatment or student's ability to self-manage.
Medications: The parents or guardians are responsible for supplying any and all prescription diabetes medications required under the Plan; the school is not responsible for providing the medications. Prescribed diabetes medications to be used by the Student under this Plan must be furnished in a current original container from the pharmacy with the student's name and the name of the medication, and where applicable, the strength and the dosage to be given. If the prescribed medication, dosage or time of medication changes, the parents or guardians must promptly submit to the school nurse or designee the new prescription and as necessary a new diabetes action plan. Any non-prescription medication must be furnished in the original container from the manufacturer. The school will store any backup supply needed in accordance with its medication storage procedures. The student may have access to the backup supply when necessary by requesting such from the health office.
Disposal of Medical Supplies: The student shall be responsible for proper disposal of used syringes and other medical supplies. Used syringes and blood borne pathogen materials shall be immediately placed in a safe receptacle and properly disposed of in accordance with directions of the school health office and school administration.
Health care services the Student may receive at school relating to Student's Health Condition. 1. Standard health services available to all students. 2. Storage of backup diabetes medication supplies. 3. Individual Health Plan (IHP) for diabetes management may be developed on request.
Consultations: The school may consult with a registered nurse or other health care professional employed by such school during development of the plan.
Permitted Self-Management: Pursuant to the Diabetes Medical Management Plan the Student shall be permitted to self-manage the Student's diabetes condition in the classroom or any part of the school or on school grounds, during any school-related activity, or in any private location specified in the plan.
Student Reports of Self-Administration: The Student is not required to report self-administration when the Student has self-administered prescription diabetes medication pursuant to the Plan. The school health office will maintain a log of self-administration reports upon request of the parent or guardian.
Responses to Student Misuse: The possession of medications by Students is a violation of the school's drug and student conduct policies and may result in an expulsion from school. To the extent this Diabetes Medical Management Plan permits the Student to be in possession of prescribed diabetes medications, the Plan allows the Student an exception to the school drug and student conduct policies. However, this exception only extends to the extent provided in the Plan. In the event the Student uses his or her prescription diabetes medication other than as prescribed, or possesses medication other than as permitted by the Plan, the Student is subject to disciplinary action by the school, up to and including an expulsion. The school will promptly notify the parent or guardian of any disciplinary action imposed. The disciplinary action will not include a limitation or restriction on the student's access to such medication unless the school determines that the Student has endangered himself, herself, or others through the misuse or threatened misuse of such medical supplies. It is agreed that in the event of any such misuse a re-evaluation of the Student's understanding of and ability to self-manage Student's Health Condition will occur and the re-evaluation may result in a modification or termination of this Plan.
Sharing Plan: It is agreed that this Diabetes Medical Management Plan may be shared with school officials and agents who have a need to be aware of it; that those who have the need to be aware of it include student health staff and also include staff responsible for student discipline (e.g. staff need to know that the Student is authorized to have the medication on the Student's person so the Student is not reported for a violation of the school's drug policies). The school officials who may be informed of the Plan thus include: administration, school nurse, school office staff, teachers and any paraeducators or specialists who provide services to the Student, and the coaches and sponsors of extracurricular activities in which the Student participates.

Filing of Plan: This Diabetes Medical Management Plan is to be kept on file at the school where the Student is enrolled.

VI. SCHOOL NURSE ACKNOWLEDGEMENT OF DIABETES MEDICAL MANAGEMENT PLAN

□ Parent Request and Liability Waiver signed □ Student Agreement signed.
□ Management Plan (including Action Plan) signed by Physician.
□ Guidelines reviewed with the Student and Parent/Guardian.
□ Copy of Guidelines and Student Agreement received by Parent/Guardian for reference.

School Nurse or designee signature: _______________________________________ Date: ___________

Diabetes Self-Management Log (Optional)

Student Name____

Student Date of Birth _____________________

Date Started	**Medication**	**Dosage**	**Time**	**Frequency**	**Physician**	**Phone #**

Date/time of report	**Date/time administration**	**Observation/Complications**	**Employee Recording Student Report**	**Parent Notification**
				Date:___________ ☐Phone ☐Form
				Date:___________ ☐Phone ☐Form
				Date:___________ ☐Phone ☐Form
				Date:___________ ☐Phone ☐Form
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				Date:___________ ☐Phone ☐Form

Parents/Guardian_____________________________ Phone_______________

Teacher____________________________________ Grade________