American Diabetes Association.
Connected for Life

Safe at School®

Diabetes Medical Management Plan

(Add student photo here.)

SCHOOL YEAR:

STUDENT LAST NAME: FIRST NAME: DOB:

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PARENTS/GUARDIANS: Please complete pages 1 and 2 of this form and approve the final plan on page 6.

1. DEMOGRAPHIC INFORMATION—PARENT/GUARDIAN TO COMPLETE

Student First Name: Last Name: DOB: Student's Cell #: Diabetes Type: Date Diagnosed: Month: Year:

School Name: School Phone #: School Fax #: Grade:

Home Room: School Point of Contact: Contact Phone #:

STUDENT'S SCHEDULE Arrival Time: Dismissal Time:

Travels to school by (check all that apply):
- ☐ Foot/Bicycle
- ☐ Car
- ☐ Bus
- ☐ Attends Before School Program

Meals Times:
- ☐ Breakfast
- ☐ AM Snack
- ☐ Lunch
- ☐ PM Snack
- ☐ Pre Dismissal Snack

Physical Activity:
- ☐ Gym
- ☐ Recess
- ☐ Sports
- ☐ Additional information:

Travels to:
- ☐ Home ☐ After School Program
- Via: ☐ Foot/Bicycle
- ☐ Car
- ☐ Student Driver
- ☐ Bus

Parent/Guardian #1 (contact first): Relationship:

Cell #: Home #: Work #:

E-mail Address:

Indicate preferred contact method:

Parent/Guardian #2: Relationship:

Cell #: Home #: Work #:

E-mail Address:

Indicate preferred contact method:

2. NECESSARY SUPPLIES / DISASTER PLANNING / EXTENDED FIELD TRIPS

1. A 3-day minimum of the following Diabetes Management Supplies should be provided by the parent/guardian and accessible for the care of the student at all times.

- Insulin
- Syringe/Pen Needles
- Ketone Strips
- Treatment for lows and snacks
- Glucagon
- Antiseptic Wipes
- Blood Glucose (BG) Meter with (test strips, lancets, extra battery) – required for all Continuous Glucose Monitor (CGM) users
- Pump Supplies (Infusion Set, Cartridge, extra Battery/Charging Cord) if applicable
- Additional supplies:

2. View Disaster/Emergency Planning details – refer to Safe at School Guide

3. Please review expiration dates and quantities monthly and replace items prior to expiration dates

4. In the event of a disaster or extended field trip, a school nurse or other designated personnel will take student's diabetes supplies and medications to student's location.

Name of Health Care Provider/Clinic: Contact #: Fax #:

Email Address (non-essential communication): Other:

STUDENT LAST NAME: FIRST NAME: DOB:

3. SELF-MANAGEMENT SKILLS (DEFINITIONS BELOW)

		Full Support	Supervision	Self-Care
Glucose Monitoring:	Meter	☐	☐	☐
	CGM ☐(Requires Calibration)	☐	☐	☐
Carbohydrate Counting		☐	☐	☐
Insulin Administration:	Syringe	☐	☐	☐
	Pen	☐	☐	☐
	Pump	☐	☐	☐
Can Calculate Insulin Doses		☐	☐	☐
Glucose Management:	Low Glucose	☐	☐	☐
	High Glucose	☐	☐	☐

Self-Carry Diabetes Supplies: ☐ Yes ☐ No Please specify items:
Smart Phone: ☐ Yes ☐ No

Device Independence: ☐ CGM ☐ Interpretation & Alarm Management ☐ Sensor Insertion ☐ Calibration ☐ Insulin Pumps ☐ Bolus
☐ Connects/Disconnects ☐ Temp Basal Adjustment ☐ Interpretation & Alarm Management ☐ Site Insertion ☐ Cartridge Change

Full Support: All care performed by school nurse and trained staff (as permitted by state law).
Supervision: Trained staff to assist & supervise. Guide & encourage independence.
Self-Care: Manages diabetes independently. Support is provided upon request and as needed.

4. STUDENT RECOGNITION OF HIGH OR LOW GLUCOSE SYMPTOMS (CHECK ALL THAT APPLY)

Symptoms of High:
☐ Thirsty ☐ Frequent Urination ☐ Fatigued/Tired/Drowsy ☐ Headache ☐ Blurred Vision ☐ Warm/Dry/Flushed Skin
☐ Abdominal Discomfort ☐ Nausea/Vomiting ☐ Fruity Breath ☐ Unaware ☐ Other:

Symptoms of Low:
☐ None ☐ Hungry ☐ Shaky ☐ Pale ☐ Sweaty ☐ Tired/Sleepy ☐ Tearful/Crying ☐ Dizzy Irritable
☐ Unable to Concentrate ☐ Confusion ☐ Personality Changes ☐ Other:

Has student lost consciousness, experienced a seizure or required Glucagon: ☐ Yes ☐ No If yes, date of last event:
Has student been admitted for DKA after diagnosis: ☐ Yes ☐ No If yes, date of last event:

5. GLUCOSE MONITORING AT SCHOOL

Monitor Glucose:
☐ Before Meals ☐ With Physical Complaints/Illness (include ketone testing) ☐ High or Low Glucose Symptoms
☐ Before Exams ☐ Before Physical Activity ☐ After Physical Activity ☐ Before Leaving School ☐ Other:

CONTINUOUS GLUCOSE MONITORING (CGM)

(Specify Brand & Model:

Specify Viewing Equipment: ☐ Device Reader ☐ Smart Phone
☐ Insulin Pump ☐ Smart Watch ☐ iPod/iPad/Tablet

☐ CGM is remotely monitored by parent/guardian.
Document individualized communication plan in Section 504 or other plan to minimize interruptions for the student.
☐ May use CGM for monitoring/treatment/insulin dosing unless symptoms do not match reading.

CGM Alarms:

Low alarm mg/dL

High alarm mg/dL if applicable

☐ **Section 1-5 completed by Parent/Guardian**

Please:
- Permit student access to viewing device at all times
- Permit access to School Wi-Fi for sensor data collection and data sharing
- Do not discard transmitter if sensor falls

Perform finger stick if:
- Glucose reading is below mg/dL or above mg/dL
- If CGM is still reading below mg/dL (DEFAULT 70 mg/dL) 15 minutes following low treatment
- CGM sensor is dislodged or sensor reading is unavailable. (see CGM addenda for more information)
- Sensor readings are inconsistent or in the presence of alerts/alarms
- Dexcom does not have both a number and arrow present
- Libre displays Check Blood Glucose Symbol
- Using Medtronic system with Guardian sensor

Notify parent/guardian if glucose is:

below mg/dL (<55 mg/dL DEFAULT)

above mg/dL (>300 mg/d DEFAULT)

Name of Health Care Provider/Clinic: Contact #: Fax #:
Email Address (non-essential communication): Other:

STUDENT LAST NAME: FIRST NAME: DOB:

6. INSULIN DOSES AT SCHOOL - HEALTHCARE PROVIDER TO COMPLETE

Insulin Administered Via:

☐ Syringe ☐ Insulin Pen (☐ Whole Units ☐ Half Units) ☐ Insulin Pump (Specify Brand & Model:)
☐ i-Port ☐ Smart Pen
☐ Other

☐ Insulin Pump is using Automated Insulin Delivery (automatic dosing) using an FDA-approved device
☐ Insulin Pump is using DIY Looping Technology (child/parent manages device independently, nurse will assist with all other diabetes management)

☐ **DOSING** to be determined by Bolus Calculator in insulin pump or smart pen/meter unless moderate or large ketones are present or in the event of device failure (provide insulin via injection using dosing table in section 6A).

Insulin Administration Guidelines

Insulin Delivery Timing: Pre-meal insulin delivery is important in maintaining good glucose control. Late or partial doses are used with students that demonstrate unpredictable eating patterns or refuse food. Provide substitution carbohydrates when student does not complete their meal.

☐ **Prior to Meal** (DEFAULT)
☐ **After Meal** as soon as possible and within 30 minutes
☐ **Snacking** avoid snacking hours (DEFAULT 2 hours) before and after meals

Partial Dose Prior to Meal: (preferred for unpredictable eating patterns using **insulin pump therapy**)

☐ Calculate meal dose using grams of carbohydrate prior to the meal
☐ Follow meal with remainder of grams of carbohydrates (may not be necessary with advanced hybrid pump therapy)
☐ May advance to Prior to Meal when student demonstrates consistent eating patterns.

For Injections, Calculate Insulin Dose To The Nearest:

☐ Half Unit (round down for < 0.25 or < 0.75 and round up for ≥ 0.25 or ≥ 0.75)
☐ Whole Unit (round down for < 0.5 and round up for ≥ 0.5)

Supplemental Insulin Orders:

☐ Check for **KETONES** before administering insulin dose if BG > mg/dL (DEFAULT >300 mg/dL or >250 mg/dL on insulin pump) or if student complains of physical symptoms. Refer to section 9. for high blood glucose management information.

☐ Parents/guardians are authorized to adjust insulin dose +/- units

- ☐ Insulin dose +/- units
- ☐ Insulin dose +/- %
- ☐ Insulin to Carb Ratio +/- grams/units
- ☐ Insulin Factor +/- mg/dL/unit

Additional guidance on parent adjustments:

Name of Health Care Provider/Clinic: Contact #: Fax #:
Email Address (non-essential communication): Other:

American Diabetes Association. Connected for Life | Safe at School®

Diabetes Medical Management Plan

STUDENT LAST NAME: _____ FIRST NAME: _____ DOB: _____

6A. DOSING TABLE—HEALTHCARE PROVIDER TO COMPLETE – SINGLE PAGE UPDATE ORDER FORM

Insulin: (administered for food and/or correction)

Rapid Acting Insulin: ☐ Humalog/Admelog (Lispro), Novolog (Aspart), Apidra (Glulisine) ☐ Other: _____

Ultra Rapid Acting Insulin: ☐ Fiasp (Aspart) ☐ Lyumjev (Lispro-aabc) ☐ Other: _____

Other insulin: ☐ Humulin R ☐ Novolin R

Meal & Times	Food Dose		Glucose Correction Dose ☐ Use Formula ☐ See Sliding Scale 6B	☐ PE/Activity Day Dose
Select if dosing is required for meal	☐ **Carbohydrate Ratio:** Total Grams of Carbohydrate divided by Carbohydrate Ratio = Carbohydrate Dose	☐ **Fixed Meal Dose**	**Formula:** (Pre-Meal Glucose Reading minus **Target Glucose**) divided by **Correction Factor** = Correction Dose ☐ May give Correction dose every ____ hours as needed (DEFAULT 3 hours)	**Adjust:** ☐ **Carbohydrate Dose** ☐ **Total Dose** Indicate dose instructions below:
☐ **Breakfast**	Breakfast Carb Ratio = ____ g/unit	**Breakfast** ____ units	☐ **Target Glucose** is: ____ mg/dL & **Correction Factor** is: ____ mg/dL/unit ☐ **No Correction dose**	Carb Ratio ____ g/unit Subtract ____ % Subtract ____ units
☐ **AM Snack**	AM Snack Carb Ratio = ____ g/unit ☐ No Carb Dose ☐ No Insulin if < ____ grams	**AM Snack** ____ units	☐ **Target Glucose** is: ____ mg/dL & **Correction Factor** is: ____ mg/dL/unit ☐ **No Correction dose**	Carb Ratio ____ g/unit Subtract ____ % Subtract ____ units
☐ **Lunch**	Lunch Carb Ratio = ____ g/unit	**Lunch** ____ units	☐ **Target Glucose** is: ____ mg/dL & **Correction Factor** is: ____ mg/dL/unit ☐ **No Correction dose**	Carb Ratio ____ g/unit Subtract ____ % Subtract ____ units
☐ **PM Snack**	PM Snack Carb Ratio = ____ g/unit ☐ No Carb Dose ☐ No Insulin if < ____ grams	**PM Snack** ____ units	☐ **Target Glucose** is: ____ mg/dL & **Correction Factor** is: ____ mg/dL/unit ☐ **No Correction dose**	Carb Ratio ____ g/unit Subtract ____ % Subtract ____ units
☐ **Dinner**	Dinner Carb Ratio = ____ g/unit	**Dinner** ____ units	☐ **Target Glucose** is: ____ mg/dL & **Correction Factor** is: ____ mg/dL/unit ☐ **No Correction dose**	Carb Ratio ____ g/unit Subtract ____ % Subtract ____ units

6B. CORRECTION SLIDING SCALE

☐ Meals Only ☐ Meals and Snacks ☐ Every ____ hours as needed

____ to ____ mg/dL = ____ units	____ to ____ mg/dL = ____ units	____ to ____ mg/dL = ____ units
____ to ____ mg/dL = ____ units	____ to ____ mg/dL = ____ units	____ to ____ mg/dL = ____ units
____ to ____ mg/dL = ____ units	____ to ____ mg/dL = ____ units	____ to ____ mg/dL = ____ units

6C. LONG ACTING INSULIN

Time		units		
____	☐ Lantus, Basaglar, Toujeo (Glargine) ☐ Levemir (Detemir) ☐ Tresiba (Degludec) ☐ Other _____	____	☐ Daily Dose ☐ Overnight Field Trip Dose ☐ Disaster/Emergency Dose	Subcutaneously

6D. OTHER MEDICATIONS

Time		units		
____	☐ Metformin ☐ Other _____	____	☐ Daily Dose ☐ Overnight Field Trip Dose ☐ Disaster/Emergency Dose	Route ____

Signature is required here if sending ONLY this one-page dosing update.

Diabetes Provider Signature: _____ **Date:** _____

Name of Health Care Provider/Clinic: _____ Contact #: _____ Fax #: _____

Email Address (non-essential communication): _____ Other: _____

STUDENT LAST NAME: FIRST NAME: DOB:

7. LOW GLUCOSE PREVENTION (HYPOGLYCEMIA)

Allow Early Interventions

☐ Allow Mini-Dosing of carbohydrate (i.e.,1-2 glucose tablets) when low glucose is predicted, sensor readings are dropping (down arrow) at mg/dL (DEFAULT 80 mg/dL or 120 mg/dL prior to exercise) or with symptoms.

☐ Allow student to carry and consume snacks ☐ School staff to administer

☐ Allow Trained Staff/Parent/Guardian to adjust mini dosing and snacking amounts (DEFAULT)

Insulin Management (Insulin Pumps)

Temporary Basal Rate Initiate pre-programmed rate as indicated below to avoid or treat hypoglycemia.

☐ Pre-programmed Temporary Basal Rate Named (Omnipod)

☐ Temp Target (Medtronic) ☐ Exercise Activity Setting (Tandem) ☐ Activity Feature (Omnipod 5)

Start: minutes prior to exercise for minutes duration (DEFAULT 1 hour prior, during, and 2 hours following exercise).

Initiated by: ☐ Student ☐ Trained School Staff ☐ School Nurse

☐ May disconnect and suspend insulin pump up to minutes (DEFAULT 60 minutes) to avoid hypoglycemia, personal injury with certain physical activities or damage to the device (keep in a cool and clean location away from direct sunlight).

Exercise (Exercise is a very important part of diabetes management and should always be encouraged and facilitated).

Exercise Glucose Monitoring

☐ prior to exercise ☐ every 30 minutes during extended exercise ☐ following exercise ☐ with symptoms

Delay exercise if glucose is < mg/dL (120 mg/dL DEFAULT)

Pre-Exercise Routine

☐ **Fixed Snack:** Provide grams of carbohydrate prior to physical activity if glucose < mg/dL

☐ **Added Carbs:** If glucose is < mg/dL (120 DEFAULT) give grams of carbohydrates (15 DEFAULT)

☐ **TEMPORARY BASAL RATE as indicated above**

Encourage and provide access to water for hydration, carbohydrates to treat/prevent hypoglycemia, and bathroom privileges during physical activity

8. LOW GLUCOSE MANAGEMENT (HYPOGLYCEMIA)

Low Glucose below mg/dL (below 70 mg/dL DEFAULT) or below mg/dL before/during exercise (DEFAULT is < 120 mg/dl).

1. If student is awake and able to swallow give grams of fast acting carbohydrate (DEFAULT 15 grams). Examples include 4 ounces of juice or regular soda, 4 glucose tabs, 1 small tube glucose gel.
   ☐ School nurse/parent may change amount given
2. Check blood glucose every 15 minutes and re-treat until glucose > mg/dL (DEFAULT is 80 mg/dL or 120 mg/dL before exercise).

SEVERE LOW GLUCOSE (unconscious, seizure, or unable to swallow)
Administer Glucagon, position student on their side and monitor for vomiting, call 911 and notify parent/guardian. If BG meter is available, confirm hypoglycemia via BG fingerstick. Do not delay treatment if meter is not immediately available. If wearing an insulin pump, place pump in suspend/stop mode or disconnect tubing from infusion site. Keep pump with student.

☐ Gvoke PFS (prefilled syringe) by SC Injection ☐ 0.5 mg ☐ 1.0 mg

☐ Gvoke HypoPen (auto-injector) by SC Injection ☐ 0.5 mg ☐ 1.0 mg

☐ Gvoke Kit (ready to use vial and syringe, 1mg/0.2 ml) by SC injection

☐ Zegalogue (dasiglucagon) 0.6 mg SC by Auto-Injector ☐ Zegalogue (dasiglucagon) 0.6 mg SC by Pre-Filled Syringe

☐ Baqsimi Nasal Glucagon 3 mg

STUDENT LAST NAME: FIRST NAME: DOB:

9. HIGH GLUCOSE MANAGEMENT (HYPERGLYCEMIA)

Management of High Glucose over mg/dL (Default is 300 mg/dL OR 250 mg/dl if on an insulin pump).

1. Provide and encourage consumption of water or sugar-free fluids. Give 4-8 ounces of water every 30 minutes. May consume fluids in classroom. Allow frequent bathroom privileges.
2. Check for Ketones (before giving insulin correction)

   a. If Trace or Small Urine Ketones (0.1 – 0.5 mmol/L if measured in blood)

   - Consider insulin correction dose. Refer to the "Correction Dose" Section 6.A-B. for designated times correction insulin may be given.
   - *Can return to class and PE unless symptomatic*
   - Recheck glucose and ketones in 2 hours

   b. If Moderate or Large Urine Ketones (0.6 – 1.4 mmol/L or >1.5 mmol/L blood ketones). This may be serious and requires action.

   - Contact parents/guardian or, if unavailable, healthcare provider
   - **Administer correction dose via injection.** If using Automated Insulin Delivery contact parent/provider about turning off automatic pump features. Refer to the "Blood Glucose Correction Dose" Section 6.A-B
   - If using insulin pump change infusion site/cartridge or use injections until dismissal.
   - No physical activity until ketones have cleared
   - Report nausea, vomiting, and abdominal pain to parent/guardian to take student home.
   - Call 911 if changes in mental status and labored breathing are present and notify parents/guardians.

☐ Send student's diabetes log to Health Care Provider (include details): If pre-meal blood glucose is below 70 mg/dL or above 240 mg/dL more than 3 times per week or you have any other concerns.

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 this 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 collaborate with my child's physician/health care provider.

Acknowledged and received by:

Student's Parent/Guardian: Date:

Acknowledged and received by:

School Nurse or Designee: Date:

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON
QUICK REFERENCE EMERGENCY PLAN and INDEMNIFICATION AGREEMENT
FOR USE WITH DIABETES MEDICAL MANAGEMENT PLAN

Part A
HYPOGLYCEMIA (Low Blood Sugar)

See reverse for Part B and signatures

Student Name _____ **School** _____ **Teacher/grade** _____

Mother/Guardian _____ **Father/Guardian** _____

Home phone _____ **Work phone** _____ **Cell** _____ **Home phone** _____ **Work phone** _____ **Cell** _____

Trained Diabetes Personnel _____ **Contact Number(s)** _____

NEVER SEND A CHILD WITH SUSPECTED LOW BLOOD SUGAR ANYWHERE ALONE.

Causes of Hypoglycemia
- Too much insulin
- Missed food
- Delayed food
- Too much or too intense exercise
- Unscheduled exercise

Onset
- Sudden

Symptoms

Mild
- Hunger
- Shakiness
- Weakness
- Paleness
- Sweating
- Drowsiness
- Personality change
- Inability to concentrate
- Anxiety
- Irritability
- Dizziness
- Other: _____

Circle student's usual symptoms.

Moderate
- Headache
- Behavior change
- Blurry vision
- Weakness
- Slurred Speech
- Poor coordination
- Confusion
- Other _____

Circle student's usual symptoms.

Severe
- Loss of consciousness
- Seizure
- Inability to swallow

Circle student's usual symptoms.

Actions needed

Notify School Nurse or Trained Diabetes Personnel. If possible check blood sugar, per Diabetes Medical Management Plan. When in doubt, always TREAT FOR HYPOGLYCEMIA

Mild
- Student may/may not treat self.
- Provide quick-sugar source.
  - 3-4 glucose tablets
  - or
  - 4 oz. juice
  - or
  - 6 oz. regular soda
  - or
  - 3 teaspoons of glucose gel
- Wait 10 to 15 minutes.
- Recheck blood glucose.
- Repeat food if symptoms persist or blood glucose is less than _____.
- Follow with a snack of carbohydrate and protein (e.g., cheese and crackers).

Moderate
- Someone assists.
- Give student quick-sugar source per MILD guidelines.
- Wait 10 to 15 minutes.
- Recheck blood glucose.
- Repeat food if symptoms persist or blood glucose is less than _____.
- Follow with a snack of carbohydrate and protein (e.g., cheese and crackers).

Severe
- Don't attempt to give anything by mouth.
- Position on side, if possible.
- Contact school nurse or trained diabetes personnel.
- Administer glucagon via IM or Inhaled, as prescribed.
- **Call 911.**
- Contact parents/guardian.
- Stay with student.

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON Appendix F-5

QUICK REFERENCE EMERGENCY PLAN and INDEMNIFICATION AGREEMENT

FOR USE WITH DIABETES MEDICAL MANAGEMENT PLAN

Part B

HYPERGLYCEMIA (High Blood Sugar)

_____ _____ _____

Student Name **School** **Teacher/grade**

Causes of Hyperglycemia
- Too much food
- Illness
- Too little insulin
- Infection
- Decreased activity
- Stress

Onset
- Over time—several hours or days

Symptoms

Mild
- Thirst
- Frequent urination
- Fatigue/sleepiness
- Increased hunger
- Blurred vision
- Weight loss
- Stomach pains
- Flushing of skin
- Lack of concentration
- Sweet, fruity breath
- Other: _____

Circle student's usual symptoms.

Moderate
- Mild symptoms plus:
- Dry mouth
- Nausea
- Stomach cramps
- Vomiting
- Other:_____

Circle student's usual symptoms.

Severe
- Mild and moderate symptoms plus:
- Labored breathing
- Very weak
- Confused
- Unconscious

Circle student's usual symptoms.

Actions Needed
- Allow free use of the bathroom.
- Encourage student to drink water or sugar-free drinks.
- Contact the school nurse or trained diabetes personnel to check urine or administer insulin, per student's Diabetes Medical Management Plan
- If student is nauseous, vomiting, or lethargic, ____ call the

This quick reference emergency plan reflects orders stated in the Diabetes Medical Management Plan (DMMP), I hereby request designated school personnel to administer medication as directed by this authorization and the attached DMMP. I agree to release, indemnify, and hold harmless the designated school personnel, or agents from lawsuits, claim expense, demand or action, etc., against them for helping this student use medication, provided the designated school personnel comply with the Licensed Healthcare Provider (LHCP) or parent or guardian orders set forth in accordance with the provision of the DMMP. I have read the procedures outlined on the back of this form and assume responsibility as required.

_____ _____ _____

Parent/Guardian Signature Telephone Date

Appendix F-5

IT INFORMATION ABOUT MEDICATION PROCEDURES

1. **In no case may any health, school, or staff member administer any medication outside the framework of the procedures outlined here in the *Office of Catholic Schools Policies and Guidelines* and *Virginia School Health Guidelines* manual**.
2. **Schools do NOT provide routine medications for student use**.
3. Medications should be taken at home whenever possible. The first dose of any new medication must be given at home to ensure the student does not have a negative reaction.
4. Medication forms are required for each Prescription and Over the Counter (OTC) medication administered in school.
5. **All** medication taken in school must have a parent/guardian signed authorization. Prescription medications, herbals and OTC medications taken for 4 or more consecutive days **also** require a licensed healthcare provider's (LHCP) written order. **No medication will be accepted by school personnel without the accompanying complete and appropriate medication authorization form**.
6. **The parent or guardian must transport medications to and from school.**
7. Medication must be kept in the school health office, or other principal approved location, during the school day. All medication will be stored in a locked cabinet or refrigerator, within a locked area, accessible only to authorized personnel, unless the student has prior written approval to self-carry a medication (inhaler, Epi-pen). If the student self carries, it is advised that a backup medication be kept in the clinic.
8. Parents/guardians are responsible for submitting a new medication authorization form to the school at the start of the school year and each time there is a change in the dosage or the time of medication administration.
9. A Licensed Health Care Provider (LHCP) may use office stationery, prescription pad or other appropriate documentation in lieu of completing the DMMP. The following information written in lay language with no abbreviations must be included and attached to this medication administration form. Signed faxes are acceptable.
    a. Student name
    b. Date of Birth
    c. Diagnosis
    d. Signs or symptoms
    e. Name of medication to be given in school
    f. Exact dosage to be taken in school
    g. Route of medication
    h. Time and frequency to give medications, as well as exact time interval for additional dosages.
    i. Sequence in which two or more medications are to be administered
    j. Common side effects
    k. Duration of medication order or effective start and end dates
    l. LHCP's name, signature and telephone number
    m. Date of order

10. All prescription medications, including physician's samples, must be in their original containers and labeled by a LHCP or pharmacist. Medication must not exceed its expiration date.
11. All Over the Counter (OTC) medication must be in the original, small, sealed container with the name of the medication and expiration date clearly visible. Parents/guardians must label the original container of the OTC with:
    a. Name of student
    b. Exact dosage to be taken in school
    c. Frequency or time interval dosage is to be administered
12. The student is to come to the clinic or a predetermined location at the prescribed time to receive medication. Parents must develop a plan with the student to ensure compliance. Medication will be given no more than one half hour before or after the prescribed time.
13. **Students are NOT permitted to self medicate**. **The school does not assume responsibility for medication taken independently by the student.** Exceptions may be made on a case-by-case basis for students who demonstrate the capability to self-administer emergency life saving medications (e.g. inhaler, Epi-pen)
14. Within one week after expiration of the effective date on the order, or on the last day of school, the parent or guardian must personally collect any unused portion of the medication. Medications not claimed within that period will be destroyed.