MANCOMUNIDAD DE VIRGINIA

FORMULARIO DE SALUD PARA EL INGRESO ESCOLAR

Formulario de información médica/Informe de examen físico integral/Certificación de vacunación

Parte I – FORMULARIO DE INFORMACIÓN MÉDICA

La ley estatal (Código de Virginia Ref. § 22.1-270) requiere que su hijo esté vacunado y reciba un examen físico integral antes de ingresar al kínder o escuela primaria pública. **El padre/madre o tutor completa esta página (Parte I) del formulario.** El proveedor médico completa la Parte II y la Parte III del formulario. Este formulario debe completarse no más de un año antes del ingreso de su hijo a la escuela.

Nombre de la escuela: _____ Grado actual: _____

Nombre del estudiante: _____
Apellido Nombre Segundo nombre

Fecha nacimiento del estudiante: ___/___/____ Sexo: _____ Estado o país de nacimiento: _____ Idioma principal que habla: _____

Dirección del estudiante _____ Ciudad _____ Estado _____ Código Postal _____

Nombre del padre/madre o tutor legal 1: _____ Teléfono: ____-____-____ Trabajo/celular: ____-____-____

Nombre del padre/madre o tutor legal 2: _____ Teléfono: ____-____-____ Trabajo/celular: ____-____-____

Contacto de emergencia: _____ Teléfono: ____-____-____ Trabajo/celular: ____-____-____

Preferencia de hospital: _____

Seguro médico del niño: Ninguno ☐ FAMIS Plus (Medicaid) ☐ FAMIS ☐ Privado/comercial/patrocinado por el empleador ☐ _____

Cuadro 1. Afecciones preexistentes

Afección	Sí	Comentarios	Afección	Sí	Comentarios
Alergias (alimentos, insectos, medicamentos,látex). Indique **alergias potencialmente mortales**:			Diabetes: Tipo 1		
			Diabetes: Tipo 2		
			Bomba de insulina		
Alergias (estacionales)			Traumatismo craneal, conmoción cerebral		
Asma o afecciones respiratorias			Afecciones auditivas o sordera		
Trastorno por déficit de atención/hiperactividad			Afecciones cardíacas		
Afecciones conductuales/psíquicas/sociales			Intoxicación con plomo		
Afecciones del desarrollo			Afecciones musculares		
Afecciones de la vejiga			Convulsiones		
Afecciones de sangrado			Anemia de células falciformes (no trazas)		
Afecciones intestinales			Afecciones del habla		
Parálisis cerebral			Lesión de la médula espinal		
Fibrosis quística			Cirugía		
Afecciones de la salud dental			Afecciones de la vista		

Describa cualquier otra información importante relacionada con la salud de su hijo (☐ Sonda de alimentación, ☐ Traqueostomía, ☐ Aporte suplementario de oxígeno, ☐ Audífonos, ☐ Aparato dental, Silla de ruedas, Hospitalizaciones, etc.):

Cuadro 2. Medicamentos

Enumere todos los medicamentos recetados, de emergencia, de venta libre y hierbas medicinales que su hijo toma con regularidad (hogar/escuela):

Nombre del medicamento	Dosis	Hora de administración (hogar/escuela)	Notas
1.			
2.			
3.			
4.			
Medicamentos adicionales (nombre, dosis, hora de administración, notas)			

Marque aquí si desea discutir información confidencial con la enfermera de la escuela u otra autoridad escolar. ☐ Sí ☐ No Proporcione la siguiente información:

	Nombre	Teléfono	Fecha de la última cita
Pediatra/proveedor de atención primaria			
Especialista			
Dentista			
Trabajador del caso (si corresponde)			

Yo _____ (autorizo) (no autorizo) al proveedor de atención de salud de mi hijo y al proveedor de atención de salud designado en el entorno escolar para discutir las preocupaciones de salud de mi hijo o intercambiar información relacionada con este formulario. Esta autorización estará vigente hasta que usted la retire. Puede retirar su autorización en cualquier momento comunicándose con la escuela de su hijo. Cuando se divulga información del expediente de su hijo, la documentación de la divulgación se mantiene en el expediente académico o de salud de su hijo.

Firma del padre/madre o tutor legal: _____ Fecha: ____/____/____

Firma del intérprete: _____ Fecha: ____/____/____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization

Part I – HEALTH INFORMATION FORM

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no earlier than one year before your child's entry into school.

Name of School: _____ Current Grade: _____

Student's Name: _____
Last First Middle

Student's Date of Birth: ____/____/_____ Sex: _____ State or Country of Birth: _____ Main Language Spoken: _____

Student's Address _____ City _____ State _____ Zip Code _____

Name of Parent or Legal Guardian 1: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Name of Parent or Legal Guardian 2: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Emergency Contact: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Hospital Preference: _____

Child's Health Insurance: None☐ FAMIS Plus (Medicaid) ☐ FAMIS ☐ Private/Commercial/ Employer Sponsored☐ _____

Box 1. Pre-Existing Conditions

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes: Type 1		
Please list **Life Threatening Allergies**:			Diabetes: Type 2		
			Insulin pump		
Allergies (seasonal)			Head injury, concussion		
Asthma or breathing conditions			Hearing conditions or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart conditions		
Behavioral/Psych/ Social conditions			Lead poisoning		
Developmental conditions			Muscle conditions		
Bladder conditions			Seizures		
Bleeding conditions			Sickle Cell Disease (not trait)		
Bowel conditions			Speech conditions		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental Health conditions			Vision conditions		

Describe any other important health-related information about your child (⊓ Feeding tube , ⊓ Trach , ⊓ Oxygen support, ⊓ Hearing aids, ⊓ Dental appliance, ⊓ Wheelchair, Hospitalizations, etc.):

Box 2. Medications

List all prescription, emergency, over-the-counter, and herbal medications your child takes regularly (Home/ School):

Medication Name	Dosage	Time Administered (Home/School)	Notes
1.			
2.			
3.			
4.			

Additional Medications (Name, Dose, Time Administered, Notes)

Check here if you want to discuss confidential information with the school nurse or other school authority. ☐ Yes ☐ No Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Case Worker (if applicable)			

I _____ (do) (do not) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.

Signature of Parent or Legal Guardian: _____ Date: ____/____/_____

Signature of Interpreter: _____ Date ____/____/_____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Part II - Certification of Immunization

Check if the student's Immunization Records are attached using a separate form signed by HCP ☐

Section I

See Section II for conditional enrollment and exemptions.

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box. Please contact your local health department for assistance with foreign vaccine records.

Student Name: **Date of Birth :** / / **Sex:**

Race (Optional): **Ethnicity:** **Hispanic** **Non-Hispanic**

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
Diphtheria, Tetanus, Pertussis Vaccine (DTP, DTaP)	1	2	3	4	5
Diphtheria, Tetanus (DT) or Tdap or Td Vaccine (given after 7 years of age)	1	2	3	4	5
Tdap Vaccine booster	1				
Poliomyelitis Vaccine (IPV, OPV)	1	2	3	4	5
Haemophilus influenzae Type b Vaccine (Hib conjugate) only for children <60 months of age	1	2	3	4	
Rotavirus Vaccine (RV) only for children < 8 months of age	1	2	3		
Pneumococcal Vaccine (PCV conjugate) only for children <60 months of age	1	2	3	4	
Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Measles, Mumps, Rubella Vaccine (MMR vaccine)	1	2			
Measles Vaccine (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
Rubella Vaccine	1	2	Serological Confirmation of Rubella Immunity:		
Mumps Vaccine	1	2	Serological Confirmation of Mumps Immunity:		
Hepatitis **B** Vaccine (HBV) ☐ Merck adult formulation used	1	2	3	4	
Hepatitis **A** Vaccine	1	2			
Meningococcal **ACWY** Vaccine	1	2			
Meningococcal **B** Vaccine	1	2	3		
Human Papillomavirus Vaccine (HPV)	1	2	3		
Influenza (Yearly)	1	2	3	4	5
Other	1	2	3	4	5
Other	1	2	3	4	5

Certification of Immunization

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (Reference Section III).

Signature of Medical Provider or Health Department Official:_____ **Date (*Mo., Day, Yr.*):** __/__/____

Section II
Conditional Enrollment and Exemptions

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date. This section must be attached to Part I Health Information (to be filled out and signed by parent).

Student's Name: _____ Date of Birth: |____|____|_____|
Parent or Legal Guardian Name: _____
Parent or Legal Guardian Name: _____
Phone Number: _____

MEDICAL EXEMPTION: As specified in the *Code of Virginia* § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

_____

_____

_____

DTP/DTaP/Tdap :[____]; DT/Td:[____]; OPV/IPV:[____]; Hib:[____]; PCV:[____]; RV:[____]; Measles :[____];

Mumps:[____]; Rubella :[____]; VAR:[____]; Men ACWY:[____]; Men B:[____]; Hep A:[____]; HBV:[____]

This contraindication is permanent: [ ], or temporary [ ] and expected to preclude immunizations until: Date (*Mo., Day, Yr.*): |____|____|____|.

Signature of Medical Provider or Health Department Official:_____Date (*Mo., Day, Yr.*):___/___/___

RELIGIOUS EXEMPTION: The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

CONDITIONAL ENROLLMENT: As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on_____.

Signature of Medical Provider or Health Department Official:_____Date (*Mo., Day, Yr.*):|___|___|___|

Section III Requirements

For Minimum Immunization Requirements for Entry into School and Day Care, consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization

Children shall be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), otherwise known as ACIP recommendations (Ref. *Code of Virginia* § 32.1-46(a))
(Requirements are subject to change.)

Part III – COMPREHENSIVE PHYSICAL EXAMINATION REPORT

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at www.vahealth.org/schoolhealth.

Student's Name: _____ Date of Birth: ____/____/____ Sex: ☐ M ☐ F

Health Assessment

Date of Assessment: ____/____/____

Weight:_____lbs. Height:_____ft._____in.

Body Mass Index (BMI):_____BP_____

☐ Age / gender appropriate history completed

☐ Anticipatory guidance provided

Physical Examination

1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment

	1	2	3		1	2	3		1	2	3	
HEENT				Neurological				Skin				
Lungs				Abdomen				Genital				
Heart				Extremities				Urinary				

Tuberculosis Screening

Check the box that applies:

☐ No risk for TB infection identified	☐ No symptoms compatible with active TB disease	☐ Risk for TB infection or symptoms identified

Test for TB Infection: TST IGRA Date:_____ TST Reading____ mm TST/IGRA Result: ☐ Negative ☐ Positive

CXR required if positive test for TB infection or TB symptoms. CXR Date:_____ ☐ Normal ☐ Abnormal

EPSDT Screens Required for Head Start – include specific results and date:

Blood Lead:_____ Hct/Hgb _____

Developmental Screen

Assessed for:	*Assessment Method:*	*Within normal*	*Concern identified:*	*Referred for Evaluation*
Emotional/Social				
Problem Solving				
Language/Communication				
Fine Motor Skills				
Gross Motor Skills				

Hearing Screen

☐ Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.

☐ Screened by OAE (Otoacoustic Emissions): ☐ Pass ☐ Referred

	1000	2000	4000
R			
L			

☐ Referred to Audiologist/ENT ☐ **Unable to test – needs rescreen**

☐ Permanent Hearing Loss Previously identified: ☐ Left ☐ Right

☐ Hearing aid or another assistive device

Vision Screen

☐ With Corrective Lenses (Check if yes)

Stereopsis ☐ Pass ☐ Fail				☐ Not tested
Distance	Both	R	L	Test used:
	20/	20/	20/	

☐ Pass ☐ Referred to eye doctor ☐ **Unable to test-needs rescreen**

Dental Screen

☐ Problems Identified: Referred for Treatment

☐ No Problem: Referred for prevention

☐ No Referral: Already receiving dental care

☐ **Unable to perform**

Recommendations to (Pre) School, Child Care, or Early Intervention Personnel

Summary of Findings (check one):

☐ Well child; no conditions identified of concern to school program activities

☐ Conditions identified that are important to schooling or physical activity (complete sections below and/or explain here):

_____

Allergy: ☐ food:_____ ☐ insect:_____ ☐ medicine:_____ ☐ other:_____

Type of allergic reaction: ☐ *anaphylaxis* ☐ *local reaction* *Response required:* ☐ *none* ☐ *epinephrine auto-injector* ☐ other::_____

Individualized Health Care Plan needed (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)

Restricted Activity Specify: :_____

Developmental Evaluation ☐ Has IEP ☐ Further evaluation needed for: _____

Medication. Child takes medicine for specific health condition(s). ☐ Medication must be given and/or available at school.

Special Diet Specify: _____

Special Needs Specify:_____

Other Comments:_____

Health Care Professional's Certification (Write legibly or stamp) ☐ **By checking this box, I certify with an electronic signature that all of the information entered above is accurate (enter name and date on signature and date lines below).**

Name:_____ **Signature:**_____ **Date:**_____

Practice/Clinic Name: _____ **Address:**_____

Phone:_____-_____-_____ **Fax:** _____-_____-_____ **Email:**_____

Medication Authorization Form

For Prescription and Non-prescription Medications

VDSS Division of Licensing Programs Model Form

VIRGINIA DEPARTMENT OF SOCIAL SERVICES

INSTRUCTIONS:

- **Section A** must be completed by the parent/guardian for **ALL** medication authorizations.
- **Section A and Section B** must be completed for any **long-term medication authorizations** (those lasting longer than 10 working days).

Section A: To be completed by parent/guardian

Medication authorization for: _____
(Child's name)

_____ has my permission to administer the following medication:
(Name of Child Care Provider)

Medication name: _____

Dosage and times to be administered: _____

Special instructions (if any): _____

_____

This authorization is effective from: _____ until: _____
(Start date) **(End date)**

Parent's or Guardian's Signature: _____ **Date:** _____

Section B: to be completed by child's physician

I, _____ certify that it is medically necessary for the medication(s) listed
(Name of Physician)

below to be administered to: _____ for a duration that exceeds 10 work days.
(Child's name)

Medication(s): _____

Dosage and Times to be administered: _____

Special instructions (if any): _____

_____

This authorization is effective from: _____ until: _____
(Start date) **(End date)**

Physician's Signature: _____ **Date:** _____

Physicians Phone: _____

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

Attach child's photo

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)

IMPORTANT REMINDER
Anaphylaxis is a potentially life-threating, 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 than13 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
DEDICATED TO THE HEALTH OF ALL CHILDREN®

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: _____

VIRGINIA PEDIATRIC ASTHMA ACTION PLAN

Child Name:	
DOB:	
School Year:	
Healthcare Provider	
Contact Number:	

EMERGENCY CONTACT

Name:	Phone:
Relationship:	

Additional info:

GREEN ZONE: GO!

- No trouble breathing
- No cough or wheeze
- Sleeps well
- Can play as usual

☐ **Daily Maintenance/Controller** — **Day puffs** — **Night puffs**

☐ Montelukast/Singulair Mg once daily.

Use controller daily, even when I feel fine. Use a spacer if recommended.

For Asthma with exercise add: puffs (with spacer if needed) 15 minutes prior to exercise:

And ☐ Ipratropium ☐ Only if needed

YELLOW ZONE: Caution!

- Cough, wheeze, chest tightness
- Waking at night due to asthma
- Problems sleeping, working, or playing

Add: quick-relief medicine—to your GREEN ZONE medicines.

First

Your quick reliever medicine(s) is: or

Take: puffs or ☐ Nebulizer every – 20 minutes if needed for up to 1 hour. If your symptoms resolve return to GREEN ZONE.

Second

If your symptoms continue or return within a few hours of above treatment, take:

☐ Puffs every 4-6 hours as needed until symptoms resolve.

☐ Continue every 4-6 hours daily for days.

☐ Add:

Call Healthcare Provider if you need quick-relief medicine for more than 24 hours or if quick-relief medicine does not work.

You should not use more than 8 puffs for ages 4-11 or 12 puffs ICS/formoterol for ages 12+ a day.

RED ZONE: DANGER!

- Can't talk, eat, walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Nonstop cough
- Ribs show

CALL 911 Now/Go to the Emergency Department!

Continue CONTROL & RELIEVER Medicines every 15 minutes for 3 treatments total – while waiting for help.

Take: ☐ 2 puffs ☐ 4 puffs ☐ 6 puffs or ☐ nebulizer

I approve and give permission for school personnel to follow this asthma management plan of care for my child, contact my child's healthcare provider when needed, and administer medication per the healthcare providers orders. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. With HCP authorization & parental consent, the inhaler will be located: ☐ in clinic or ☐ with student (self-carry).

Parent/Guardian signature Date

School Nurse/Staff Signature Date

SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER

☐ Student may carry and self-administer inhaler at school.

☐ Student needs assistance & should not self-carry.

MD/NP/PA signature Date

Approved June 2023, Virginia Asthma Action Plan Expert Group convened by the Consortium for Infant and Child Health at Eastern Virginia Medical School.

Updated March 2024

SEIZURE ACTION PLAN (SAP)

EPILEPSY FOUNDATION

Name: _____ **Birth Date:** _____

Address: _____ **Phone:** _____

Emergency Contact/Relationship: _____ **Phone:** _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

How to respond to a seizure (check all that apply)

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify emergency contact
- ☐ Notify emergency contact 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 _____

epilepsy.com

 Revised 03/2023 130SRP/PAB1216

Care after seizure

What type of help is needed? (describe)

When is person 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:

 Revised 03/2023 130SRP/PAB1216

EPILEPSY FOUNDATION

Name: _____ DOB: _____ Date: _____ School Year: _____ -_____

Virginia Diabetes Medical Management Plan (DMMP)

Adapted from the National Diabetes Education Program DMMP (2019)

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.

Student information

Student's name:	Date of birth:
Date of diabetes diagnosis:	☐ Type 1 ☐ Type 2 ☐ Other:
School name:	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 Contact	**Relationship to Student:**	
Telephone: : Home: _____	Work: _____	Cell: _____
Email address:		

Suggested Supplies to Bring to School

• Glucose meter, testing strips, lancets, and batteries for the meter • Insulin(s), syringes, and/or insulin pen(s) and supplies • Insulin pump and supplies in case of failure: Reservoirs, sets, prep wipes, pump batteries / charging	• Treatment for low blood sugar (see page 3) • Protein containing snacks: such as granola bars • Glucagon emergency kit • Antiseptic wipes or wet wipes • Water • Urine and/or blood ketone test strips and meter • Other medication

Name: _____ DOB: _____Date: _____ School Year: _____ -_____

Student's Self-care Skills

Blood Glucose:

☐ Independently checks own blood glucose

☐ May check blood glucose with supervision

☐ Requires school nurse or trained diabetes personnel to check blood glucose

☐ Uses a smartphone or other monitoring technology to track blood glucose values

Insulin Administration:

☐ Independently calculates / gives own injections

☐ May calculate / give own injections with direct supervision to confirm glucose and insulin dose

☐ 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

Nutrition:

☐ Independently counts carbohydrates

☐ May count carbohydrates with supervision

☐ Requires school nurse/trained diabetes personnel to count carbohydrates

☐ Parents'/Guardians' discretion for **special event/party food**

☐ Student discretion for **special event/party food**

Parents / Guardians Authorization to Adjust Insulin Dose

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 from: ____ unit(s) for every _____grams of carbohydrate **to** ____ unit(s) for every _____grams of carbohydrate	☐ Yes	☐ No
Parents/guardians are authorized to increase or decrease fixed insulin dose within the following range: +/- _____ units of insulin.	☐ Yes	☐ No

Checking Blood Glucose

Target Blood Glucose: ❑ Before Meal _____ - _____ mg / dL ❑Other _____ - ____mg/dL

☐ Before breakfast	❑ Before lunch	☐ Before PE	❑ As needed for signs/symptoms of illness
❑ _____ Hours after breakfast	☐ _____ Hours after lunch	☐ After PE	❑ As needed for signs/symptoms of high/low blood glucose
☐ _____Hours after correction dose	☐ Before dismissal	☐ Other: _____	

Name: _____ DOB: _____ Date: _____ School Year: _____ -_____

Continuous Glucose Monitoring (CGM)

☐ Yes ☐ No Brand/model: _____

Alarms set for: ☐ Severe Low: _____ ☐ Low: _____ ☐ High: _____

Predictive alarm: ☐ Rapid Fall: _____ ☐ Rapid Rise: _____

Student/School Personnel may use CGM for insulin calculation

if glucose reading between _____-_____mg/dL ☐ Yes ☐ No

Student/School Personnel may use CGM for hypoglycemia and hyperglycemia management ☐ Yes ☐ No

(Refer to Hypoglycemia and Hyperglycemia section of this document once confirmed)

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 any medical adhesive or tape the parent / guardian has provided.
- If the CGM becomes dislodged, remove, and return everything to the parents/guardian. Do not throw anything away. Check glucose by finger stick until CGM is replaced / reinserted by parent/guardian.
- Refer to the manufacturer's instructions on how to use the student's device.

Student's Self-care CGM Skills	Independent?	
The student is able to troubleshoot alarms and alerts	☐ Yes	☐ No
The student is able to respond to HIGH alarm.	☐ Yes	☐ No
The student is able to respond to LOW alarm.	☐ Yes	☐ No
The student is able to adjust alarms.	☐ Yes	☐ No
The student is able to calibrate the CGM.	☐ Yes	☐ No
The student is able to respond when the CGM indicates a rapid trending rise or fall in the blood glucose level.	☐ Yes	☐ No
School nurse or trained personnel notified if CGM alarms	☐ High	☐ Low
Other instructions for the school health team:		

Physical activity and sports

A quick-acting source of glucose must be available at the site of physical education activities and sports.
Examples include glucose tabs, juice, glucose gel, gummies, skittles, starbursts, cake icing.
Student should eat:

Carbohydrate Amount	Before	Every 30 minutes	Every 60 minutes	After activity	Per Parent
15 grams	☐	☐	☐	☐	☐
30 grams	☐	☐	☐	☐	☐

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

AND / OR if urine ketones are moderate to large / blood ketones are > 1.0 mmol/L.

For insulin pump users: see **"Additional Information for Student with Insulin Pump", page 7".**

Name: _____ DOB: _____ Date: _____ School Year: _____ - _____

Hypoglycemia (Low Blood Glucose)

Hypoglycemia: Any blood glucose below _____ mg / dL checked by blood glucose meter or CGM.

Student's usual symptoms of hypoglycemia (circled):

Hunger	Sweating	Shakiness	Paleness	Dizziness
Confusion	Loss of coordination	Fatigue	Irritable/Anger	Crying
Headache	Inability to concentrate	Hypoglycemia Unawareness	Passing-out	Seizure

Mild to Moderate Hypoglycemia:
Student is exhibiting symptoms of hypoglycemia AND / OR blood glucose level is less than _____ mg/dL

1. Give a fast-acting glucose product equal to _____ **grams fast-acting carbohydrate** such as:
   glucose tablets, juice, glucose gel, gummies, skittles, starbursts, cake icing
2. Recheck blood glucose in 15 minutes
3. If blood glucose level is less than _____, repeat treatment with _____ grams of fast-acting carbohydrates.
4. Consider providing a carbohydrate/protein snack once glucose returns to normal range, as per parent/guardian.
5. **Additional Treatment:**

Severe Hypoglycemia:
Student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movement)

1. Position the student on his or her side to prevent choking
2. Administer glucagon Dose: ☐ 1 mg ☐ 0.5 mg ☐ Other _____
   Route: ☐ Subcutaneous (SC) ☐ Intramuscular (IM)
   Site: ☐ Buttocks ☐ Arm ☐ Thigh ☐ Other: _____
3. **Call 911** (Emergency Medical Services)
   - AND the student's parents / guardians.
   - AND the health care provider.
4. **If on INSULIN PUMP**, Stop insulin pump by any of the following methods:
   - Place pump in "suspend" or "stop mode" (See manufacturer's instructions)
   - Disconnect/remove at site/cut tubing

ALWAYS send pump with EMS to hospital

Name: _____ DOB: _____Date: _____ School Year: _____ -_____

Hyperglycemia (High Blood Glucose)

Hyperglycemia: Any blood glucose above _____ mg/dL checked by blood glucose meter or CGM.

Student's usual symptoms of hyperglycemia (circled):

Extreme thirst	Frequent urination	Blurry Vision	Hunger	Headache
Nausea	Hyperactivity	Irritable	Dizziness	Stomach ache

Insulin Correction Dose

For blood glucose greater than _____mg/dL AND at least _____ hours since last insulin dose, give correction dose of insulin (see correction dose orders, page 5).
Notify parents/guardians if blood glucose is over _____ mg/dL.
For insulin pump users: see **"Additional Information for Student with Insulin Pump", page 6".**

Ketones

Check ☐ Urine for ketones OR ☐ Blood for ketones:
If blood glucose is above ____ mg/ dL, two times in a row, at least one hour apart
AND / OR when student complains of nausea, vomiting or abdominal pain,
Give ____ounces of water and allow unrestricted access to the bathroom

If urine ketones are negative to small OR blood ketones < 0.6 mmol/L - 1.0 mmol/L:
1. If insulin has not been administered within ____ hours, provide correction insulin according to student's correction factor and target pre-meal blood glucose (refer to page 5)
2. Return student to his / her classroom
3. Recheck blood glucose and ketones in ____ hours after administering insulin

If urine ketones are moderate to large OR blood ketones >1.0 mmol/L:
1. Do NOT allow student to participate in exercise
2. Call parent / guardian, If unable to reach parent / guardian call health care provider
3. If insulin has not been administered within ____ hours, provide correction insulin according to student's correction factor and target blood glucose. (refer page 5)
4. **IF ON INSULIN PUMP: See "Additional Information for Student with Insulin Pump", page 6**

HYPERGLYCEMIA EMERGENCY
Presence of ketones associated with the following symptoms Call 911

Chest pain	Nausea and vomiting	Severe abdominal pain
Heavy breathing or shortness of breath	Increasing sleepiness or lethargy	Depressed level of consciousness

Name: _____ DOB: _____ Date: _____ School Year: _____ -_____

Insulin therapy ❑ Insulin pen or Syringe ❑ Insulin pump (refer to page 7)

Type of Insulin therapy at school:

❑Adjustable Bolus insulin ❑Fixed insulin therapy ❑Long-Acting Insulin ❑ None

❑ **Adjustable Bolus Insulin Therapy:**
Apidra, Novolog, Humalog, Fiasp, Admelog (brands interchangeable).

When to give insulin:

❑ INSULIN to CARBOHYDRATE Dose Calculation

Total Grams of Carbohydrate to Be Eaten / *"A" Insulin-to-Carbohydrate Ratio* X "B" Units of Insulin = _____ *Units of Insulin*

	INSULIN to CARBOHYDRATE Dose Calculation only	INSULIN to CARBOHYDRATE Dose Calculation + correction	Correction dose only	None
Breakfast	❑	❑	❑	❑
Lunch	❑	❑	❑	❑
Snack AM	❑	❑	❑	❑
Snack PM	❑	❑	❑	❑

		"A" Insulin-to-Carbohydrate Ratio	*"B" Units of Insulin*
❑	*Breakfast*	per_____ gm of carbohydrate	_____ unit of insulin
❑	*Lunch*	per_____ gm of carbohydrate	_____ unit of insulin
❑	*Snack*	per_____ gm of carbohydrate	_____ unit of insulin
❑	*Dinner*	per_____ gm of carbohydrate	_____ unit of insulin

❑ CORRECTION Dose Calculation

Current Blood Glucose – "C" Target Blood Glucose / *"D" Correction Factor* X "E" Units of insulin = ___ *Units of Insulin*

"C" Target Blood Glucose	*"D" Correction Factor*	*"E" Units of insulin*
_____	_____	❑ 0.5 unit ❑ 1.0 unit

❑ CORRECTION Dose Scale

Blood Glucose	Insulin Dose
_____ to _____ mg/dL	give _____ units
_____ to _____ mg/dL	give _____ units
_____ to _____ mg/dL	give _____ units
_____ to _____ mg/dL	give _____ units

❑ 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: _____

Name: _____ DOB: _____ Date: _____ School Year: _____ - _____

☐ Long-Acting Insulin Therapy

Name of Insulin (Circle): Lantus Basaglar Levemir Tresiba (u100/u200) Toujeo (u300)

☐ 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: _____
☐ Name: _____ Dose: _____ Route: _____ Times given: _____

Disaster Plan/Extended Day Field Trips - To prepare for an unplanned disaster or emergency (72 hours):

☐ Obtain emergency supply kit from parents/guardians.
☐ Continue to follow orders contained in this DMMP.
☐ Additional insulin orders as follows (e.g., dinner and nighttime doses): _____

Additional Information for Students with Insulin Pumps

Brand / model of pump: _____ Manufacturer's phone number: _____
Basal rates during school: ☐ _____
☐ Refer to attached pump settings
Other pump instructions: _____

Hyperglycemia Management:

☐ If Blood glucose greater than _____mg/dL that has not decreased within _____hours after correction and / or if student has moderate to large ketones. Notify parents/ guardians
☐ For infusion site failure: Insert new infusion set and/or replace reservoir, or give insulin by syringe or pen using insulin dosing prescribed on page 6
☐ For suspected pump failure: Suspend or remove pump and give insulin by syringe or pen using insulin dosing prescribed on page 6

Adjustments for Physical Activity Using Insulin Pump

May disconnect from pump for sports activities: ☐ Yes, for _____ hours	☐ No
Set temporary basal rate: ☐ Yes, ____% temporary basal for ___ hours	☐ No
Suspend pump use: ☐ Yes, for _____ hours	☐ No
Temp Target (specific to Medtronic): 150 mg/dL ☐ Yes, for _____ hours	☐ No

Student's Self-care Pump Skills	Independent?	
Counts carbohydrates	☐ Yes	☐ No
Calculates correct amount of insulin for carbohydrates consumed	☐ Yes	☐ No
Administers correction bolus	☐ Yes	☐ No
Calculates and sets basal profiles	☐ Yes	☐ No
Calculates and sets temporary basal rate	☐ Yes	☐ No
Changes batteries	☐ Yes	☐ No
Disconnects pump	☐ Yes	☐ No
Reconnects pump to infusion set	☐ Yes	☐ No
Prepares reservoir, pod, and/or tubing	☐ Yes	☐ No
Inserts infusion set	☐ Yes	☐ No
Troubleshoots alarms and malfunctions	☐ Yes	☐ No

Name: _____ DOB: _____ Date: _____ School Year: _____ - _____

Authorization to Treat and Administer Medication in the School Setting as Required by Virginia Law

This Diabetes Medical Management Plan has been approved by the undersigned Health Care Provider.

It further authorizes schools to treat and administer medication as indicated by this plan and required by Virginia Law.

Providers:

My signature below provides authorization for the Virginia Diabetes Medical Management Plan contained herein. I understand that all treatments and procedures may be performed by the student, the school nurse, unlicensed trained designated school personnel, as allowed by school policy, state law or emergency services as outlined in this plan. I give permission to the school nurse and designated school personnel who have been trained to perform and carry out the diabetes care tasks for the student as outlined in the student's Diabetes Medical Management Plan as ordered by the prescribing health care provider (Code of Virginia § 22.1-274).

Parents:

I also consent to the release of information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my student and who may need to know this information to maintain my student's health and safety. I also give permission to the school nurse or another qualified health care professional to contact my student's diabetes health care providers.

I give permission to the student to carry with him/her and use supplies, including a reasonable and appropriate short-term supply of carbohydrates, an insulin pump, and equipment for immediate treatment of high and low blood glucose levels, and to self-check his/her own blood glucose levels on a school bus, on school property, and at a school-sponsored activity (Code of Virginia §22.1-274.01:1).

SELF-CARRY

Parent authorization for student to self-administer insulin	☐ YES ☐ NO
Parent authorization for student to self-monitor blood glucose	☐ YES ☐ NO
Prescriber authorization for student to self-administer insulin	☐ YES ☐ NO
Prescriber authorization for student to self-monitor blood glucose	☐ YES ☐ NO

***For self-carry: Provider and Parent must both agree to the statements above per** (Code of Virginia §22.1-274.01:1)

Parent / Guardian Name / Signature:	Date:
School representative Name / Signature:	Date:
Student's Physician / Health Care Provider Name / Signature:	Date: