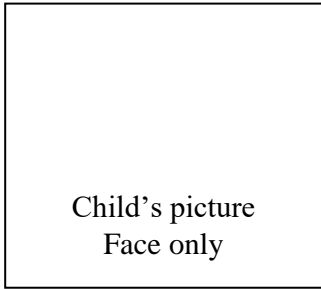


Student Name \_\_\_\_\_ Attachment D

**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**

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

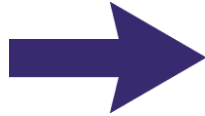
Date \_\_\_\_\_ Parent/Guardian \_\_\_\_\_  
Signature \_\_\_\_\_

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



**ACTION**

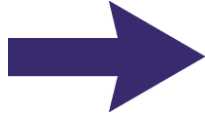
- Stay with the student. **Never send alone anywhere.**
- Check blood sugar (BS) if possible. **If not, treat for a low BS.**
- Give 15 grams of fast acting carbohydrate (4oz juice, or chew 3-4 glucose tablets, or consume other sugar source.)
- Wait 15 minutes & re-check BS.
- Repeat treatment of 15 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 \_\_\_\_\_

**\*Common Causes\*** (can happen quickly)

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

**Signs of EMERGENCY**

- Loss of consciousness
- Seizure
- Inability to swallow

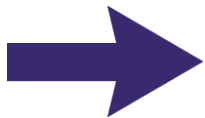


**ACTION**

- **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



**ACTION**

**Check urine for ketones:**

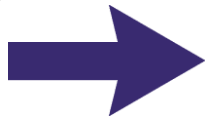
- ✓ Ketones Moderate or Large (see **EMERGENCY** below)
- ✓ Ketones Negative, Trace or Small, **go to next bullet**
- Give water or sugar free drink (8 oz every hour)
- For **Small** ketones, recheck after one hour or at next urination **Notify parent/guardian**
- **No exercise if ketones are present**
- 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.

**\*Common Causes\*** (happens slowly, hours to days)

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

**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.