Health Conditions/ Medication at School

*****If your child is new to Randolph and has a health condition, or if your current Randolph student has developed a new health condition that we are not aware of yet, please contact Mrs. Wilson at jwilson4@livoniapublicschools.org or Mrs. Wehner at awehner@livoniapublicschools.org as soon as possible *before the first day of school*.**

Dear Families,

Please download the forms your child needs for school, based on their health conditions. New forms must be completed by you and your child's physician each year (dated after the last day of school of the previous school year). Please ensure that the forms include both your signature and your child's doctor's signature. We cannot dispense any medication without these completed forms.

****Note: A "Medication Authorization," which is included in the packets for each health condition, needs to be completed for each medication. Here's a quick link, if your child has more than one medication.*

- *Medication Authorization*

Life-Threatening Food and/or Insect Allergy

- *Allergy IHCP*
- *Medication Authorization*
- *Nut & Seed Restricted Lunch Table Guidelines*
- *Lunch Table Needs Lunchroom Addendum*
- *Parent Medication Drop-Off Checklist*
- *Letter from Principal—Randolph Student Medications at School*

Asthma

- *Medication Authorization*
- *Parent Medication Drop-Off Checklist*
- *Letter from Principal—Randolph Student Medications at School*

Diabetes

- *Diabetes IHCP*
- *Medication Authorization*
- *Parent Medication Drop-Off Checklist*
- *Letter from Principal—Randolph Student Medications at School*

Seizure Disorder

- *Seizure IHCP*
- *Medication Authorization*
- *Parent Medication Drop-Off Checklist*
- *Letter from Principal—Randolph Student Medications at School*

Other

- *Medication Authorization*
- *Parent Medication Drop-Off Checklist*
- *Letter from Principal—Randolph Student Medications at School*
- *Contact Mrs. Wilson at jwilson4@livoniapublicschools.org or Mrs. Wehner at awehner@livoniapublicschools.org*

Please make sure that the forms are very specific. For example, if your doctor says the medication can be distributed "as needed," ask them to define a limit, such as "as needed up to three times in a school day."

It is our hope that all of the forms will be returned to Randolph (or Johnson for current 4th graders) on the first day of school. It is very important that we have all of this information on file in the office and distributed to the staff and teachers to keep your child safe. **Please drop off your child's completed Health Care Plan, Medication Authorization, and medication on the first day of school.**

If you have any questions or would like to set up a meeting to discuss your child's health care plan, please contact Mrs. Wilson at jwilson4@livoniapublicschools.org or Mrs. Wehner at awehner@livoniapublicschools.org (email is the best way to reach us). When school is open, you may also call the Randolph Office at (734) 744-2770 and ask for one of us.

Thank you so much for your support and have a wonderful summer!

Sincerely,

Mrs. Wilson & Mrs. Wehner
Randolph Elementary Support Teachers (ESTs)

INDIVIDUALIZED HEALTH CARE PLAN

Livonia Public Schools

Confidential

Name: School Year:

Health Concern: **DIABETES** ☐ Type I ☐ Type 2

Date of Birth: Student ID:

Case Manager: Ext:

Click Here to Add Picture

Blood Glucose Monitoring

Target blood glucose range _____ mg/dl to _____ mg/dl

Usual times to check blood glucose ________________

Times to do extra blood glucose checks (check all that apply) ☐ before exercise ☐ after exercise

☐ when student exhibits symptoms of hyperglycemia ☐ when student exhibits symptoms of hypoglycemia

☐ other (explain) ________________

Can student perform own blood glucose checks? ☐ Yes ☐ No Exceptions ________________

Type of blood glucose meter student uses ________________

Insulin

Times, types and dosages of insulin injections to be given during school:

Time	Type(s)	Dosage
________	________	________
________	________	________
________	________	________

Can student . . .

give own injections? ☐ Yes ☐ No

determine correct amount of insulin? ☐ Yes ☐ No

draw correct dose of insulin? ☐ Yes ☐ No

For Students with Insulin Pumps

Type of pump ________________

Insulin/carbohydrate ratio ________________

Correction factor ________________

____

Is student competent regarding pump? ☐ Yes ☐ No

Can student effectively troubleshoot problems (i.e. ketosis, pump malfunction, etc.)? ☐ Yes ☐ No

Comments ________________

____

____

Meals and Snacks Eaten at School (The carbohydrate content of the food is important in maintaining a stable blood glucose level)

	Time	Food Content/Amount
Breakfast	________	________
A.M. snack	________	________
Lunch	________	________
P.M. snack	________	________

Snack before exercise? ☐ Yes ☐ No

Snack after exercise? ☐ Yes ☐ No

A source of glucose, such as ________________ should be readily available at all times.

Preferred snack foods ________________

Foods to avoid (if any) ________________

Instructions for when food is provided to the class (i.e. class party or food sampling) ________________

____

Other times to give snacks and content/amount ________________

Exercise and Sports

A snack such as ________________ should be available at the site of exercise or sports.

Restrictions on activity (if any) ________________

Student should not exercise if blood glucose is below ________ mg/dl

INDIVIDUALIZED HEALTH CARE PLAN

Confidential

Livonia Public Schools

Location of Supplies

Blood glucose monitoring equipment ____________________

Insulin administration supplies ____________________

Glucagon emergency kit____________________

Ketone testing supplies ____________________

Other ____________________

____

Hypoglycemia – Low Blood Sugar

Common Causes
Too much insulin
Missed or delayed food
Too much or too intense exercise
Unscheduled exercise

SYMPTOMS

MILD

Hunger
Weakness
Dizziness
Paleness
Shakiness
Confusion
Sweating
Lack of concentration
Poor coordination
Personality or behavior change

Other ____________________

SEVERE

Loss of consciousness
Seizure
Inability to swallow

Other ____________________

ACTION PLAN

MILD BLOOD GLUCOSE < 70

- Provide 15 grams of carbohydrate OR 4 oz. of juice OR 3-4 glucose tablets
- Wait 15 minutes
- Recheck blood glucose
- Repeat treatment if blood glucose is < _____
- If > 1 hour before a meal, give a snack of carbohydrate and protein

SEVERE

- Call 911
- DO NOT give anything by mouth
- Contact trained medical personnel
- Administer Glucagon as prescribed
- Position on side, if possible
- Stay with student
- Contact parents

Hyperglycemia – High Blood Sugar

Common Causes
Too little insulin
Too much food
Decreased activity
Illness / infection or stress

SYMPTOMS

MILD

Increased hunger / thirst
Frequent urination
Fatigue / sleepiness
Blurred vision
Stomach pains
Lack of concentration

Other ____________________

SEVERE

Nausea / vomiting
Moderate or large ketones
Sweet, fruity breath
Labored breathing
Confused
Unconscious

Other ____________________

ACTION PLAN

NEGATIVE KETONES

- Give extra water or sugar free drinks
- Allow use of bathroom as needed
- Encourage exercise
- Inform parents of frequent high readings

TRACE TO SMALL

- Give at least 8 oz. water every hour
- Recheck ketones at next urination

MODERATE TO LARGE

- Call parent
- Encourage water until parent is contacted
- If student has abdominal pain or is nauseous, vomiting, or lethargic, call for medical assistance if parent can't be reached

Emergency Contact Information

Contact # 1 ____________________ Relationship ____________________

Home ____________________ Cell ____________________ Work ____________________

Contact # 2 ____________________ Relationship ____________________

Home ____________________ Cell ____________________ Work ____________________

Student's Doctor ____________________ Work ____________________

Address ____________________ Fax ____________________

The following individuals have reviewed this Health Care Plan and support its implementation.

Parent / Guardian Signature	Date	Administrator Signature	Date	Doctor Signature (required)	Date

Revised 2017

LIVONIA PUBLIC SCHOOLS

15125 Farmington Road ◆ Livonia, Michigan ◆ 48154

Medication Authorization

Student's Name ______________________ Date ______________

Date of Birth ______________________ School ______________

Teacher / Counselor ______________________ Grade ______________

<u>Both</u> prescription and nonprescription medications require a completed Medication Authorization form signed by a physician and parent/guardian. If medication is related to a life-threatening health condition, Livonia Public Schools staff will develop an Individualized Health Care Plan in conjunction with the student's physician.

TO BE COMPLETED BY THE PHYSICIAN

Name of Medication ______________________ ☐ Prescription ☐ Non-Prescription

Reason for Medication ______________________

Form of Treatment ☐ Tablet / Capsule ☐ Inhaler ☐ Liquid ☐ Injection ☐ Nebulizer

Instructions ______________________

Dosage ______________________

Time of Day ☐ Daily ☐ As Needed ☐ Emergency Only ☐ Other - ______________

If dosage is "as needed" or "emergency only" specify symptoms and limits: ______________________

Relevant Side Effects ______________________

Storage Requirements ☐ None ☐ Refrigerate ☐ Other - ______________

Student is capable and responsible for self-possession and self-administering: ☐ Inhaler ☐ Emergency Meds

Please indicate if you have provided additional information: ☐ On the back of this form ☐ As an attachment

Physician's Name ______________________ Phone ______________

Address ______________________ Fax ______________

____

______________________ ______________

Physician's Signature Date

TO BE COMPLETED BY THE PARENT / GUARDIAN

I request that ______________________ (Student's Name)

☐ receive the above medication at school according to district policy.

☐ be allowed to self-administer the above medication (inhaler or emergency medication) at school according to district policy.

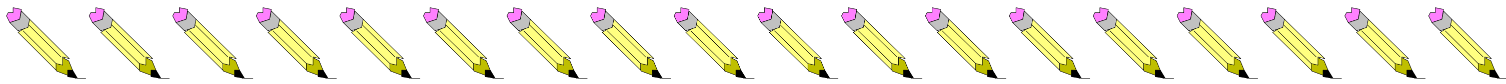
☐ I authorize school personnel to contact the above physician with questions or concerns relative to this authorization and medication.

______________________ ______________

Parent / Guardian's Signature Date

NOTES

① Medication includes prescription, non-prescription and herbal medications, and includes those taken by mouth, by inhaler, those that are injectable, and those applied as drops to eyes, nose, or medications applied to the skin.
② Medications must be in an appropriately labeled container.
③ This authorization is valid for the current school year only.
④ This authorization must be maintained with the Individual Student Medication Log.
⑤ It will be the student's responsibility to make contact with school personnel for the administration of medication, unless other arrangements have been made by the administrator.



Child's Name:____

Parent's Name:____

Parent Medication Drop Off

Please put a check on each line, once you confirm that the following information is true:

_____ 1. I have checked the expiration dates on the medication I am turning in to make sure that they will NOT expire during this school year. If that is not possible, I have marked my calendar to remind myself to bring new medication to school before the old one expires.

_____2. I have a Medication Authorization completed for EACH medication I am turning in to the Randolph office.

_____3. I have checked to make sure that the name of the medication I am giving Randolph matches the name on the Medication Authorization form (and the Health Care Plan, if the child has one). (For example, we cannot accept an EpiPen if the doctor listed Auvi-Q.)

_____4. There is a prescription label with my child's name on it for every prescription medication I am giving Randolph.

_____5. If I am giving Randolph prescription pills, I have counted to make sure that the number of pills in the bottle matches the number of pills on the prescription label typed in by the pharmacist.

_____6. I am giving Randolph every medication that is listed by the doctor on the Health Care Plan (if my child has a Health Care Plan).

_____7. I have made sure that the doctor signed every form I am giving Randolph.

_____8. I have signed and dated every form I am giving Randolph.

_____9. If my child has a nut or seed allergy, I have completed the Lunchroom Addendum.

_____10. If I have requested my child to sit at the Nut-Restricted & Seed-Restricted Lunch Table, I have signed the Nut-Restricted and Seed-Restricted Lunch Table Guidelines Contract.

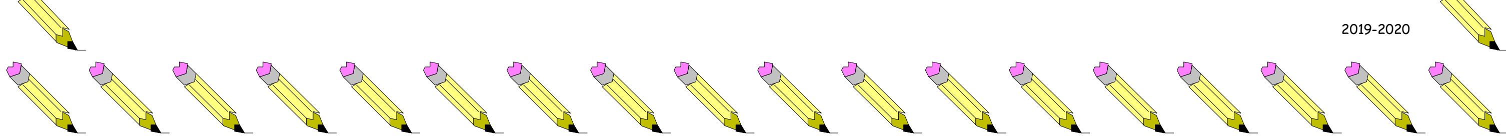
_____11. I have provided my email address and phone number where I can be contacted for questions.

email address:______________________________ phone number:____________________

Please return this form to the Randolph office when you drop off your medications and your forms. Thank you!

Parent Signature____ Date__________

2019-2020



Randolph Elementary School

Livonia Public Schools
14470 Norman Street, Livonia, MI 48154
Phone: 734.774.2770 Fax: 734.744.2772

Mike Daraskavich, Principal

Dear Parents:

It is recognized that certain medications may be necessary and must be prescribed at certain times of the day. In many instances, the administration of medication can be adjusted to avoid the necessity of administration during school hours. However, there may be instances when medication must be administered to your child during school hours.

When medication is necessary during school hours:

1. It may be necessary and appropriate for a parent or guardian to administer medication to his/her child. Please contact the school office to make appropriate arrangements.
2. If school personnel will be administering medication, the accompanying Medication Authorization form must be completed by the student's physician and parent or guardian and returned to the school office before administration of medication. This authorization is valid for the current school year only.
3. It will be the student's responsibility to make contact with the designated staff member for the administration of medication unless other arrangements have been agreed to by the building principal.
4. "As needed" medication requires a physician's statement specifying dosage limits.
5. All medications to be administered at school must be in an original appropriately labeled container. (Must specify student name, medication name, frequency, and dosage to be given.)
6. Both prescription and nonprescription medications require a completed physician and parental/guardian authorization form.
7. All medications that are to be administered by school personnel must be brought to school and immediately turned in the school office. Inhalers or medication for life threatening situations may be maintained by the student or in other locations as approved by the building administrator.
8. All controlled-substance medications (defined as drugs regulated by the Federal Controlled Substances Acts, including opiates, depressants, stimulants, and hallucinogens) will be counted and recorded upon receipt with the parent/guardian.
9. Medication left over at the end of the school year, or after the student has left the district, shall be picked up by the parent/guardian. If this is not done, the individual who administers the medication will dispose of the medication and record this disposal on the medication log.
10. Individual exceptions to these procedures must be approved by the building principal.

Thank you for your cooperation. If you have any questions or concerns, please contact your building principal.

Sincerely,

Michael Daraskavich
Principal, Randolph Elementary

We Are A Leader In Me School! The 7 Habits of Randolph Leaders:

Be Proactive (You're in Charge) - - - Begin With The End In Mind (Have a Plan)
Put First Things First (Work First, Then Play) - - - Think Win-Win (Everyone Can Win)
Seek First to Understand, Then to Be Understood (Listen Before You Talk) - - - Synergize (Together Is Better)
Sharpen the Saw (Take Care of Yourself)