TOOELE COUNTY SCHOOL DISTRICT
HEALTH CARE PLAN
COVER SHEET

Student's Name: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher: _____

Parent/Guardian: _____ Phone: _____

Address: _____

Other Emergency Contacts: #1) _____
Name Phone

#2) _____
Name Phone

Is student in Resource or Special Ed? ☐ yes ☐ no
Does student ride the bus? ☐ yes ☐ no Bus #____

Doctor's Name: _____

Telephone #: _____ Fax #: _____

Medical Diagnosis: _____

- ☐ **Student will carry/self administer medication**
- ☐ **School staff will store and administer medication**
- ☐ **No medication is required**

Medication and/or medical supplies will be located at:

- ☐ **Office**
- ☐ **Student's desk**
- ☐ **Locker**
- ☐ **Teacher's desk**
- ☐ **Student's backpack**
- ☐ **Other _____**

I have read and approve student's healthcare plan.

_____ _____
Principal Date **School Nurse Date**

_____ _____
Teacher/School Staff Date **Teacher/School Staff Date**

_____ _____
Teacher/School Staff Date **Teacher/School Staff Date**

Utah Department of Health/Utah State Office of Education
Glucagon Authorization Form
In accordance with Utah Code 53A-11-604

Student Name: _____
Date of Birth: _____
Name of School: _____ Grade: _____
Name of School District: _____

Health Care Provider Authorization
The above name student is under my care. The medication prescribed for this student to be used in an emergency is:

Name of Medication: Glucagon
Dosage: 1 mg (1ml) Other: _____
Possible Side Effects: nausea/vomiting

Printed Name of Health Care Provider: _____

Signature of Health Care Provider: _____ Date: _____

Parent/Guardian Authorization
I _____ parent/guardian (circle one) of above student certify that Glucagon medication has been prescribed for him/her. I request that the student's public school identify and train school personnel who volunteer to be trained in the administration of Glucagon medication in accordance with Utah Code 53A-11-603. I authorize the administration of Glucagon medication in an emergency to the student in accordance with Utah Code 53A-11-603.

Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date: _____

EMERGENCY CONTACT INFORMATION:
Name: _____ Phone/Cell_____

Name: _____ Phone/Cell _____

Updated: November 2010

Medical Statement to Request Special Meals, Accommodations, and Milk Substitutions

1. School/Agency	2. Site	3. Site Manager & Telephone Number
4. Name of Student		5. Age or Grade
6. Name of Parent or Guardian		7. Telephone Number

8. Check One Box:

☐ Student has a disability which *requires* a special meal or accommodation. (Refer to definitions on reverse side of this form.) A *licensed medical physician* must sign this form.

☐ Student does not have a disability, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. Schools and agencies participating in federal nutrition programs *may* accommodate reasonable requests. A *licensed medical physician, physician's assistant, registered nurse, nurse practitioner, or registered dietitian* must sign this form.

☐ The student does not have a disability. A fluid milk substitution is being requested for the student. Schools and agencies participating in federal nutrition programs *may* choose to accommodate this request by providing a USDA approved fluid milk substitute. A *licensed medical physician, physician's assistant, registered nurse, nurse practitioner, registered dietitian, parent, or guardian* must sign this form.

9. State the disability or medical condition requiring a special meal, accommodation, or fluid milk substitute.

10. If student has a disability, provide a brief description of the major life activity affected by the disability.

11. Diet prescription and/or accommodation: (Please describe in detail to ensure proper implementation.)

12. Indicate texture: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

13. Specific foods to be omitted and substituted. You may attach a sheet with additional information.

A. Foods to be Omitted	B. Foods to be Substituted

14. Adaptive Equipment Needed:

15. Signature of Preparer	16. Printed Name	17. Telephone Number	18. Date
19. Signature of Medical Authority and Credentials	20. Printed Name	21. Telephone Number	22. Date

23. To be completed by the LEA/School: ☐ Additional information needed ☐ Approves request ☐ Denies request

LEA Comments:

This information may be shared with the school nurse or other administrative staff to accommodate the student in all school activities.

Medical Statement to Request Special Meals, Accommodations, and Milk Substitutions

Instructions

This form must be kept on file at the school site. The following instructions are provided to assist in completing this form. If you have specific questions, please contact Kimi Sycamore, RD at 801-974-8380

8. Check One: Check (√) a box to indicate whether a participant has a disability, non-disability, or need for a fluid milk substitute. The appropriate authority must sign based on the request.

9. State Disability or medical condition requiring a special meal, accommodation, or fluid milk substitute: Describe the medical condition that requires a special meal, accommodation, or fluid milk substitute (e.g., juvenile diabetes, allergy to peanuts, PKU, etc.)

10. If Student has a disability, provide a brief description of the major life activity affected by the disability: Describe how the physical or medical condition affects the disability. For example, "Allergy to peanuts causes a life-threatening reaction."

11. Diet prescription and/or accommodation: Describe a specific diet or accommodation that has been prescribed by a physician, or describe the diet modification requested for a non-disabling condition. For example, "All foods must be either in liquid or pureed form. Participant cannot consume any solid foods."

12. Indicate texture: Check (√) a box to indicate the type of food texture required. If no texture modification is needed, check regular.

13. Specific foods to be omitted and substituted: List specific foods to be omitted and substituted. Attach a sheet with additional information if needed.

Foods to be Omitted: List specific foods to be omitted. For example, "peanut butter"

Foods to be Substituted: List specific foods to be substituted. For example, "peanut free soy butter or SunButter®."

14. Adaptive Equipment Needed: Describe specific equipment required to assist the participant with dining. Examples could include: Sippy cup, large handled spoon, wheel-chair accessible furniture, etc.

Definitions

A Person with a Disability- any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

Physical or Mental Impairment-(a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genitor-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

Major Life Activities-functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

Record of Impairment-having a history of, or have been classified (or misclassified) as having a mental or physical impairment that substantially limits one or more major life activities.

***Citations from Section 504 of the Rehabilitation Act of 1973**

USDA Guidelines for Accommodating Special Dietary Needs

Disability-Schools and agencies participating in federal nutrition programs **must** comply with requests for special dietary meals and any adaptive equipment with a documented disability and completed request form.

Non-disability-Schools and agencies participating in federal nutrition programs **may** comply with requests for non-disabling medical conditions. Accommodations will be made on a case-by-case basis. However, if accommodations are made for a specific medical condition, complete requests for the same medical condition must be accommodated.

Fluid Milk Substitutions-Fluid milk substitutions apply to non-disability requests. Schools and agencies participating in federal nutrition program **may** accommodate complete requests with a USDA approved non-milk equivalent. If accommodations are made for one student requesting a fluid milk substitute, accommodations must be made for all students requesting a fluid milk substitute.

This information may be shared with the school nurse or other administrative staff to accommodate the student in all school activities.

TOOELE COUNTY SCHOOL DISTRICT
AUTHORIZATION TO ADMINISTER/CARRY MEDICATION AT SCHOOL
HEALTH CARE PLAN APPROVAL

Student's Name: _____ Date of Birth: _____

According to Utah Code 53A-11-602 and Tooele County School District Policy, medication is not allowed at school until the pertinent information is completed below (see back for Tooele County School District Policy).

NAME OF MEDICATION	DOSAGE	ROUTE	TIME
1.			
2.			
3.			
4.			

- ☐ **Allow student to carry medication(s) and self administer during the school day.**
- ☐ **Have school staff store and/or administer medication(s).**
- ☐ **No medication is required.**

I approve of my patient's/child's healthcare plan and prescribed medications as stated above.

Physician Signature: _____ Date: _____

Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____

ADMINISTERING MEDICATION:

Employees of the Tooele County School District may administer medication to a student during periods when the student is under the control of the school, subject to the following conditions:

1. The District has received a current written and signed request to administer the medication during regular school hours to the student from the parent, legal guardian, or other person having legal control of the student.
2. The student's physician, dentist, nurse practitioner or physician assistant has provided a signed statement describing the medication, method, amount and time schedule for administration and a statement that administration of medication by school employees during periods when the student is under the control of the school is necessary. In the event of a life-threatening emergency a designated school employee may administer prescribed medications to a student without a physician authorization if approved by the school nurse and parent.
3. Administering over-the-counter medications requires a prescribing practitioner statement as well as consent of the parent or guardian. Protocol for administering over-the-counter medications is the same as for administering prescription medications.
4. Oral, topical or inhalant medication may be administered by assigned school personnel. Medications requiring other routes of administration will not be given by school personnel except in emergency situations. In non-emergency situations, medications requiring other routes of administration must be given by a registered nurse.
5. All medication that is to be given at school must be furnished by the parent or guardian and delivered to school by a responsible adult.
6. All prescription medication must be in the original container labeled by the pharmacy with the name of the student, the name of the physician, the name of the medication, the amount to be given (dose) and the duration of the treatment. Over-the-counter drugs must be in the original bottle and labeled with the student's name.
7. All medication provided to the school is to be kept in a secure location under lock and key.
8. Insofar as possible, the Principal, in consultation with the local health department, shall assign one person the responsibility of administering student medication.
9. A record, including the type of medication, amount, the time of day it was administered, must be kept for each student receiving medication at school. The person administering the medication must sign the record each time medication is given.
10. Elementary and middle school students shall not carry or self-administer medication on school premises unless it is expressly ordered by the student's physician because of life threatening circumstances.
11. Authorization for administration of medication by school personnel may be withdrawn by the school at any time following actual notice to the student's parent or guardian.
12. In no circumstance shall a student give another student his or her prescribed or over-the-counter medications while at school or during a school activity.

Utah Code Ann. 53A-11-601

AUTHORIZED EMPLOYEES

The Principal, in consultation with the Superintendent, shall consult with the local Department of Health and other health professionals to determine:

1. Designation of employees who may administer medication.
2. Proper identification and safekeeping of medications.
3. Training of designated employees.
4. Maintenance of records of administration.

Utah Code Ann. 53A-11-601(1)(a)

CIVIL LIABILITY IMMUNITY

School personnel shall substantially comply with the physician's or prescribing practitioner's written statement in order to take full advantage of the immunity from liability granted under Utah Code Ann. 53A-11-601(3).

Utah Code Ann. 53A-11-601(1)

DIABETES – HEALTH CARE PLAN

Student's Name: _____

This Health Care Plan and the appropriate Utah Department of Health Glucagon Authorization Form must be completed by the student's parent/guardian and/or their health care provider and returned to the school nurse or the school secretary. (The Health Care Plan should be individualized to meet the student's specific needs.)

Diabetes is a condition in which the body cannot use or does not produce enough insulin. Without insulin, the body cannot use the blood sugars that are the result of food digestion, and provide the energy for our cells. As a consequence, high levels of sugar build in the blood stream. Diabetes results in too much sugar in the blood.

Type of diabetes (the student's parent/guardian and/or their health care provider should check the appropriate boxes.)

- ☐ Diabetes type I (juvenile onset)
- ☐ Diabetes type II

Medication distributed by (the student's parent/guardian and/or their health care provider should check the appropriate boxes):

- ☐ Insulin injections
- ☐ Pump
- ☐ Oral medications

Diabetic supplies to be kept at school (the student's parent/guardian and/or their health care provider should check appropriate boxes):

- ☐ Blood glucose monitor
- ☐ Testing strips
- ☐ Lancets
- ☐ Snacks
- ☐ Sharps container
- ☐ Other supplies _____

Location of supplies: _____

Blood Glucose Monitoring:

1. Type of meter: _____
2. Location of testing: _____
3. Time(s) of day to test: _____ Test if student is having signs or symptoms of hypoglycemia or hyperglycemia (see below).
4. Student needs assistance/supervision with blood glucose monitoring: ☐ Yes ☐ No
5. Call parent/guardian if blood glucose level is below _____mg/dl or above _____mg/dl.

Insulin/Carbohydrate Ratio:

- ☐ _____ units of insulin for every _____ grams of carbohydrates the student eats.
- ☐ The student will need assistance/supervision counting carbohydrates.

Hypoglycemia (low blood sugar):

- ☐ Mild hypoglycemia – typical symptoms: _____
- ☐ Severe hypoglycemia – typical symptoms: _____

Treatment of hypoglycemia (low blood sugar):

- Give _____ if blood glucose level is _____mg/dl to _____mg/dl.
- Recheck blood glucose in _____ minutes. Repeat treatment if symptoms persist or blood glucose is below ____ mg/dl.
- If more than 45 minutes until lunch, follow with: _____.
- Recheck blood glucose in _____ minutes. Repeat treatment if symptoms persist or blood glucose is below ____ mg/dl.
- If blood glucose is below _____ mg/dl and the student is conscious and able to swallow, give _____.

Hyperglycemia (high blood sugar):

- ☐ Mild hyperglycemia - typical symptoms: _____
- ☐ Severe hyperglycemia – typical symptoms: _____
- ☐ Allow liberal bathroom privileges and increased intake of non-caloric fluids.
- ☐ If student is nauseous, vomiting or lethargic, call parent/guardian or emergency contact immediately.

IF STUDENT IS UNCONSCIOUS, HAVING A SEIZURE (CONVULSION) OR UNABLE TO SWALLOW!:

- **CALL 911 AND ADMINISTER GLUCAGON IMMEDIATELY (if ordered)**
- Then notify the student's parent/guardian or emergency contact and then call the school nurse.

Additional information: _____

_____

_____