Student Name_____ Attachment D

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

Rochester Community Schools
Diabetes Medical Action Plan (MAP)

Child's picture
Face only

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

	Call First	**Try Second**
Parent/ Guardian:	Name: _____	Name: _____
	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_____

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**_____

Rochester Community Schools
Section 504 Notice of Procedural Safeguards

The following is a summary description of the rights provided by Section 504 of the Rehabilitation Act of 1973 to students with disabilities, or suspected disabilities, as well as certain rights you have under other laws. These include the Individuals with Disabilities Education Act (IDEA) and the Family Education Rights and Privacy Act (FERPA). The intent of the law is to keep you informed about decisions concerning your child, to have you be an active participant in the educational planning for your child, and to inform you of your rights in the event you disagree with any decisions concerning your child's rights under Section 504.

You have the right to:

1. Have the Rochester Community Schools advise you of your rights under federal law;
2. Receive notice with respect to: a) Section 504 identification, evaluation, and/or eligibility determinations of your child; b) your procedural safeguards; c) your opportunity to examine relevant records with regard to your child; and d) your right to an impartial due process hearing, including the right to participate, and be represented by legal counsel, but at your own expense, as well as to request a review of the decision of an impartial hearing officer.
3. Have evaluation, educational programming, and placement decisions made based upon a variety of information sources, and by a team of persons who are knowledgeable about the student, the evaluation data, and placement options;
4. Examine education records related to your child, including those concerning the decisions regarding your child's Section 504 identification, evaluation, educational program, and placement;
5. Obtain copies of educational records at a reasonable cost, unless the fee would effectively deny you access to the records;
6. Receive a response from the Rochester Community Schools to reasonable requests for explanations and interpretations of your child's records;
7. Request an amendment of your child's educational records if there is reasonable cause to believe that they are inaccurate, misleading, or otherwise in violation of the privacy rights of your child. If the Rochester Community Schools refuses this request for amendment, the School District will notify you within a reasonable time and advise you of your right to an impartial hearing;
8. Have your child receive a free appropriate public education, including related services, if he/she is found to be a qualified student with a disability. The services will be without cost to you or your child, except for those fees that are imposed on non-disabled students or their parents or guardians.
9. Have your child take part in, and receive benefits from, the School District's education programs without discrimination because of his/her disabling condition(s);
10. Have your child be educated with non-disabled students to the maximum extent appropriate. This includes the right to have the Rochester Community Schools make reasonable accommodations to allow your child an equal opportunity to participate in school and school related activities;
11. Have your child educated in facilities and receive services comparable to those provided non-disabled students;
12. Have transportation provided to and from an alternative placement setting at no greater cost to you than would be incurred if the student were placed in a program operated by the Rochester Community Schools;
13. Have your child be given an equal opportunity to participate in nonacademic and extracurricular activities offered by the Rochester Community Schools;
14. Request an impartial due process hearing regarding the Section 504 identification, evaluation, eligibility, placement or provision of a Free Appropriate Public Education ("FAPE") for your child.
15. File a complaint in accordance with the Rochester Community Schools' Section 504 grievance procedure.