IVYWOOD CLASSICAL ACADEMY

DIABETES MEDICAL ACTION PLAN (MAP)

School Year _____

Student's Name_____

Date of Birth_____ **Age** _____

Please Student Photo Here

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

Contact Information

Call First	**Try Second**
Name:_____	Name: _____
Relationship:_____	Relationship: _____
Home Phone:_____	Home Phone: _____
Cell:_____	Cell: _____
Work:_____	Work: _____

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

Name: _____

Relationship:_____Phone: _____

Diabetes History

Diabetes Type: ☐ Type 1 ☐ Type 2

Date of Diabetes Diagnosis:_____

Target range of blood glucose: ☐ 70-130 mg/dL ☐ 70-180 mg/dL ☐ Other:_____

Check blood glucose level (check all that apply):

☐ before lunch

☐ _____ hours after lunch

☐ 2 hours after a correction dose

☐ mid-morning

☐ before Physical Education, PE

☐ after Physical Education, PE

☐ before dismissal

☐ as needed for signs/symptoms of low or high blood glucose

☐ as need for signs/symptoms of illness

☐ other:_____

Preferred site of testing: ☐ fingertip ☐ forearm ☐ thigh ☐ other:_____

**the fingertip should always be used to check blood glucose level if hypoglycemia is suspected.

Brand/Model of blood glucose meter:_____

Student's self-care blood glucose checking skills:

☐ Independently checks own blood glucose

☐ May check blood glucose with supervision

☐ Requires trained diabetes personnel to check blood glucose

Continuous Glucose Monitor (CGM): ☐ Yes ☐ No

Brand/Model:_____ Alarms set for: ☐ Low ☐ High

**Confirm CGM results with blood glucose meter check before taking action on sensor blood glucose level. If student has symptoms of hypoglycemia, check fingertip blood glucose level regardless of CGM.

Hypoglycemia Treatment:

Student's usual symptoms of hypoglycemia (list below):

_____

_____

Other instructions_____

Any special considerations or safety precautions:

_____

I agree to have the information in this plan shared with staff needing to know. I understand that my child's name may appear on a list with other students having seizures to better identify needs. 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 administer any medication ordered for seizure activity plan and to contact the ordering physician/licensed prescriber for clarification of this plan if needed.

Parent/Guardian Signature_____Date_____

Action if student has a seizure

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully awake
- Record seizure in a log

In addition for tonic-clonic (grand mal) seizure

- Keep airway open/monitor breathing
- Protect head
- Turn child on side
- Follow medical orders (below)
- Follow directions of parent (page one of MAP)

General Signs of a Seizure EMERGENCY

- **Convulsion (tonic-clonic/grand mal) longer than 5 minutes** or per 911 instructions below inOrder
- **Student has repeated seizures (starts another seizure right after the first)**
- **Student is injured or has diabetes**
- **Student has breathing difficulties**
- **Student has a seizure in water**

Action

- ✓ **Stay with student until help arrives**
- ✓ **Call Parent or Guardian**
- ✓ **CPR if needed**

Call 911

Location(s) of Emergency Medication (if ordered below) in the school:

_____

Physician/Licensed Prescriber Order & Agreement with Protocol

This section must be completed by the Physician or Licensed Prescriber

☐ **Administer_____for seizure lasting longer than_____minutes.**

Dose_____

Other instructions:_____

☐ **Administer_____for a seizure lasting longer than_____minutes.**

Dose_____

Other instructions:_____

Does student have a Vagal Nerve Stimulator □ Yes □ No

(if YES, please describe magnet use)_____

_____

Call 911 if: (please check and complete)

☐ Seizure does not stop by itself within___minutes

☐ Anytime medication is given to stop a seizure

☐ Only if seizure does not stop within___minutes after giving medication

☐ Other directions:

Physician/Licensed Prescriber's Name_____

Phone number_____Fax number_____

Physician's Signature_____Date_____

Parental Permission

It is my understanding that Ivywood Classical Academy has taken every precaution to safeguard my child. I release and agree to hold the Academy, its Board members, staff working at the Academy, volunteers, and agents harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from the administration of the medication/treatment.

I also agree to defend, indemnify, and hold harmless the Academy, its Board members, staff working at the Academy, volunteers and agents from and against any such claims, demands, suits, damages, liability, costs, and expenses (including reasonable attorney fees) incurred as a consequence either directly or indirectly of the granting of this authorization to administer the medication/treatment.

I request that school staff give my child the above medication as ordered. I give permission for the prescriber to be contacted by school staff about this order if clarification is needed.

Parent/Guardian_____Date_____
Signature

Phone Number_____Alternate number_____

Medication should be in the original labeled container. It is the parent/guardian's responsibility to: replace expired medication; provide refills when needed; transport the medication to & from the school office; and pick it up at the end of the school year. The school does not store medicine over the summer.