DIABETES MEDICAL MANAGEMENT PLAN

School Year: ***2019-2020***

Student's Name: _____ Date of Birth: _____

Parent/Guardian: _____ Phone at Home: _____ Work: _____ Cell/Pager: _____

Parent/Guardian: _____ Phone at Home: _____ Work: _____ Cell/Pager: _____

Other emergency contact: _____ Phone #: _____ Relationship: _____

Insurance Carrier: _____ Preferred Hospital: _____

BLOOD GLUCOSE (BG) MONITORING: (Treat BG below _____ mg/dl or above _____mg/dl as outlined below.)

☑ Before meals ☑ as needed for suspected low/high BG ☐ 2 hours after correction
☐ Midmorning ☐ Mid-afternoon ☐ Before dismissal

INSULIN ADMINISTRATION:

Insulin delivery system: ❑ Syringe or ❑ Pen or ❑ Pump **Insulin type:** ❑Humalog or ❑Novolog or ❑Apidra

MEAL INSULIN: (Best if given right **before eating**. For small children, can give within 15-30 minutes of the first bite of food-or right after meal)

☐ Insulin to Carbohydrate Ratio:
Breakfast: **1** unit per _____ grams carbohydrate
Lunch: **1** unit per _____ grams carbohydrate

☐ Fixed Dose per meal:
Breakfast: Give ___ units/Eat ____ grams of carbohydrate
Lunch: Give ___ units/Eat ____ grams of carbohydrate

CORRECTION INSULIN: (For high blood sugar. Add before *MEAL INSULIN to CORRECTION INSULIN* for *TOTAL INSULIN* dose.)

☐ Use the following correction formula
For pre-meal blood sugar over _____

(BG - ____) ÷ ____ = extra units insulin to provide

☐ Sliding Scale:
BG from ____ to ____ = _____ units
BG from ____ to ____ = _____ units
BG from ____ to ____ = _____ units
BG from ____ to ____ = _____ units
> ____ = _____ units

SNACK: ☐ A snack will be provided each day at: _____
Carbohydrate coverage only for snack (**No BG check required**):

☐ No coverage for snack
☐ **1** unit per _____ grams of carb
☐ Fixed snack dose: Give ___ units/Eat ____ grams of carb

PARENTAL AUTHORIZATION to Adjust Insulin Dose:

☐ YES ☐ NO Parents/guardians are authorized to increase or decrease insulin-to-carb ratio within the following range:
1 unit per prescribed grams of carbohydrate, +/-_____grams of carbohydrate

☐ YES ☐ NO Parents/guardians are authorized to increase or decrease correction dose with the following range: +/-_____units of insulin

☐ YES ☐ NO Parents/guardians are authorized to increase or decrease fixed insulin dose with the following range: +/-_____units of insulin

MANAGEMENT OF LOW BLOOD GLUCOSE:

MILD low sugar: Alert and cooperative student (BG below _____)
☑ Never leave student alone
☑ Give 15 grams glucose; recheck in 15 minutes
☑ If BG remains below 70, retreat and recheck in 15 minutes
☑ Notify parent if not resolved
☐ If no meal is scheduled in the next hour, provide an additional snack with carbohydrate, fat, protein.

SEVERE low sugar: Loss of consciousness or seizure
☑ Call 911. Open airway. Turn to side.
☑ Glucagon injection IM/SubQ ❑ _____ ☑ 0.50mg
☑ Notify parent.
☑ For students using insulin pump, stop pump by placing in "suspend" or stop mode, disconnecting at pigtail or clip, and/or removing an attached pump. If pump was removed, send with EMS to hospital.

MANAGEMENT OF HIGH BLOOD GLUCOSE: (above _____mg/dl)

☐ Sugar-free fluids/frequent bathroom privileges.
☐ If BG is greater than 300 and it's been 2 hours since last dose, give ❑ **HALF** ❑ **FULL** correction formula noted above.
☐ If BG is greater than 300 and it's been 4 hours since last dose, give **FULL** correction formula noted above.
☐ If BG is greater than _____, check for ketones. Notify parent if ketones are present.
☐ Child should be allowed to stay in school unless vomiting with moderate or large ketones present.

MANAGEMENT DURING PHYSICAL ACTIVITY:

Student shall have easy access to fast-acting carbohydrates, snacks, and blood glucose monitoring equipment during activities. Child should NOT exercise if blood glucose levels are below _____ mg/dl or above 300 mg/dl and urine contains moderate or large ketones.

☐ Check blood sugar right before physical education to determine need for additional snack.
☐ If BG is less than _____ mg/dl, eat 15-45 grams carbohydrate before, depending on intensity and length of exercise.
☐ Student may disconnect insulin pump for 1 hour or decrease basal rate by _____.
☐ For new activities: Check blood sugar before and after exercise only until a pattern for management is established.
☐ A snack is required prior to participation in physical education.

SIGNATURE of AUTHORIZED PRESCRIBER (MD, NP, PA): _____ Date: _____

Student's Name: _____ Date of Birth: _____

NOTIFY PARENT of the following conditions: (If unable to reach parent, call diabetes provider office.)

a. Loss of consciousness or seizure (convulsion) immediately after calling 911 and administering glucagon.
b. Blood sugars in excess of 300 mg/dl, when ketones present.
c. Abdominal pain, nausea/vomiting, fever, diarrhea, altered breathing, altered level of consciousness.

SPECIAL MANAGEMENT OF INSULIN PUMP:

☐ Contact Parent in event of: ▪ Pump alarms or malfunctions ▪ Detachment of dressing / infusion set out of place ▪ Leakage of insulin
▪ Student must give insulin injection ▪ Student has to change site ▪ Soreness or redness at site
▪ Corrective measures do not return blood glucose to target range within _____ hrs.

☐ Parents will provide extra supplies including infusion sets, reservoirs, batteries, pump insulin, and syringes.

This student requires assistance by the School Nurse or Trained Diabetes Personnel with the following aspects of diabetes management:

- ☐ Monitor and record blood glucose levels
- ☑ Respond to elevated or low blood glucose levels
- ☑ Administer glucagon when required
- ☐ Calculate and give insulin Injections
- ☐ Administer oral medication
- ☐ Monitor blood or urine ketones
- ☐ Follow instructions regarding meals and snacks
- ☐ Follow instructions as related to physical activity
- ☐ Respond to CGM alarms by checking blood glucose with glucose meter. Treat using Management plan on page 1.
- ☐ Insulin pump management: administer insulin, inspect infusion site, contact parent for problems
- ☐ Provide other specified assistance:

_____

This student may independently perform the following aspects of diabetes management:

Monitor blood glucose:
- ❑ in the classroom
- ❑ in the designated clinic office
- ❑ in any area of school and at any school related event

- ❑ Monitor urine or blood ketones
- ❑ Calculate and give own injections
- ❑ Calculate and give own injections with supervision
- ❑ Treat hypoglycemia (low blood sugar)
- ❑ Treat hyperglycemia (elevated blood sugar)
- ❑ Carry supplies for blood glucose monitoring
- ❑ Carry supplies for insulin administration
- ❑ Determine own snack/meal content
- ❑ Manage insulin pump
- ❑ Replace insulin pump infusion set
- ❑ Manage CGM

LOCATION OF SUPPLIES/EQUIPMENT: (Parent will provide and restock all supplies, snacks and low blood sugar treatment supplies.)
This section will be completed by school personnel and parent:

	Clinic room	With student		Clinic room	With student
Blood glucose equipment	❑	❑	Glucagon kit	❑	❑
Insulin administration supplies	❑	❑	Glucose gel	❑	❑
Ketone supplies	❑	❑	Juice /low blood glucose snacks	❑	❑

My signature provides authorization for the above Diabetes Mellitus Medical Management Plan.
I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.

SIGNATURE of AUTHORIZED PRESCRIBER: _____ DATE: _____
Authorized Prescriber: MD, NP, PA

Name of Authorized Prescriber:

Address:

Phone:

SIGNATURES

I, (Parent/Guardian) _____ understand that all treatments and procedures may be performed by the student and/or Trained Diabetes Personnel within the school, or by EMS in the event of loss of consciousness or seizure. I also understand that the school is not responsible for damage, loss of equipment, or expenses utilized in these treatments and procedures. I give permission for school personnel to contact my child's diabetes provider for guidance and recommendations. I have reviewed this information form and agree with the indicated information. This document serves as the Diabetes Medical Management Plan as specified by Georgia state law.

PARENT/GAURDIAN SIGNATURE: _____ DATE: _____

SCHOOL NURSE SIGNATURE: _____ DATE: _____

DIABETES EMERGENCY:
Seizure or Unconscious

1. Don't panic
2. **Has 911 been called?**
3. **Have the parents been called?**
4. If convulsions, protect head! **DO NOT PUT ANYTHING IN MOUTH!!!!!**
5. Prepare Glucagon **(Only persons designated by parents**)
    A. Remove flip-off seal from bottle of glucagon.
    B. Remove needle protector from syringe, and inject the entire contents of the syringe into the bottle of glucagon. (Do not remove plastic clip from syringe.)
    C. Remove syringe from bottle
    D. Swirl bottle gently until glucagon dissolves completely. (GLUCAGON SHOULD NOT BE USED UNLESS THE SOLUTION IS CLEAR AND OF A WATER-LIKE CONSISTENCY.)
6. Inject Glucagon (**Only persons designated by parents)**
    A. Using the same syringe, hold bottle upside down and gently withdraw the amount prescribed by the physician.
    B. Cleanse upper outer thigh with alcohol swab.
    C. Insert needle into the muscle and completely inject all of the solution. (THERE IS NO DANGER OF OVERDOSE!)
    D. Apply light pressure at the injection site and withdraw the needle.
    E. Turn the patient to his/her side. When an unconscious person awakens, he/she may vomit. Turning the patient to his/her side prevents choking.
7. HE/SHE SHOULD AWAKEN WITHIN 15 MINUTES OF INJECTING GLUCAGON. If not, he/she could be unconscious due to severe high blood sugar, which requires medical attention immediately!
8. Feed the patient as soon as he/she awakens and IS ABLE TO SWALLOW. Foods to give:

_____

_____

Other instructions:

Parent/Guardian Signature _____ Date_____

Contact Numbers _____

Physician Signature _____ Date _____

Printed Physician Name _____ Phone _____

List of Persons trained to give Glucagon:

1 .

2 .

3 .

I give permission for the above persons to administer glucagon to my child, who is diabetic, in the even that he/she has a seizure or becomes unconscious.

Parent Signature _____ Date _____

Printed Physician's Name _____ Phone _____

Physician's Signature _____ Date _____

SUPPLEMENTAL INFORMATION FOR STUDENT WEARING AN INSULIN PUMP AT SCHOOL

School Year ***2019-2020***

Student's Name: _____ Date of Birth: _____ Pump Brand/Model:_____
Pump Resource Person: _____ Phone/ Beeper _____ (See diabetes care plan for parent phone #)
Blood Glucose Target Range: _____ Pump Insulin: Humalog ☐ Regular ☐
Insulin Correction Factor for Blood Glucose Over Target: _____
Insulin Carbohydrate Ratios: _____
(Student to receive insulin bolus for carbohydrate intake immediately before / _____ minutes before eating. Circle appropriate interval)
Location of Extra Pump Supplies _____

☐ **INDEPENDENT MANAGEMENT**

This student has been trained to independently perform routine pump management and to troubleshoot problems including but not limited to:

- Giving boluses of insulin for both correction of blood glucose above target range and for food consumption.
- Changing of insulin infusion sets using universal precautions.
- Switching to injections should there be a pump malfunction.

Parents will provide extra supplies to include infusion sets, reservoirs, batteries, pump insulin and syringes.

☐ **NON-INDEPENDENT MANAGEMENT (Child Lock On? Yes ☐ No☐)**

Because of young age or other factors, this student cannot independently evaluate pump function nor independently change infusion sets.

- Insulin for meals and snacks will be given and verified as follows: _____
  _____
- Insulin for correction of blood glucose over _____ will be give and verified as follows:
  _____

PARENT NOTIFICATION: (*Refer to basic diabetes care plan and check ✓all others that apply. Contact the Parent in event of:*

☐ Pump alarms / malfunctions ☐ Corrective measures do not return blood glucose to target range within ___ hrs.
☐ Soreness or redness at site ☐ Student has to change site
☐ Detachment of dressing / infusion set our of place
☐ Leakage of insulin
☐ Student must give insulin injection
☐ Other: _____
_____

MANAGEMENT OF HIGH / VERY HIGH BLOOD GLUCOSE: Refer to previous sections and to basic Diabetes Care Plan

MANAGEMENT OF LOW BLOOD GLUCOSE *Follow instructions in basic Diabetes Care Plan, but in addition:*

If low blood glucose recurs without explanation, notify parent / diabetes provider for potential instructions to suspend pump.

If seizure or unresponsiveness occurs:

1. Give Glucagon and / or glucose gel (See basic Diabetes Health Plan)
2. CALL 911
3. Notify Parent
4. Stop insulin pump by:
   - ☐ Placing in "Suspend" or stop mode
   - ☐ Disconnecting at pigtail or clip
   - ☐ Cutting tubing
5. If pump was removed, send with EMS to hospital.

COMMENTS:

_____
_____
_____
_____

Effective Dates: From: _____ To: _____
Parent's Signature: _____ Date: _____
School Nurse's Signature: _____ Date: _____
Diabetes Care Provider Signature: _____ Date: _____

AUTHERIZATION FOR STUDENTS TO CARRY A PRESCRIPTION LABELED INHALER, EPINEPHARINE AUTO INJECTOR, INSULIN, GLUCAGON, DIABETIC SUPPLIES, EMERGENCY SEIZURE MEDICATION, OR OTHER APPROVED MEDICATION. 20***19*** - 20***20***

EACH MEDICATION WILL REQUIRE A PRESCRIPTION LABEL ATTACHED TO THE ACTUAL MEDICATION OR CONTAINER

_____ needs to carry the following prescription labeled inhaler, epinephrine auto injector, insulin, and diabetic supplies, and/or_____ prescription medication with him/her. The above-named student has been instructed in the proper use of the medication and fully understands how to administer this medication.

It is preferable that a second prescription inhaler, epinephrine auto injector, additional insulin, and diabetic supplies or other prescribed medication be kept in the school clinic, just in case the first is lost or left at home. **ASK your pharmacist to make separate prescription labels for each device, for school, for home, and for the one you are carrying.

Name of Medication: _____

Physician's Name: _____ *Date:* _____

Physician's Address: _____ *Phone:* _____

Physician's Signature: _____ *Date:* _____

I have been instructed in the proper use of my prescription labeled medication and fully understand how it is administered. I will not allow another student to use my medication under any circumstances. I also understand that should another student use my prescription, the privilege of carrying my medication may be altered. I also accept responsibility for notifying the School Nurse each time I take my medication.

Student's Signature: _____ *Date:* _____

I hereby request that the above-named student, over whom I have legal guardianship, be allowed to carry and use this prescribed medication at school:

- I accept legal responsibility should the medication be lost, given to, or taken by another person other than the above-named student.
- I understand that if this should happen, the privilege of carrying the medication may be altered.
- I release Fulton Science Academy and its employees of any legal responsibility when the above-named student administers his/her own medication.

Parent/Guardian Signature: _____ *Date:* _____

FULTON SCIENCE ACADEMY
— Private School —

REQUEST FOR ADMINISTRATION OF MEDICATION
20 19 - 20 20

ASK your pharmacist to make a separate prescription labeled bottle, and/or additional labels for each device of your inhaler, epinephrine auto injector, additional insulin, Glucagon or other prescribed medication for school, home, and for the one you carry. It is preferable that a second prescription device be kept at the school in case the first is lost or left at home.

If medications can be given at home or after school hours, please do so. However, if medication administration is absolutely necessary to be given during school hours, this form must be completed.

Permission is hereby granted to the local school principal or his/her designee to supervise my child in taking the following prescribed medication.

I hereby release and discharge the Fulton Science Academy and its employees and officials from any and all liability in case of accident or any other mishap in supervising said medication due to any side effects, illness, or other injury which might occur to my child through supervising said medication. I hereby release aforementioned officials from any liability because of any injury or damage which might occur.

I give the above-mentioned personnel permission to contact my child's health care provider and/or pharmacy to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required.

I understand that: All medications, herbals, and supplement must be approved by the U.S. Food and Drug Administration and appear in the U.S. Pharmacopeia

- **Medications must be in the original container.**
- Parent/Guardian must provide specific instructions (including drugs and related equipment) to the principal or his/her designee.
- It will be the responsibility of the parent/guardian to inform the school of any changes in pertinent data. New medications will not be given unless a new form is completed.
- All medication will be taken directly to the office by the parent or guardian. Students may not have medication in their possession, except with a physician's request or a physician's order on a Fulton Science Academy care plan.
- Students who violate these rules will be in violation of the Alcohol/Illegal Drug Use Policy (JCDAC).
- A daily record shall be kept on each medication administered. This record will include student's name, date, medication administered, time, and signature of school personnel who supervised.
- **MEDICATIONS MUST BE PICKED UP BY PARENT/GUARDIAN**. Any medication not picked up from the school by the end of the last school day of the year will be considered abandoned. Abandoned medication will be properly discarded in accordance with local, state, and federal laws/rules by the school nurse and an administrator.

NAME OF STUDENT _____ **BIRTHDATE**_____ **GRADE** _____
SCHOOL Fulton Science Academy Private School
MEDICATION **Insulin:** _____ **Amount to give** _____ **TIME to give**_____
ALLERGIES_____
PHYSICIAN'S NAME_____ **PHYSICIAN'S PHONE**_____
Doctor Office Name_____ **FAX**_____

STATEMENT OF PARENT OR GUARDIAN

I hereby give my permission for my child to receive this medication at school.

SIGNATURE OF PARENT/GUARDIAN_____ **DATE**_____
PHONE _____

To be completed by Physician for long-term medications (more than two weeks):"Physician" as defined in Article 2 of the Medical Practice Act of Georgia ***Medication that contains Aspirin, Pepto Bismol or ointments MUST have a doctor's signature

CONDITION/ILLNESS REQUIRING MEDICATION_____
POSSIBLE SIDE EFFECTS OF MEDICATION_____
OTHER MEDICATION STUDENT IS TAKING_____
PHYSICIAN'S SIGNATURE_____ **DATE**_____

Date received: _____ # _____ Initial _____
Picked up Date: _____ # _____ Initial _____
Dropped off: _____ # _____ Initial _____

Expiration Date: _____
Disposed of date: _____ # _____ Initial _____

FULTON SCIENCE ACADEMY
— Private School —

REQUEST FOR ADMINISTRATION OF MEDICATION
20 19 - 20 20

ASK your pharmacist to make a separate prescription labeled bottle, and/or additional labels for each device of your inhaler, epinephrine auto injector, additional insulin, Glucagon or other prescribed medication for school, home, and for the one you carry. It is preferable that a second prescription device be kept at the school in case the first is lost or left at home.

If medications can be given at home or after school hours, please do so. However, if medication administration is absolutely necessary to be given during school hours, this form must be completed.

Permission is hereby granted to the local school principal or his/her designee to supervise my child in taking the following prescribed medication.

I hereby release and discharge the Fulton Science Academy and its employees and officials from any and all liability in case of accident or any other mishap in supervising said medication due to any side effects, illness, or other injury which might occur to my child through supervising said medication. I hereby release aforementioned officials from any liability because of any injury or damage which might occur.

I give the above-mentioned personnel permission to contact my child's health care provider and/or pharmacy to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required.

I understand that: All medications, herbals, and supplement must be approved by the U.S. Food and Drug Administration and appear in the U.S. Pharmacopeia

- **Medications must be in the original container.**
- Parent/Guardian must provide specific instructions (including drugs and related equipment) to the principal or his/her designee.
- It will be the responsibility of the parent/guardian to inform the school of any changes in pertinent data. New medications will not be given unless a new form is completed.
- All medication will be taken directly to the office by the parent or guardian. Students may not have medication in their possession, except with a physician's request or a physician's order on a Fulton Science Academy care plan.
- Students who violate these rules will be in violation of the Alcohol/Illegal Drug Use Policy (JCDAC).
- A daily record shall be kept on each medication administered. This record will include student's name, date, medication administered, time, and signature of school personnel who supervised.
- **MEDICATIONS MUST BE PICKED UP BY PARENT/GUARDIAN**. Any medication not picked up from the school by the end of the last school day of the year will be considered abandoned. Abandoned medication will be properly discarded in accordance with local, state, and federal laws/rules by the school nurse and an administrator.

NAME OF STUDENT _____ **BIRTHDATE**_____ **GRADE** _____
SCHOOL Fulton Science Academy Private School
MEDICATION **Glucagon** _____ **Amount to give** _____ **TIME to give**_____
ALLERGIES_____
PHYSICIAN'S NAME_____ **PHYSICIAN'S PHONE**_____
Doctor Office Name_____ **FAX**_____

STATEMENT OF PARENT OR GUARDIAN

I hereby give my permission for my child to receive this medication at school.

SIGNATURE OF PARENT/GUARDIAN_____ **DATE**_____
PHONE _____

To be completed by Physician for long-term medications (more than two weeks):"Physician" as defined in Article 2 of the Medical Practice Act of Georgia ***Medication that contains Aspirin, Pepto Bismol or ointments MUST have a doctor's signature

CONDITION/ILLNESS REQUIRING MEDICATION_____
POSSIBLE SIDE EFFECTS OF MEDICATION_____
OTHER MEDICATION STUDENT IS TAKING_____
PHYSICIAN'S SIGNATURE_____ **DATE**_____

Date received: # Initial
Picked up Date: # Initial
Dropped off: # Initial

Expiration Date:
Disposed of date: # Initial

DIABETIC SUPPLY SHEET

Dear Parents/Guardians:
Your student needs the following supplies. Please send in as soon as possible.
Remember to check the expiration dates of all supplies.

SNACKS:

FAST ACTING

- Juices
- Glucose tabs
- Glucose gel/icing
- Other _____

COMPLEX SNACKS

No Peanut Butter due to Student Allergies

- Cheese crackers
- Other _____

INSULIN SUPPLIES:

- Ketone Strips
- Syringes/pen and needles
- Insulin (once opened, insulin should be used within **one** month)
- Alcohol wipes

PUMP SUPPLIES:

- Infusion sets
- Sof-serter/inserting device
- Reservoirs
- Batteries
- Other _____

GLUCOMETER SUPPLIES:

- Glucometer
- Lancets
- Alcohol wipes
- Glucose test strips
- Batteries

GLUCAGON

Expires on _____.

COMMENTS:

Please put all the supplies in a shoe box size plastic container with your child's name on.

Back to School with Diabetes

Use this checklist to ensure a safe return to school.

Children's℠
Healthcare of Atlanta

- ❑ Make an Endocrinologist appointment:
  - Refill Prescriptions (ex.- Glucagon)
  - Update the Diabetes Medical Management Plan (DMMP)
  - Discuss your child's readiness to carry supplies and perform his/her own care.

- ❑ Plan a meeting for those involved in your child's care at school.
  - School Nurse (or clinic aid/trained personnel)
  - Principal, Teachers, Coaches, and P.E. Staff
  - School Bus Driver
  - After School Staff if child participates in extracurricular activities

- ❑ Topics for discussion at school meeting:
  - Diabetes Medical Management Plan (DMMP) - Review
  - Daily schedule – Breakfast? Lunch? Dismissal? Afterschool Activities?
    - WHO will supervise? Is Self-care involved?
    - WHERE and WHEN will Blood sugar monitoring and insulin administration be performed?
  - Communication between school and parent.
    - Reporting blood sugars and doses of insulin. Daily? Weekly?
    - Class parties with unexpected snacks
    - Field trips
  - Home Concerns:
    Any observed patterns of highs/lows? Was AM insulin given?
  - 504 plan (if applicable)

- ❑ Gather diabetes supplies for school:
  - Blood sugar meter, logbook, test strips, lancets, lancing device, and control solution
  - Insulin (vials or pens), syringes or pen needles, alcohol swabs
  - Ketone test strips
  - Low blood sugar treatment (glucose tablets, juice boxes, glucose gel, Glucagon kit)
  - Extra snacks for P.E. or recess
  - Extra insulin pump supplies (reservoirs/cartridges, infusion sets, batteries, insulin, syringes or pens as a backup)
  - *Most supplies have expiration dates and will need to be replenished:*
    - *Insulin (vials or pens)- expire one month after opening*
    - *Ketone strips- expire 6 months after opening*
    - *Control solution- expires 3 months after opening*
    - *Glucagon- expires after 1 year*
  - Keep enough supplies to last at least 72 hours in case of an emergency.
  - Even if your child is carrying his/her own supplies, keep back-up supplies in the school clinic

- ❑ Keep a list of current phone numbers where you or another caregiver may be reached.

- ❑ Obtain a medical alert tag for your child to wear while at school (bracelet, necklace, shoelace, or backpack)