



## **2021 -2022 Student Medical and Health Checklist**

**\*\*All student medical documents are due to the school office by August 2nd, 2021\*\***

In order to provide a safe and healthy environment for your child, PCCS strictly adheres to state law in maintaining health and medical records. Carefully read the list below and provide the office with all required paperwork for your child. If you have any questions please contact Shanna Coyle at [scoyle@pccharterschool.org](mailto:scoyle@pccharterschool.org).

### **State Health Forms**

#### **☐ Proof of School Dental Examination Form**

Required for all kindergarten (KDG), second (2nd), and sixth (6th) grade students and New students to the state of Illinois in 1st-8th grade.

#### **☐ Eye Examination Report**

Required for all kindergarten (KDG) students and New students to the state of Illinois in 1st-8th grade.

#### **☐ Certificate of Child Health Examination (both front & back sections must be completed)**

Required for all kindergarten (KDG) and sixth (6th) grade students and New students to the state of Illinois in 1st-8th grade. Please note that proof of immunizations must be attached to form. If you are stating a religious or medical exemption for your child, you must fill out the Illinois specific exemption form at both the KDG and 6th grade timeframes.

### **School Medical Forms**

*Due to the school **office** by August 2nd, 2021. Please do not send forms or medications to the classroom teacher.*

#### **☐ Sports Physical**

By law, PCCS is required to have a valid physical dated within 395 calendar days (13 months) on file for each student participating in interscholastic sports. A standard physical form completed by a physician is sufficient, but for students in 5th – 8th grades you may submit a sports physical in its place, signed by a licensed practitioner, prior to trying out for any sport at PCCS. A sports physical is valid only in regards to interscholastic sports, not as the record of examination and immunizations required for all sixth graders.

### ☐ **Concussion Information Sheet**

As of 2017, the state requires this form to be signed by any student participating in interscholastic sporting events or practices. The parent's/guardian's signature is also required.

### ☐ **School Medication Authorization Form** (for all prescription and nonprescription medications except for asthma inhalers and emergency epinephrine injectors- inhalers and epinephrine can just be written on those specific action plan forms by the MD/NP)

Your child's pediatrician must fill out the **School Medication Authorization Form** for all prescribed and over-the-counter medication that your child needs to take during the school day. This form also needs to be signed by the parent/guardian. A new form must be filled out for each new school year.

Note: State law now requires a physician's signature for over-the-counter and prescription medication. No medication will be administered to your child unless the completed form has been provided to school administration.

As per Illinois law, we do not house a stock of any OTC medication on campus. Each student/family must supply their own medication. Additionally, please remember that things such as cough drops and topical creams must also be authorized by a licensed practitioner to be allowed during the school day.

Medication should be brought to the school office in the original container, properly labeled and accompanied by the following information:

#### Prescription Medications

- a. Student name and prescription number
- b. Name and dosage of medication
- c. Date and number of refills
- d. Licensed physician's name
- e. Pharmacy name, address, and phone number
- f. Name or initials of pharmacist
- g. Administration route or other directions

#### Nonprescription Medications

Student's first and last name on the original container.

### **Students with Allergies**

#### ☐ **Allergy and Anaphylaxis Emergency Plan**

In the case of any allergy requiring medical treatment, your child's physician is required to complete an **Allergy and Anaphylaxis Emergency Plan**. This plan must be provided to school administration **prior to your child's first day of school**.

If an epinephrine auto injector is prescribed, the Allergy and Anaphylaxis Emergency Plan will indicate it. You do not need an additional School Medication Authorization Form for the

epinephrine auto injector. Your child may carry and self-administer an epinephrine injector only when the Allergy and Anaphylaxis Emergency Plan has been completed and signed by physician and the self-administration checkbox marked. The form must also be signed by the child's parent or guardian and provided to school administration before August 2nd, 2021.

If an EpiPen® is required as part of the emergency action plan, please provide both injectors (one twin pack) to the school. Epinephrine has a short period of time in which it is active and both injectors may be needed before emergency services have arrived. **Please check the expiration date prior to turning them into the school office.**

### **Students with Asthma**

#### **☐ Asthma Action Plan**

If your child has asthma, an **Asthma Action Plan** must be completed by your child's physician and provided to school administration before August 2nd, 2021.

Prescribed asthma inhalers will be indicated on the Asthma Management Plan. You do not need to submit an additional School Medication Authorization for an asthma inhaler. Your child may carry and self-administer an asthma medication (inhaler/nebulizer) only when the Asthma Management Plan has been completed and signed by the physician and the self-administration checkbox marked. **Please check the expiration date prior to turning them into the school office.**

### **Students with Seizures**

#### **☐ Seizure Action Plan**

If your child has seizures, your child's physician is required to complete a **Seizure Action Plan**. This plan must be provided to school administration before August 2nd, 2021. Your child's physician will provide and complete this form in conjunction with you. Please make sure, if medication is needed during school hours, the School Medication Authorization Form is completed and signed by both physician and parent.

### **Students with Diabetes**

#### **☐ Diabetic Care Plan**

If your child has diabetes, your child's physician is required to complete a **Diabetic Care Plan**. This plan must be provided to school administration before August 2nd, 2021. Your child's **physician will provide** and complete this form in conjunction with you. Please make sure, if medication is needed during school hours, the School Medication Authorization Form is completed and signed by both physician and parent.

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## PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Year) / /
Address:	Street	City	ZIP Code	Telephone:
Name of School:	Grade Level:			Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent or Guardian:	Address (of parent/guardian):			

To be completed by dentist:

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1<sup>st</sup> molars.

☐ Yes ☐ No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

Treatment Needs (check all that apply)

☐ **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care** — amalgams, composites, crowns, etc.

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis

☐ **Other** — periodontal, orthodontic

Please note \_\_\_\_\_

Signature of Dentist \_\_\_\_\_

Date of Exam \_\_\_\_\_

Address \_\_\_\_\_  
Street City ZIP Code

Telephone \_\_\_\_\_





## DENTAL EXAMINATION WAIVER FORM

Please print:

Student's Name:			Last		First		Middle		Birth Date: (Month/Day/Year)		
									/ /		
Address:		Street			City			ZIP Code		Telephone:	
Name of School:					Grade Level:					Gender:	
										<input type="checkbox"/> Male <input type="checkbox"/> Female	
Parent or Guardian:					Address (of parent/guardian):						

I am unable to obtain the required dental examination because:

- ☐ My child is enrolled in the free and reduced lunch program and is not covered by private or public dental insurance (Medicaid/All Kids).
- ☐ My child is enrolled in the free and reduced lunch program and is ineligible for public insurance (Medicaid/All Kids).
- ☐ My child is enrolled in Medicaid/All Kids, but we are unable to find a dentist or dental clinic in our community that is able to see my child and will accept Medicaid/All Kids.
- ☐ My child does not have any type of dental insurance, and there are no low-cost dental clinics in our community that will see my child.

Signature \_\_\_\_\_

Date \_\_\_\_\_



## State of Illinois Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name \_\_\_\_\_  
(Last) (First) (Middle Initial)  
Birth Date \_\_\_\_\_ Gender \_\_\_\_\_ Grade \_\_\_\_\_  
(Month/Day/Year)  
Parent or Guardian \_\_\_\_\_  
(Last) (First)  
Phone \_\_\_\_\_  
(Area Code)  
Address \_\_\_\_\_  
(Number) (Street) (City) (ZIP Code)  
County \_\_\_\_\_

### To Be Completed By Examining Doctor

#### Case History

Date of exam \_\_\_\_\_

Ocular history: ☐ Normal or Positive for \_\_\_\_\_

Medical history: ☐ Normal or Positive for \_\_\_\_\_

Drug allergies: ☐ NKDA or Allergic to \_\_\_\_\_

Other information \_\_\_\_\_

#### Examination

	Distance			Near
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ☐ Yes ☐ No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal exam (vitreous, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pupillary reflex (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Binocular function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accommodation and vergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oculomotor assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

#### Diagnosis

☐ Normal ☐ Myopia ☐ Hyperopia ☐ Astigmatism ☐ Strabismus ☐ Amblyopia

Other \_\_\_\_\_



## State of Illinois Eye Examination Report

### Recommendations

1. Corrective lenses: ☐ No ☐ Yes, glasses or contacts should be worn for:  
☐ Constant wear ☐ Near vision ☐ Far vision  
☐ May be removed for physical education

2. Preferential seating recommended: ☐ No ☐ Yes

Comments \_\_\_\_\_  
\_\_\_\_\_

3. Recommend re-examination: ☐ 3 months ☐ 6 months ☐ 12 months

☐ Other \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

Print name \_\_\_\_\_

Optometrist or physician (such as an ophthalmologist)  
who provided the eye examination ☐ MD ☐ OD ☐ DO

License Number \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone \_\_\_\_\_

### Consent of Parent or Guardian

I agree to release the above information on my child  
or ward to appropriate school or health authorities.

\_\_\_\_\_  
(Parent or Guardian's Signature)

\_\_\_\_\_  
(Date)

Signature \_\_\_\_\_

Date \_\_\_\_\_

(Source: Amended at 32 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)





## Eye Examination Waiver Form

**Please print:**

Student Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
(Last) (First) (Middle Initial) (Month/Day/Year)

School Name \_\_\_\_\_ Grade Level \_\_\_\_\_ Gender: ☐ Male ☐ Female

Address \_\_\_\_\_  
(Number) (Street) (City) (ZIP Code)

Phone \_\_\_\_\_  
(Area Code)

Parent or Guardian \_\_\_\_\_  
(Last) (First)

Address of Parent or Guardian \_\_\_\_\_  
(Number) (Street) (City) (ZIP Code)

**I am unable to obtain the required vision examination because:**

- ☐ My child is enrolled in medical assistance/ALL KIDS, but we are unable to find a medical doctor who performs eye examinations or an optometrist in the community who is able to examine my child and accepts medical assistance/ALL KIDS.
- ☐ My child does not have any type of medical or vision/eye care coverage, my child does not qualify for medical assistance/ALL KIDS, there are no low-cost vision/eye clinics in our community that will see my child, and I have exhausted all other means and do not have sufficient income to provide my child with an eye examination.
- ☐ Other undue burden or a lack of access to an optometrist or to a physician who provides eye examinations:

\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

(Source: Added at 32 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

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# State of Illinois Certificate of Child Health Examination

<b>Student's Name</b> Last First Middle				<b>Birth Date</b> Month/Day/Year	<b>Sex</b>	<b>Race/Ethnicity</b>	<b>School /Grade Level/ID#</b>	
<b>Address</b> Street City Zip Code				<b>Parent/Guardian</b> Telephone # Home Work				
<b>IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for <u>every</u> dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.</b>								
<b>REQUIRED Vaccine / Dose</b>	<b>DOSE 1</b> MO DA YR		<b>DOSE 2</b> MO DA YR		<b>DOSE 3</b> MO DA YR		<b>DOSE 4</b> MO DA YR	
<b>DTP or DTap</b>								
<b>Tdap; Td or Pediatric DT (Check specific type)</b>	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	
<b>Polio (Check specific type)</b>	<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV	
<b>Hib Haemophilus influenza type b</b>								
<b>Pneumococcal Conjugate</b>								
<b>Hepatitis B</b>								
<b>MMR Measles Mumps Rubella</b>					<b>Comments:</b> * indicates invalid dose			
<b>Varicella (Chickenpox)</b>								
<b>Meningococcal conjugate (MCV4)</b>								
<b>RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose</b>								
<b>Hepatitis A</b>								
<b>HPV</b>								
<b>Influenza</b>								
<b>Other: Specify Immunization Administered/Dates</b>								
<b>Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.</b>								
<b>Signature</b>				<b>Title</b>		<b>Date</b>		
<b>Signature</b>				<b>Title</b>		<b>Date</b>		
<b>ALTERNATIVE PROOF OF IMMUNITY</b>								
<b>1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.</b> *MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR								
<b>2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.</b> Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease. <b>Date of Disease</b> Signature Title								
<b>3. Laboratory Evidence of Immunity (check one)</b> <input type="checkbox"/> Measles* <input type="checkbox"/> Mumps** <input type="checkbox"/> Rubella <input type="checkbox"/> Varicella <b>Attach copy of lab result.</b> *All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence. **All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.								
<b>Completion of Alternatives 1 or 3 MUST be accompanied by Labs &amp; Physician Signature:</b> _____ Physician Statements of Immunity MUST be submitted to IDPH for review.								

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and Maintained by the School Authority.

Last First Middle			Birth Date Month/Day/ Year		Sex	School	Grade Level/ ID
<b>HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER</b>							
<b>ALLERGIES</b> (Food, drug, insect, other) Yes <input type="checkbox"/> No <input type="checkbox"/> List:			<b>MEDICATION</b> (Prescribed or taken on a regular basis.) Yes <input type="checkbox"/> No <input type="checkbox"/> List:				
Diagnosis of asthma?			Yes <input type="checkbox"/> No <input type="checkbox"/>	Loss of function of one of paired organs? (eye/ear/kidney/testicle)		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Child wakes during night coughing?			Yes <input type="checkbox"/> No <input type="checkbox"/>	Hospitalizations?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Birth defects?			Yes <input type="checkbox"/> No <input type="checkbox"/>	When? What for?			
Developmental delay?			Yes <input type="checkbox"/> No <input type="checkbox"/>	Surgery? (List all.)		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.			Yes <input type="checkbox"/> No <input type="checkbox"/>	When? What for?			
Diabetes?			Yes <input type="checkbox"/> No <input type="checkbox"/>	Serious injury or illness?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Head injury/Concussion/Passed out?			Yes <input type="checkbox"/> No <input type="checkbox"/>	TB skin test positive (past/present)?		Yes* <input type="checkbox"/> No <input type="checkbox"/>	*If yes, refer to local health department.
Seizures? What are they like?			Yes <input type="checkbox"/> No <input type="checkbox"/>	TB disease (past or present)?		Yes* <input type="checkbox"/> No <input type="checkbox"/>	
Heart problem/Shortness of breath?			Yes <input type="checkbox"/> No <input type="checkbox"/>	Tobacco use (type, frequency)?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Heart murmur/High blood pressure?			Yes <input type="checkbox"/> No <input type="checkbox"/>	Alcohol/Drug use?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Dizziness or chest pain with exercise?			Yes <input type="checkbox"/> No <input type="checkbox"/>	Family history of sudden death before age 50? (Cause?)		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other				
Ear/Hearing problems?			Yes <input type="checkbox"/> No <input type="checkbox"/>	Information may be shared with appropriate personnel for health and educational purposes.			
Bone/Joint problem/injury/scoliosis?			Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Parent/Guardian Signature</b> _____ <b>Date</b> _____			
<b>PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA</b>							
HEAD CIRCUMFERENCE if < 2-3 years old		HEIGHT		WEIGHT		BMI	BMI PERCENTILE B/P
<b>DIABETES SCREENING (NOT REQUIRED FOR DAY CARE)</b> BMI>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: <b>Family History</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Ethnic Minority</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Signs of Insulin Resistance</b> (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> <b>At Risk</b> Yes <input type="checkbox"/> No <input type="checkbox"/>							
<b>LEAD RISK QUESTIONNAIRE:</b> Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)							
<b>Questionnaire Administered?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Indicated?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Date</b> _____ <b>Result</b> _____							
<b>TB SKIN OR BLOOD TEST</b> Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. <a href="http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm">http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm</a> . <b>No test needed</b> <input type="checkbox"/> <b>Test performed</b> <input type="checkbox"/> <b>Skin Test: Date Read</b> _____ <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>mm</b> _____ <b>Blood Test: Date Reported</b> _____ <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>Value</b> _____							
<b>LAB TESTS (Recommended)</b>		Date	Results		Date	Results	
Hemoglobin or Hematocrit						Sickle Cell (when indicated)	
Urinalysis						Developmental Screening Tool	
<b>SYSTEM REVIEW</b>	Normal <input type="checkbox"/>	Comments/Follow-up/Needs		Normal <input type="checkbox"/>	Comments/Follow-up/Needs		
Skin				Endocrine			
Ears		Screening Result:		Gastrointestinal			
Eyes		Screening Result:		Genito-Urinary		LMP	
Nose				Neurological			
Throat				Musculoskeletal			
Mouth/Dental				Spinal Exam			
Cardiovascular/HTN				Nutritional status			
Respiratory		<input type="checkbox"/> Diagnosis of Asthma		Mental Health			
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist) <input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)				Other			
NEEDS/MODIFICATIONS required in the school setting				DIETARY Needs/Restrictions			
<b>SPECIAL INSTRUCTIONS/DEVICES</b> e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup							
<b>MENTAL HEALTH/OTHER</b> Is there anything else the school should know about this student? If you would like to discuss this student's health with school or school health personnel, check title: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> Principal							
<b>EMERGENCY ACTION</b> needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> If yes, please describe.							
On the basis of the examination on this day, I approve this child's participation in _____ (If No or Modified please attach explanation.)							
<b>PHYSICAL EDUCATION</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>				<b>INTERSCHOLASTIC SPORTS</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>			
Print Name		(MD,DO, APN, PA) Signature			Date		
Address		Phone					

## **INSTRUCTIONS FOR COMPLETING**

### **ILLINOIS CERTIFICATE OF RELIGIOUS EXEMPTION TO REQUIRED IMMUNIZATIONS AND/OR EXAMINATIONS FORM**

#### **Who may use the Certificate of Religious Exemption to Required Immunizations and/or Examinations Form:**

- Parents or legal guardians who are requesting a religious exemption to immunizations or examinations **must** use this form for students entering kindergarten, sixth, or ninth grades.
- A separate form must be used for **each child** with a religious exemption enrolled to enter any public, charter, private or parochial preschool, kindergarten, elementary or secondary school.
- This form may not be used for exemptions from immunizations and/or examination for personal or philosophical reasons. Illinois law does not allow for such exemptions. (See excerpts below from Public Act 099-0249 enacted August 3, 2015 at page bottom.)

#### **When use of this form becomes required: October 16, 2015**

#### **How to complete the Certificate of Religious Exemption to Required Immunizations and/or Examinations Form:**

- Complete the Parent/Guardian sections, which include key information about the student and the school the student will be entering, and the immunizations or examinations for which religious exemption is being requested. Provide a statement of religious belief(s) **for each vaccination/examination requested**.
- The form must be signed by the child's parent or legal guardian **AND** the child's health care provider\* **responsible for performing the child's health examination**.
- Submit the completed form to local school authority on or before October 15th of the school year, or by an earlier enrollment date established by a school district.

#### **Religious Exemption from Immunizations and/or Examination Form Process:**

- The local school authority is responsible for determining whether the information supplied on the Certificate of Religious Exemption to Required Immunizations and/or Examinations Form constitutes a valid religious objection.
- The local school authority shall inform the parent or legal guardian, at the time that the exemption is presented, of exclusion procedures, should there be an outbreak of one or more diseases from which the student is not protected, in accordance with the Illinois Department of Public Health (IDPH) rules, Control of Communicable Diseases Code (77 Ill. Adm. Code 690).
- Exempting a child from health, dental, or eye examination does not exempt the child from participation in the program of physical education training provided in Section 27-5 through 27-7 of the Illinois School Code [105 ILCS 5/27-5 through 105 ILCS 5/27-7]. A separate request for exemption from physical education, if desired, would need to be presented.

#### **Excerpt from Public Act 099-0249 enacted August 3, 2015:**

Children of parents or legal guardians who object to health, dental, or eye examinations or any part thereof, or to immunizations or to vision and hearing screening tests on religious grounds shall not be required to undergo the examinations or immunizations if the parents or legal guardians present to the appropriate local school authority a signed Certificate of Religious Exemption detailing the grounds for objection and the specific immunizations and/or examinations to which they object. The grounds for objection must set forth the specific religious belief(s) that conflict with the examination, immunization, or other medical intervention. The certificate will be signed by the parent or legal guardian to confirm their awareness of the school's exclusion policies in the case of a vaccine preventable disease outbreak or exposure. The certificate must also be signed by the child's health care provider responsible for performing the child's examination for entry into kindergarten, sixth or ninth grade. This signature affirms that the provider educated the parent or legal guardian about the benefits of immunization and the health risks to the student and to the community from the communicable diseases for which immunization is required in Illinois.

The religious objection provided need not be directed by the tenets of an established religious organization. However, general philosophical or moral reluctance to allow physical examinations, eye examinations, immunizations, vision and hearing screening or dental examinations will not provide a sufficient basis for an exception to statutory requirements. The local school authority is responsible for determining if the content of the Certificate of Religious Exemption constitutes a valid religious objection.

The local school authority shall inform the parent or legal guardian of exclusion procedures in accordance with IDPH's rules, Control of Communicable Diseases Code (77 Ill. Adm. Code 690) at the time the objection is presented.

**ILLINOIS CERTIFICATE OF RELIGIOUS EXEMPTION  
TO REQUIRED IMMUNIZATIONS AND/OR EXAMINATIONS FORM**

**PARENT OR LEGAL GUARDIAN - COMPLETE THIS SECTION**

*Note: This form is required for all students entering kindergarten, sixth or ninth grades when parent(s) or legal guardian(s) is requesting a religious exemption on or after October 16, 2015. This form also must be submitted to request religious exemption for any student enrolling to enter any public, charter, private or parochial preschool, kindergarten, elementary or secondary school on or after October 16, 2015.*

***This form may NOT be used for personal or philosophical reasons. Illinois law does not allow for such exemptions.***

<b>Student Name:</b> (last, first, middle)  <b>Parent/Guardian Name:</b>  <b>Address:</b>  	<b>Student Date of Birth:</b> Month    Day    Year  <b>Gender:</b> <input type="checkbox"/> M <input type="checkbox"/> F  <b>Telephone Number(s):</b>  	<b>School Name:</b> _____  <b>City:</b> _____  <b>Grade:</b> _____  <b>Exemption requested for (mark all that apply):</b> <input type="checkbox"/> Hepatitis B <input type="checkbox"/> DTaP <input type="checkbox"/> Polio <input type="checkbox"/> Hib <input type="checkbox"/> Pneumococcal <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> Td/Tdap <input type="checkbox"/> Meningococcal <input type="checkbox"/> Health Exam <input type="checkbox"/> Eye Exam <input type="checkbox"/> Dental Exam <input type="checkbox"/> Vision/Hearing Tests <input type="checkbox"/> Other (indicate below)
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**To receive an exemption to vaccination/examination, a parent or legal guardian must provide a statement detailing the religious beliefs that prevent the child from receiving each required school vaccinations/examination being requested.**

**In the space provided below, state each vaccination or examination exemption requested and state the religious grounds for each request. If additional space is needed, attach additional page(s).**

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**Religious Exemption Notice:**

No student is required to have an immunization/examination that is contrary to the religious beliefs of his/her parent or legal guardian. However, not following vaccination recommendations may endanger the health or life of the unvaccinated student, others with whom they come in contact, and individuals in the community. In a disease outbreak, or after exposure to any of the diseases for which immunization is required, schools may exclude children who are not vaccinated in order to protect all students.

I have read the Religious Exemption Notice (above) and have provided requested information for each vaccination/examination being requested for religious exemption.

Signature of parent or legal guardian    (required)

Date

**HEALTH CARE PROVIDER\* – COMPLETE THIS SECTION**

**Provision of information:** I have provided the parent or legal guardian of the student named above, with information regarding **1) the required examinations, 2) the benefits of immunization, and 3) the health risks to the student and to the community from the communicable diseases for which immunization is required in Illinois.** I understand that my signature only reflects that this information was provided; I am not affirming the parent or legal guardian's religious beliefs regarding any examination, immunization or immunizing agent.

Signature of health care provider\*

Date:

(Must be within 1 year prior to school entry)

Health Care Provider Name:

Address:

Telephone #: \_\_\_\_\_

\*Health care provider responsible for performing child's health examination includes physicians licensed to practice medicine in all of its branches, advanced practice nurses, or physician assistants.



## ■ PREPARTICIPATION PHYSICAL EVALUATION

### HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Date of examination: \_\_\_\_\_ Sport(s): \_\_\_\_\_

Sex assigned at birth (F, M, or intersex): \_\_\_\_\_ How do you identify your gender? (F, M, or other): \_\_\_\_\_

List past and current medical conditions. \_\_\_\_\_

Have you ever had surgery? If yes, list all past surgical procedures. \_\_\_\_\_

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). \_\_\_\_\_

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). \_\_\_\_\_

#### Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of  $\geq 3$  is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

#### GENERAL QUESTIONS

(Explain "Yes" answers at the end of this form.

Circle questions if you don't know the answer.)

	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU		
	Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

#### HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)

	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		
	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		



## ■ PREPARTICIPATION PHYSICAL EVALUATION

### MEDICAL ELIGIBILITY FORM

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

- ☐ Medically eligible for all sports without restriction
- ☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

\_\_\_\_\_

\_\_\_\_\_

- ☐ Medically eligible for certain sports

\_\_\_\_\_

\_\_\_\_\_

- ☐ Not medically eligible pending further evaluation

- ☐ Not medically eligible for any sports

Recommendations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA

### SHARED EMERGENCY INFORMATION

Allergies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Emergency contacts: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_





## ■ PREPARTICIPATION PHYSICAL EVALUATION

### PHYSICAL EXAMINATION FORM

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

#### PHYSICIAN REMINDERS

- Consider additional questions on more-sensitive issues.
  - Do you feel stressed out or under a lot of pressure?
  - Do you ever feel sad, hopeless, depressed, or anxious?
  - Do you feel safe at your home or residence?
  - During the past 30 days, did you use chewing tobacco, snuff, or dip?
  - Do you drink alcohol or use any other drugs?
  - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
  - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
  - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: _____	Weight: _____	
BP: _____ / _____ ( _____ / _____ )	Pulse: _____	Vision: R 20/ _____ L 20/ _____ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)</li> </ul>		
Eyes, ears, nose, and throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>		
Lymph nodes		
Heart <sup>a</sup> <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)</li> </ul>		
Lungs		
Abdomen		
Skin <ul style="list-style-type: none"> <li>Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis</li> </ul>		
Neurological		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional <ul style="list-style-type: none"> <li>Double-leg squat test, single-leg squat test, and box drop or step drop test</li> </ul>		

<sup>a</sup> Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA

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Keep for Personal Records



## Concussion Information Sheet

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a “ding” or a bump on the head can be serious. You can’t see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

<b>Symptoms may include one or more of the following:</b>	
<ul style="list-style-type: none"><li>• Headaches</li><li>• “Pressure in head”</li><li>• Nausea or vomiting</li><li>• Neck pain</li><li>• Balance problems or dizziness</li><li>• Blurred, double, or fuzzy vision</li><li>• Sensitivity to light or noise</li><li>• Feeling sluggish or slowed down</li><li>• Feeling foggy or groggy</li><li>• Drowsiness</li><li>• Change in sleep patterns</li></ul>	<ul style="list-style-type: none"><li>• Amnesia</li><li>• “Don’t feel right”</li><li>• Fatigue or low energy</li><li>• Sadness</li><li>• Nervousness or anxiety</li><li>• Irritability</li><li>• More emotional</li><li>• Confusion</li><li>• Concentration or memory problems (forgetting game plays)</li><li>• Repeating the same question/comment</li></ul>
<b>Signs observed by teammates, parents and coaches include:</b>	
<ul style="list-style-type: none"><li>• Appears dazed</li><li>• Vacant facial expression</li><li>• Confused about assignment</li><li>• Forgets plays</li><li>• Is unsure of game, score, or opponent</li><li>• Moves clumsily or displays in coordination</li><li>• Answers questions slowly</li><li>• Slurred speech</li><li>• Shows behavior or personality changes</li><li>• Can’t recall events prior to hit</li><li>• Can’t recall events after hit</li><li>• Seizures or convulsions</li><li>• Any change in typical behavior or personality</li><li>• Loses consciousness</li></ul>	

## Concussion Information Sheet

### What can happen if my child keeps on playing with a concussion or returns too soon?

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often fail to report symptoms of injuries. Concussions are no different. As a result, education of administrators, coaches, parents and students is the key to student-athlete's safety.

### If you think your child has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. The Return-to-Play Policy of the IESA and IHSA requires athletes to provide their school with written clearance from either a physician licensed to practice medicine in all its branches or a certified athletic trainer working in conjunction with a physician licensed to practice medicine in all its branches prior to returning to play or practice following a concussion or after being removed from an interscholastic contest due to a possible head injury or concussion and not cleared to return to that same contest. In accordance with state law, all schools are required to follow this policy.

You should also inform your child's coach if you think that your child may have a concussion. Remember it's better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to:  
<http://www.cdc.gov/ConcussionInYouthSports/>

### **Student/Parent Consent and Acknowledgements**

By signing this form, we acknowledge we have been provided information regarding concussions.

#### **Student**

Student Name (Print): \_\_\_\_\_ Grade: \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### **Parent or Legal Guardian**

Name (Print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_

Each year IESA member schools are required to keep a signed Acknowledgement and Consent form and a current Pre-participation Physical Examination on file for all student athletes.



## MEDICATION FORM

Name: \_\_\_\_\_

D.O.B: \_\_\_\_\_

Do NOT use this form for epinephrine auto-injectors or asthma inhalers/medication. For those, please use the Food Allergy and/or Asthma Action Plan forms.

### TO BE COMPLETED BY THE LICENSED PRESCRIBER (MD, APN, OR PA-C):

Medication/Dose/Frequency: \_\_\_\_\_

Duration (length of time to be given): \_\_\_\_\_

Indication of medication (diagnosis/symptom): \_\_\_\_\_

Medication/Dose/Frequency: \_\_\_\_\_

Duration (length of time to be given): \_\_\_\_\_

Indication of medication (diagnosis/symptom): \_\_\_\_\_

Medication/Dose/Frequency: \_\_\_\_\_

Duration (length of time to be given): \_\_\_\_\_

Indication of medication (diagnosis/symptom): \_\_\_\_\_

Medication/Dose/Frequency: \_\_\_\_\_

Duration (length of time to be given): \_\_\_\_\_

Indication of medication (diagnosis/symptom): \_\_\_\_\_

Prescriber (print name): \_\_\_\_\_

*(use for original Prescriber stamp or fill out below)*

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_



## Prairie Crossing Charter School Procedure for Administration of Medication to Students

This procedure shall apply both to prescription and nonprescription medication. Medication shall not be administered to a student unless absolutely necessary to maintain the attendance of the student. If it is determined that the student must be given medication, the procedure set below shall be followed:

- 1) Medication shall be administered by a certified school nurse, registered nurse, or certified employee designated by the Director.
- 2) The student's physician shall provide written orders with the name of student, date of birth, name of medication, dose/route/frequency, as well as diagnosis for which medication ordered, intended effects and side effects of medication. List any other medication that the student is on and an emergency number where the physician/practitioner can be reached.
- 3) The student's parent/guardian shall provide to the nurse a signed authorization to administer the medication, which has been ordered by the physician/licensed practitioner. The authorization shall include the parent/guardian signature and phone number to be reached in the case of an emergency.
- 4) Medication brought to school shall be given to nurse/certified employee in original package or appropriately labeled container. For prescription medication, the student's name, medication name and dosage, administration directions, date and refill, licensed prescriber's name, pharmacy name, number, address, and name or initials of pharmacist. Over the counter medication to be in the original box with manufacturer's label listing all contents. Student's name must be on container. Medication should be delivered to school by parent/guardian.
- 5) Medication will be kept in a locked cabinet.
- 6) The school nurse will keep a written record of all medications administered. This record will include the student's name, medication, dose, time, date and who administered medication. In the event a dosage is not administered as ordered, the reason will be entered in the record. This documentation, along with the physician's order and parental/guardian authorization is considered part of the student's temporary record.
- 7) The student's parent/guardian will be responsible for removing any unused medication from the school at the end of the prescribed regimen, or end of school year. If the parent/guardian fails to remove unused medication, the school nurse will appropriately dispose of in the presence of a witness.

No medication will be administered to students unless these guidelines are followed. A student with asthma inhalers, epinephrine auto-injectors, and insulin may self-administered as long as the following information is kept on file in the Health Office. The student's parent/guardian will provide a parental written authorization for self-administration of medication and written order from the student's physician containing the following information: name and purpose of medication, prescribed dosage and time or special circumstances under which the medication is administered.

The Director or designee shall have the discretion to reject requests for administration subject to the requirements of Individuals with Disabilities Education Act and Section 504 of the Rehabilitation Act of 1973.

### TO BE COMPLETED BY PARENT:

I hereby request and grant permission for PCCS school personnel to administer medication to/by my daughter/son according to the above instructions. I understand that administration by school personnel may be performed by an individual other than a registered nurse, and I specifically consent to this. I further waive any claims against the school district, members of the Board of Directors, its employees and agents, arising out of the administration of said medication (s), and agree to hold harmless and indemnify PCCS, the members of the Board, its employees and agents, either jointly or separately, from and against any and all liability, claims, demands, damages or causes of action or injuries, costs and expenses, including attorney's fees, resulting from or arising out of the administration of the medication.

Parent/guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Sick Day Guidelines: Making the right choice!

Dear Parents:

To help prevent the spread of illness, we would like to give you some guidelines to help with your decision on whether or not to send your child to school. We ask that you keep your child home if he or she:

- Has a fever of 100.0 (oral) degrees or higher
- Has vomited more than once within a 24 hour period
- Has a persistent cough (dry or productive)
- Has diarrhea (three or more episodes in 24 hours)
- Has open and draining sores
- Has symptoms that prevent him or her from participating in school, such as:
  - Excessive tiredness or lack of appetite
  - Headaches, body aches, earaches
  - Severe sore throat (*could be strep-throat even without fever. Other symptoms of strep throat in children are headache & stomach upset. Contact your pediatrician to assess for diagnosis of strep throat*).

If your child has recently been ill, please be aware of the following guidelines before having your child return to school, athletic or social activities:

- They should feel fit for at least 24 hours.
- Be free of fever for at least 24 hours (**without medication**)
- Be free of vomiting and or diarrhea for at least 24 hours.
- If strep throat, they must be on the appropriate antibiotic for at least 24 hours.
- If conjunctivitis, they must be on the appropriate eye drops for at least 24 hours or cleared by a physician.
- Rash illnesses should be assessed by a doctor. For chicken pox, keep home for at least 5 days after the appearance of the rash or until all blisters have scabbed over.

For head lice, child should receive prompt and proper treatment with a specifically designated lice shampoo/lotion. Your child is free to return as long as we have evidence of treatment being initiated and no live lice. The child then will be rechecked 7-10 days later after the second treatment has been completed. There will no longer be whole-class checks for lice; only upon parental request for a child or if the child shows itchiness/ evidence of lice or nits while in class.

To keep children healthy, make sure they have plenty of rest and a nutritious diet. Show your child the proper way to wash their hands and to do it frequently throughout the day. Make sure to use soap & water and to rub hands together for at least 20 seconds. Limit touching areas such as the eyes, nose or mouth. Teach your child to cover coughs and sneezes with a tissue or their arm. Minimize the time your child spends with others who are ill. Avoid sharing personal items such as hats, brushes, combs, lip balms or towels.

Please notify the school if your child has been diagnosed with an infectious condition such as strep throat, chickenpox, scarlet fever, pertussis, head lice, etc.

Thank you for your cooperation.

*Adapted from information provided by Lake County Health Department/Community Health Center*

## **Instrucciones para días de enfermedades: Tomando la decisión correcta!**

Estimados Padres:

Para poder prevenir la propagación de enfermedades le estamos proveyendo instrucciones para ayudarlo a decidir si debe mandar a su hijo (a) a la escuela. Pedimos que mantenga a su hijo (a) en su casa si tiene alguno de los síntomas siguientes:

- Tiene 100.0 grados o mas de fiebre (calentura) oral
- Tiene vómitos
- Tiene una tos seca persistente
- Tiene diarrea (3 veces o mas en 24 horas)
- Tiene lesiones con pus
- Tiene síntomas que previenen que su hijo (a) participe en actividades escolares como:
  - Cansancio o falta de apetito
  - Dolor de cabeza, cuerpo, o de oídos
  - Dolor de garganta severa (podría tener dolor de garganta aunque no tenga fiebre, otros síntomas de dolor de garganta en los niños dolor de cabeza y de estomago. Llame al pediatra para que determine si su hijo (a) tiene dolor de garganta).

Si su hijo (a) ha estado enfermo recientemente, por favor siga las siguientes pautas antes de mandarlo a la escuela, actividades atléticas o sociales:

- Deben sentirse bien por lo menos 24 horas.
- No haber tenido fiebre por 24 horas (sin haber tomado medicamentos)
- Si es dolor de garganta deben de estar en antibiótico apropiado por 24 horas
- Si es conjuntivitis, debe de estar recibiendo el antibiótico en gotas apropiado por 24 horas o tener permiso de un medico
- Si es varicela, mantenga a su hijo (a) en su casa por 5 días o hasta que las lesiones se hayan secado.

Para mantener a los niños saludables ellos necesitan suficiente descanso y una dieta nutricional. Asegurándose que su hijo (a) practique buen lavado de manos con frecuencia. Lave las manos usando jabón, usando mucha fricción por 20 segundos y enjuagar las manos bajo agua corriente. Trate de mantener sus manos alejadas de ojos, nariz y boca. Enseñe a su hijo (a) a cubrir sus tos de estornudar con una pañuelos desechables (kleenex) o con su brazo. Trate de evitar que su hijo (a) no pase mucho tiempo con personas enfermas. Evite compartir objetos personales tales como gorras, cepillos del cabello, peines y toallas.

Por favor notifique a la escuelas si su hijo (a) ha sido diagnosticado con una condición infecciosa tal como dolor de garganta, varicela, fiebre escarlantina, tos ferina, piojos, etc.

Gracias por su cooperacion.

*Basada en la información de el Departamento de Salud y el Centro de Salud Comunitario*



# Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®



Child's name: \_\_\_\_\_ Date of plan: \_\_\_\_\_

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Weight: \_\_\_\_\_ kg

Child has allergy to \_\_\_\_\_

Child has asthma. ☐ Yes ☐ No (If yes, higher chance severe reaction)

Child has had anaphylaxis. ☐ Yes ☐ No

Child may carry medicine. ☐ Yes ☐ No

Child may give him/herself medicine. ☐ Yes ☐ No (If child refuses/is unable to self-treat, an adult must give medicine)

Attach  
child's  
photo

## IMPORTANT REMINDER

Anaphylaxis is a potentially life-threatening, severe allergic reaction. If in doubt, give epinephrine.

### For Severe Allergy and Anaphylaxis What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine**.

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

☐ **SPECIAL SITUATION:** If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): \_\_\_\_\_. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**.

### Give epinephrine! What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
  - Ask for ambulance with epinephrine.
  - Tell rescue squad when epinephrine was given.
3. Stay with child and:
  - Call parents and child's doctor.
  - Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.
  - Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
  - Antihistamine
  - Inhaler/bronchodilator

### For Mild Allergic Reaction What to look for

If child has had any mild symptoms, **monitor child**.

Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

### Monitor child What to do

Stay with child and:

- Watch child closely.
- Give antihistamine (if prescribed).
- Call parents and child's doctor.
- If more than 1 symptom or symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

## Medicines/Doses

Epinephrine, intramuscular (list type): \_\_\_\_\_ Dose: ☐ 0.10 mg (7.5 kg to less than 13 kg)\*

☐ 0.15 mg (13 kg to less than 25 kg)

☐ 0.30 mg (25 kg or more)

Antihistamine, by mouth (type and dose): \_\_\_\_\_ (\*Use 0.15 mg, if 0.10 mg is not available)

Other (for example, inhaler/bronchodilator if child has asthma): \_\_\_\_\_

Parent/Guardian Authorization Signature \_\_\_\_\_

Date \_\_\_\_\_

Physician/HCP Authorization Signature \_\_\_\_\_

Date \_\_\_\_\_

# Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics  
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Child's name: \_\_\_\_\_ Date of plan: \_\_\_\_\_

## Additional Instructions:

## Contacts

Call 911 / Rescue squad: \_\_\_\_\_

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

## Other Emergency Contacts

Name/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

# Asthma Action Plan for Home and School



Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Severity Classification ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list) \_\_\_\_\_

Peak Flow Meter Personal Best \_\_\_\_\_

## Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night

Peak Flow Meter \_\_\_\_\_ (more than 80% of personal best)

Control Medicine(s)	Medicine	How much to take	When and how often to take it	Take at
	_____	_____	_____	<input type="checkbox"/> Home <input type="checkbox"/> School
	_____	_____	_____	<input type="checkbox"/> Home <input type="checkbox"/> School

Physical Activity ☐ Use albuterol/levalbuterol \_\_\_\_\_ puffs, 15 minutes before activity ☐ with all activity ☐ when the child feels he/she needs it

## Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or chest tight – Problems working or playing – Wake at night

Peak Flow Meter \_\_\_\_\_ to \_\_\_\_\_ (between 50% and 79% of personal best)

Quick-relief Medicine(s) ☐ Albuterol/levalbuterol \_\_\_\_\_ puffs, every 4 hours as needed

Control Medicine(s) ☐ Continue Green Zone medicines

☐ Add \_\_\_\_\_ ☐ Change to \_\_\_\_\_

The child should feel better within 20–60 minutes of the quick-relief treatment. If the child is getting worse or is in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

## Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping

Peak Flow Meter \_\_\_\_\_ (less than 50% of personal best)

Take Quick-relief Medicine NOW! ☐ Albuterol/levalbuterol \_\_\_\_\_ puffs, \_\_\_\_\_ (how frequently)

Call 911 immediately if the following danger signs are present

- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

**School Staff:** Follow the Yellow and Red Zone instructions for the quick-relief medicines according to asthma symptoms.

The only control medicines to be administered in the school are those listed in the Green Zone with a check mark next to "Take at School".

☐ Both the Healthcare Provider and the Parent/Guardian feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

### Healthcare Provider

Name \_\_\_\_\_ Date \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Signature \_\_\_\_\_

### Parent/Guardian

☐ I give permission for the medicines listed in the action plan to be administered in school by the nurse or other school staff as appropriate.

☐ I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medicine.

Name \_\_\_\_\_ Date \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Signature \_\_\_\_\_

### School Nurse

☐ The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Name \_\_\_\_\_ Date \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Signature \_\_\_\_\_

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# SEIZURE ACTION PLAN (SAP)



**END EPILEPSY**

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_  
Emergency Contact/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

## Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

### Protocol for seizure during school (check all that apply) ☒

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify parent/emergency contact
- ☐ Contact school nurse at \_\_\_\_\_
- ☐ Call 911 for transport to \_\_\_\_\_
- ☐ Other \_\_\_\_\_

### First aid for any seizure

- ☐ **STAY** calm, keep calm, **begin timing seizure**
- ☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe magnet for VNS
- ☐ Write down what happens \_\_\_\_\_
- ☐ Other \_\_\_\_\_

### When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

### When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked

### When rescue therapy may be needed:

#### WHEN AND WHAT TO DO

If seizure (cluster, # or length) \_\_\_\_\_

Name of Med/Rx \_\_\_\_\_ How much to give (dose) \_\_\_\_\_

How to give \_\_\_\_\_

If seizure (cluster, # or length) \_\_\_\_\_

Name of Med/Rx \_\_\_\_\_ How much to give (dose) \_\_\_\_\_

How to give \_\_\_\_\_

If seizure (cluster, # or length) \_\_\_\_\_

Name of Med/Rx \_\_\_\_\_ How much to give (dose) \_\_\_\_\_

How to give \_\_\_\_\_

## Care after seizure

What type of help is needed? (describe) \_\_\_\_\_

When is student able to resume usual activity? \_\_\_\_\_

## Special instructions

First Responders: \_\_\_\_\_

Emergency Department: \_\_\_\_\_

## Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

## Other information

Triggers: \_\_\_\_\_

Important Medical History \_\_\_\_\_

Allergies \_\_\_\_\_

Epilepsy Surgery (type, date, side effects) \_\_\_\_\_

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted \_\_\_\_\_

Diet Therapy ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) \_\_\_\_\_

Special Instructions: \_\_\_\_\_

## Health care contacts

Epilepsy Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

My signature \_\_\_\_\_ Date \_\_\_\_\_

Provider signature \_\_\_\_\_ Date \_\_\_\_\_

# Diabetes Medical Management Plan (DMMP)

This plan should be completed by the student's personal diabetes health care team, including the parents/guardians. It should be reviewed with relevant school staff and copies should be kept in a place that can be accessed easily by the school nurse, trained diabetes personnel and other authorized personnel.

Date of plan: \_\_\_\_\_ This plan is valid for the current school year: \_\_\_\_\_ - \_\_\_\_\_

## Student information

Student's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Date of diabetes diagnosis: \_\_\_\_\_ ☐ Type 1 ☐ Type 2 ☐ Other: \_\_\_\_\_  
School: \_\_\_\_\_ School phone number: \_\_\_\_\_  
Grade: \_\_\_\_\_ Homeroom teacher: \_\_\_\_\_  
School nurse \_\_\_\_\_ Phone: \_\_\_\_\_

## Contact information

Parent/guardian 1: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Email address: \_\_\_\_\_

Parent/guardian 2: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Email address: \_\_\_\_\_

Student's physician/health care provider: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Emergency number: \_\_\_\_\_  
Email address: \_\_\_\_\_

## Other emergency contacts:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

## Checking blood glucose

Brand/model of blood glucose meter: \_\_\_\_\_

Target range of blood glucose:

Before meals: ☐ 90–130 mg/dL ☐ Other: \_\_\_\_\_

### Check blood glucose level:

- ☐ Before breakfast      ☐ After breakfast      ☐ \_\_\_\_\_ Hours after breakfast      ☐ 2 hours after a correction dose  
☐ Before lunch      ☐ After lunch      ☐ \_\_\_\_\_ Hours after lunch      ☐ Before dismissal  
☐ Mid-morning      ☐ Before PE      ☐ After PE      ☐ Other: \_\_\_\_\_  
☐ As needed for signs/symptoms of low or high blood glucose      ☐ As needed for signs/symptoms of illness

Preferred site of testing: ☐ Side of fingertip ☐ Other: \_\_\_\_\_

*Note: The side of the fingertip should always be used to check blood glucose level if hypoglycemia is suspected.*

### Student's self-care blood glucose checking skills:

- ☐ Independently checks own blood glucose  
☐ May check blood glucose with supervision  
☐ Requires a school nurse or trained diabetes personnel to check blood glucose  
☐ Uses a smartphone or other monitoring technology to track blood glucose value

Continuous glucose monitor (CGM): ☐ Yes ☐ No Brand/model: \_\_\_\_\_

Alarms set for: Severe Low: \_\_\_\_\_ Low: \_\_\_\_\_ High: \_\_\_\_\_

Predictive alarm: Low: \_\_\_\_\_ High: \_\_\_\_\_ Rate of change: Low: \_\_\_\_\_ High: \_\_\_\_\_

Threshold suspend setting: \_\_\_\_\_

CGM may be used for insulin calculation if glucose is between \_\_\_\_ - \_\_\_\_ mg/dL \_\_\_\_ Yes \_\_\_\_ No

CGM may be used for hypoglycemia management \_\_\_\_ Yes \_\_\_\_ No

CGM may be used for hyperglycemia management \_\_\_\_ Yes \_\_\_\_ No

### Additional information for student with CGM

- Insulin injections should be given at least three inches away from the CGM insertion site.
- Do not disconnect from the CGM for sports activities.
- If the adhesive is peeling, reinforce it with approved medical tape.
- If the CGM becomes dislodged, return everything to the parents/guardians. Do not throw any part away.
- Refer to the manufacturer's instructions on how to use the student's device.

Student's self-care CGM skills	Independent?	
The student troubleshoots alarms and malfunctions.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The student knows what to do and is able to deal with a HIGH alarm.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The student knows what to do and is able to deal with a LOW alarm.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The student can calibrate the CGM.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The student knows what to do when the CGM indicates a rapid trending rise or fall in the blood glucose level.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

The student should be escorted to the nurse if the CGM alarm goes off: ☐ Yes ☐ No

Other instructions for the school health team:



## Hypoglycemia treatment

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

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If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than \_\_\_\_\_ mg/dL, give a quick-acting glucose product equal to \_\_\_\_\_ grams of carbohydrate.

Recheck blood glucose in 15 minutes and repeat treatment if blood glucose level is less than \_\_\_\_\_ mg/dL.

Additional treatment:

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If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerk movement):

- Position the student on his or her side to prevent choking.
- Administer glucagon Name of glucagon used: \_\_\_\_\_

Injection:

- ☐ 1 mg ☐ ½ mg ☐ Other (dose) \_\_\_\_\_
- Route: ☐ Subcutaneous (SC) ☐ Intramuscular (IM)
- Site for glucagon injection: ☐ Buttocks ☐ Arm ☐ Thigh ☐ Other: \_\_\_\_\_

Nasal route:

- ☐ 3 mg
- Route: ☐ Intranasal (IN)
- Site: ☐ Nose

- Call 911 (Emergency Medical Services) and the student's parents/guardians.
- Contact the student's health care provider.
- If on insulin pump, stop by placing mode in suspend or disconnect. Always send pump with EMS to hospital.

## Hyperglycemia treatment

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

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- Check ☐ Urine ☐ Blood for ketones every \_\_\_\_\_ hours when blood glucose levels are above \_\_\_\_\_ mg/dL.
- For blood glucose greater than \_\_\_\_\_ mg/dL AND at least \_\_\_\_\_ hours since last insulin dose, give correction dose of insulin (see correction dose orders).
- Notify parents/guardians if blood glucose is over \_\_\_\_\_ mg/dL.
- For insulin pump users: see **Additional Information for Student with Insulin Pump**.
- Allow unrestricted access to the bathroom.
- Give extra water and/or non-sugar-containing drinks (not fruit juices): \_\_\_\_\_ ounces per hour.

Additional treatment for ketones: \_\_\_\_\_

- Follow physical activity and sports orders. (See **Physical Activity and Sports**)

If the student has symptoms of a hyperglycemia emergency, call 911 (Emergency Medical Services) and contact the student's parents/guardians and health care provider. Symptoms of a hyperglycemia emergency include: dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy or depressed level of consciousness.

## Insulin therapy

### Insulin delivery device:

☐ Syringe

☐ Insulin pen

☐ Insulin pump

### Type of insulin therapy at school:

☐ Adjustable (basal-bolus) insulin

☐ Fixed insulin therapy

☐ No insulin

### Adjustable (Basal-bolus) Insulin Therapy

- **Carbohydrate Coverage/Correction Dose:** Name of insulin: \_\_\_\_\_

- **Carbohydrate Coverage:**

**Insulin-to-carbohydrate ratio:**

**Breakfast:** 1 unit of insulin per \_\_\_\_\_ grams of carbohydrate

**Lunch:** 1 unit of insulin per \_\_\_\_\_ grams of carbohydrate

**Snack:** 1 unit of insulin per \_\_\_\_\_ grams of carbohydrate

#### Carbohydrate Dose Calculation Example

$$\frac{\text{Total Grams of Carbohydrate to Be Eaten}}{\text{Insulin-to-Carbohydrate Ratio}} = \text{_____ Units of Insulin}$$

**Correction Dose:** Blood glucose correction factor (insulin sensitivity factor) = \_\_\_\_\_

Target blood glucose = \_\_\_\_\_ mg/dL

#### Correction Dose Calculation Example

$$\frac{\text{Current Blood Glucose} - \text{Target Blood Glucose}}{\text{Correction Factor}} = \text{_____ Units of Insulin}$$

**Correction dose scale** (use instead of calculation above to determine insulin correction dose):

Blood glucose \_\_\_\_\_ to \_\_\_\_\_ mg/dL, give \_\_\_\_\_ units    Blood glucose \_\_\_\_\_ to \_\_\_\_\_ mg/dL, give \_\_\_\_\_ units

Blood glucose \_\_\_\_\_ to \_\_\_\_\_ mg/dL, give \_\_\_\_\_ units    Blood glucose \_\_\_\_\_ to \_\_\_\_\_ mg/dL, give \_\_\_\_\_ units

See the worksheet examples in **Advanced Insulin Management: Using Insulin-to-Carb Ratios and Correction Factors** for instructions on how to compute the insulin dose using a student's insulin-to-carb ratio and insulin correction factor.

## Insulin therapy (continued)

### When to give insulin:

#### Breakfast

- ☐ Carbohydrate coverage only
- ☐ Carbohydrate coverage plus correction dose when blood glucose is greater than \_\_\_\_\_ mg/dL and \_\_\_\_\_ hours since last insulin dose.
- ☐ Other: \_\_\_\_\_

#### Lunch

- ☐ Carbohydrate coverage only
- ☐ Carbohydrate coverage plus correction dose when blood glucose is greater than \_\_\_\_\_ mg/dL and \_\_\_\_\_ hours since last insulin dose.
- ☐ Other: \_\_\_\_\_

#### Snack

- ☐ No coverage for snack
- ☐ Carbohydrate coverage only
- ☐ Carbohydrate coverage plus correction dose when blood glucose is greater than \_\_\_\_\_ mg/dL and \_\_\_\_\_ hours since last insulin dose.
- ☐ Correction dose only: For blood glucose greater than \_\_\_\_\_ mg/dL AND at least \_\_\_\_\_ hours since last insulin dose.
- ☐ Other: \_\_\_\_\_

### Fixed Insulin Therapy Name of insulin: \_\_\_\_\_

- ☐ \_\_\_\_\_ Units of insulin given pre-breakfast daily
- ☐ \_\_\_\_\_ Units of insulin given pre-lunch daily
- ☐ \_\_\_\_\_ Units of insulin given pre-snack daily
- ☐ Other: \_\_\_\_\_

### Basal Insulin Therapy Name of insulin: \_\_\_\_\_

To be given during school hours:

_____ Pre-breakfast dose:	_____ units
_____ Pre-lunch dose:	_____ units
_____ Pre-dinner dose:	_____ units

#### Other diabetes medications:

Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Times given: \_\_\_\_\_

Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Times given: \_\_\_\_\_

**Parents/Guardians authorization to adjust insulin dose:**

- ☐ Yes      ☐ No      Parents/guardians authorization should be obtained before administering a correction dose.
- ☐ Yes      ☐ No      Parents/guardians are authorized to increase or decrease correction dose scale within the following range: +/- \_\_\_\_\_ units of insulin.
- ☐ Yes      ☐ No      Parents/guardians are authorized to increase or decrease insulin-to-carbohydrate ratio within the following range: \_\_\_\_\_ units per prescribed grams of carbohydrate, +/- \_\_\_\_\_ grams of carbohydrate.
- ☐ Yes      ☐ No      Parents/guardians are authorized to increase or decrease fixed insulin dose within the following range: +/- \_\_\_\_\_ units of insulin.

**Student's self-care insulin administration skills:**

- ☐ Independently calculates and gives own injections.
- ☐ May calculate/give own injections with supervision.
- ☐ Requires school nurse or trained diabetes personnel to calculate dose and student can give own injection with supervision.
- ☐ Requires school nurse or trained diabetes personnel to calculate dose and give the injection.

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**Additional information for student with insulin pump**

Brand/model of pump: \_\_\_\_\_ Type of insulin in pump: \_\_\_\_\_

Basal rates during school: Time: \_\_\_\_\_ Basal rate: \_\_\_\_\_ Time: \_\_\_\_\_ Basal rate: \_\_\_\_\_  
Time: \_\_\_\_\_ Basal rate: \_\_\_\_\_ Time: \_\_\_\_\_ Basal rate: \_\_\_\_\_  
Time: \_\_\_\_\_ Basal rate: \_\_\_\_\_

Other pump instructions:

\_\_\_\_\_

\_\_\_\_\_

Type of infusion set: \_\_\_\_\_

Appropriate infusion site(s): \_\_\_\_\_

- ☐ For blood glucose greater than \_\_\_\_\_ mg/dL that has not decreased within \_\_\_\_\_ hours after correction, consider pump failure or infusion site failure. Notify parents/guardians.
- ☐ For infusion site failure: Insert new infusion set and/or replace reservoir, or give insulin by syringe or pen.
- ☐ For suspected pump failure: Suspend or remove pump and give insulin by syringe or pen.

**Physical Activity**

- May disconnect from pump for sports activities: ☐ Yes, for \_\_\_\_\_ hours ☐ No
- Set a temporary basal rate: ☐ Yes, \_\_\_\_\_% temporary basal for \_\_\_\_\_ hours ☐ No
- Suspend pump use: ☐ Yes, for \_\_\_\_\_ hours ☐ No

## Additional information for student with insulin pump (continued)

Student's self-care pump skills	Independent?	
Counts carbohydrates	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculates correct amount of insulin for carbohydrates consumed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Administers correction bolus	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculates and sets basal profiles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculates and sets temporary basal rate	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Changes batteries	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Disconnects pump	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reconnects pump to infusion set	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prepares reservoir, pod and/or tubing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Inserts infusion set	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Troubleshoots alarms and malfunctions	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Meal/Snack	Time	Carbohydrate Content (grams)
Breakfast		_____ to _____
Mid-morning snack		_____ to _____
Lunch		_____ to _____
Mid-afternoon snack		_____ to _____

Other times to give snacks and content/amount: \_\_\_\_\_

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event): \_\_\_\_\_

Parent/guardian substitution of food for meals, snacks and special events/parties permitted.

Special event/party food permitted: ☐ Parents'/Guardians' discretion ☐ Student discretion

### Student's self-care nutrition skills:

- ☐ Independently counts carbohydrates
- ☐ May count carbohydrates with supervision
- ☐ Requires school nurse/trained diabetes personnel to count carbohydrates

### Physical activity and sports

A quick-acting source of glucose such as ☐ glucose tabs and/or ☐ sugar-containing juice must be available at the site of physical education activities and sports.

Student should eat ☐ 15 grams ☐ 30 grams of carbohydrate ☐ other: \_\_\_\_\_

☐ before ☐ every 30 minutes during ☐ every 60 minutes during ☐ after vigorous physical activity

☐ other: \_\_\_\_\_

If most recent blood glucose is less than \_\_\_\_\_ mg/dL, student can participate in physical activity when blood glucose is corrected and above \_\_\_\_\_ mg/dL.

Avoid physical activity when blood glucose is greater than \_\_\_\_\_ mg/dL or if urine/blood ketones are moderate to large.

(See **Administer Insulin** for additional information for students on insulin pumps.)

## Disaster/Emergency and Drill Plan

To prepare for an unplanned disaster, emergency (72 hours) or drill, obtain emergency supply kit from parents/guardians. School nurse or other designated personnel should take student's diabetes supplies and medications to student's destination to make available to student for the duration of the unplanned disaster, emergency or drill.

☐ Continue to follow orders contained in this DMMP.

☐ Additional insulin orders as follows (e.g., dinner and nighttime):

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☐ Other: 

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## Signatures

This Diabetes Medical Management Plan has been approved by:

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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 (student \_\_\_\_\_ 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 contact my child's physician/health care provider.

Acknowledged and received by:

---

Student's Parent/Guardian

Date

---

Student's Parent/Guardian

Date

---

School Nurse/Other Qualified Health Care Personnel

Date

This form was developed by the American Diabetes Association.

October 2019

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