DIABETES MANAGEMENT POLICY
TOWN OF TOLLAND

Summer Camp Program

The Town of Tolland is committed to making its programs and activities available on a nondiscriminatory basis, including to children with disabilities, as required under Title II of the Americans with Disabilities Act (ADA). In accordance with the ADA and its implementing regulation, the Town will make reasonable modifications to its policies, practices or procedures when such modifications are necessary to avoid discrimination on the basis of disability, unless the Town finds that making such modification would fundamentally alter the nature of the service, program, or activity.

The Town recognizes that children with insulin-dependent diabetes who participate in the Town's summer camp program may require assistance with diabetes management. The management regime of every child with diabetes may be different and, for this reason, one policy cannot dictate the particular protocol for all individuals. This policy is limited to diabetes management and does not apply to the administration of any other medications.

The Town affirms that successful participation of the children and accommodation of the children's needs depend on an actively cooperative relationship and ongoing communication between the parent/guardian of the child and the Town.

A. Town's Responsibilities:

1. Individualized Assessment and Reasonable Modification

When registering for a particular session or program, a parent/guardian should print a copy of this Policy, a Diabetes Management Plan Form, a Physical Examination Form, Youth Camp Health Exam/Record and Authorization for Administration of Medication available on the Recreation Department website to be filled out by parent/guardian and a healthcare professional.

Within a reasonable amount of time, but in most cases no less than two weeks prior to the first day of the camp session, the Town will make an individual assessment of the needs of each child with diabetes on a case-by-case basis and will work with families to provide reasonable modifications in accordance with this Policy and applicable laws. To this end, the Town will assess the level of assistance or supervision that is reasonable based upon the situation and will provide whatever assistance is appropriate and consistent with the Diabetes Management Plan. The Town may request additional information or guidance from the child's health care provider or parent/guardians, as necessary.

If an agreement cannot be reached for the Town to either provide reasonable modifications consistent with the prescribed regimen as set forth in the child's Diabetes Management Plan or an equally effective modification appropriate to the child's individual needs, the Town will notify the parent/guardian of its final determination. The determination will document which modifications the Town will provide and which modifications it will not provide, demonstrating that the modification not provided would fundamentally alter the nature of its service, program, or activity.

At any time, the parent/guardian may file a formal complaint with the Town Manager.

Reasonable modifications may include, but are not limited to, providing the services of a trained professional to (1) administer blood glucose monitoring tests, (2) operate an insulin pump, (3) administering fast-acting carbohydrates, and (4) administering glucagon while a child with diabetes participates in any summer camp program, whether on Town premises or elsewhere while attending the Town's summer camp programs.

Notwithstanding the forgoing, in all cases the Town will allow the parent/guardian or authorized agent to enter the Town's premises to monitor the child's blood glucose levels and take appropriate action in response to those levels. The Town will also allow the child to monitor his or her own blood glucose levels and take appropriate action, when the child's parent/guardian has provided the Town with the written authorization to do so.

If the child self-identifies, or staff recognizes symptoms of hyperglycemia or hypoglycemia, the Town staff will assist the child to check blood sugar and treat the symptoms, and take steps reasonably consistent with the Diabetes Management Plan.

2. Training

In accordance with applicable law, including regulations enforced by the Eastern Highlands Health District, if a child with diabetes applies for any session or program, and if requested by a parent/guardian, the Town will arrange for a qualified health care professional to provide basic training to appropriate camp personnel. The basic training will include a general overview of diabetes and typical health care needs of diabetics, recognition of common symptoms of hypoglycemia and hyperglycemia, and will discuss ways to get help quickly.

The Town will arrange for any camp staff working directly with a camper with diabetes to receive training that enables the Town to provide all care required to comply with applicable law, if requested by the parent/guardian. The training will include an overview of diabetes, general information on how to recognize signs and symptoms of hypoglycemia and hyperglycemia, and diabetic care practices related to glucose monitoring and regulating glucagon and insulin administration, including by insulin pump. In addition, depending on the unique needs of the child, training may include information about dietary requirements for individuals with diabetes and training and guidance from parents or guardians of children about any reasonable modifications needed by a child as identified in each child's Diabetes Management Plan. Parents or guardians must provide information and training necessary for staff to be trained with regard to any unique needs of their camper.

B. Parent's/Guardian's Responsibilities:

Within twenty (20) business days prior to the beginning of any session or program, the

parent/guardian of a child with diabetes will provide the Recreation Department the following:

(1) a completed Diabetes Management Form, legible and in easy to understand terms, detailing any and all care necessary for the child's management, which is signed by the child's health care provider (endocrinologist) and signed by the child's parent/ guardian to permit the Town to undertake steps indicated on the Diabetes Management Form (Appendix A);

(2) a completed Physical Exam Form and any other health-related documents deemed relevant by the child's medical provider (Appendix B); and

(3) a signed general release, if applicable.

For children currently attending a camp program who would require treatment for diabetes for the first time during any session, the parent/guardian must immediately submit the completed Diabetes Management Plan as set forth above, and comply with the remaining aspects of this Policy with sufficient time to allow the Town to make good faith efforts for continuation of the camp program consistent with this Policy.

The parents/guardian will be available at the request of the Town to attend and participate on the first day of a camp session with the child and, if deemed necessary by either party, to attend a run-through prior to the first day, and to continue to meet with and advise the staff working with the child about proper diabetes care.

The parent/guardian will be available by phone or have other emergency contacts (which may include the child's health care provider) available by phone each day that the child is participating in a camp session to answer questions regarding the child's management of diabetes care and to approve particular actions related to proper care, when necessary.

The parent/guardian will provide specific information and training about the child's diabetes and particular needs related to diabetes care to the Town, and will permit the child's personal health care providers to share information with staff and other health care personnel when necessary to assure the child's safety and compliance with the child's Diabetes Management Plan.

The parent/guardian will promptly inform the Town of relevant changes in the child's health status.

The parent/guardian will provide, along with instructions about proper maintenance or use of all items, all supplies and equipment necessary for the child's safe participation in all activities. The parent/guardian will provide and properly maintain all supplies and equipment for the child's diabetes and assist with proper disposal of equipment and supplies. Children may carry their own medical supplies and snacks in a safe fashion that meets local code or safety standards for the care and disposal of medical supplies so that these supplies are in close proximity to the child. When the child cannot hold these supplies, the supplies will be held at the administrative office or health office, or by a staff member.

As applicable, the parent/guardian will furnish all appropriate meals and snacks that are not regularly provided by the Town and that are necessary to meet the child's needs. The parent/guardian will also ensure that the carbohydrate content falls within the proper amounts set forth in the Diabetes

Management Plan so that the totals will be predetermined and calculated by the parent/guardian. Carbohydrate values will be calculated and provided on labels on each food item provided by the parent/guardian so that the staff may monitor the appropriate use of insulin and insulin pumps or other equipment to administer insulin.

The parent/guardian will check the child's blood sugar levels each morning when the child arrives at camp to ensure they are within the established "target range" in the child's Diabetes Management Plan.

If you have any questions about this Policy, please contact the Recreation Department at 860-871-3610.

DIABETES MANAGEMENT PLAN

This plan should be completed by both the child's health care provider (endocrinologist) and the child's parent/guardian. It should be immediately updated with any new information, as necessary.

Effective Dates: _____
Child's Name: _____
Date of Birth: _____
Physical Condition (Identify and Explain): _____
_____
_____
_____
Date of Diagnosis: _____
Grade: _____

Contact information: *Circle the primary contact person and phone number*
Parent/Guardian: _____
Home Address: _____
Employer: _____
Employer's Address: _____
Telephone: Home: _____ Work: _____ Cell: _____
Parent/Guardian (2): _____
Home Address: _____
Employer: _____
Employer's Address: _____
Telephone: Home: _____ Work: _____ Cell: _____
Who has custody of the child? _____

Child's Health Care Provider (endocrinologist)**:**
Name: _____
Address: _____
Telephone: _____
Emergency Number: _____
Other Emergency Contacts:
Name: _____
Relationship: _____
Telephone: Home: _____ Work: _____ Cell: _____
Name: _____
Relationship: _____
Telephone: Home: _____ Work: _____ Cell: _____
Notify parent/guardian or emergency contact in the following situations: _____
_____
_____
Recommended Monitoring of Child: _____
_____
_____
Specify any medical time requirements: _____
_____
Can child perform own monitoring? □Yes □No
Exceptions: _____
_____
Identify the type of any meter, monitor, nebulizer, applicator, needle, pump, or any other devices

necessary for the child's Diabetes Management Plan (include model and instruction booklet):

_____

_____

_____

What signs does the child demonstrate when the child is symptomatic? _____

_____

Foods to avoid, if any: _____

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

_____

_____

Exercise and Sports Limitations

List, identify, and explain any restrictions to exercise, sports, or any other activities:

_____

_____

_____

_____

Treatment Supplies to be kept at the Camp's site and provided by parent/guardian are as follows (Please provide specific instructions regarding the storage and treatment of all supplies):

_____

_____

_____

_____

For the children with medical concerns, please complete the supplemental form.

This Diabetes Management Plan has been approved by:

_____ _____

Child's Endocrinologist Date

I give permission to the Town to perform and carry out the care tasks as outlined in the Diabetes Management Plan. I also consent to the release of the information contained in this Diabetes Management Plan to all staff members and other adults who have custodial care of my child, such as those persons on the emergency list and who may need to know this information to maintain my child's health and safety. A written revocation or amendment to this document must be delivered to the Camp's Director of First Aid by the child's Parent/Guardian in order to effectuate a revocation of the same. The Town reserves the right to request additional documentation after review of the information contained in the document.

Acknowledged and received by:

_____ _____

Child's Parent/Guardian Date

_____ _____

Child's Parent/Guardian Date

PHYSICAL EXAM FORM / MEDICAL MANAGEMENT PLAN

To be completed by Parent/Guardian and Child's Health Care Provider
To Parent/Guardian: Please complete the information in the box BEFORE submitting to your child's health care provider.

Name of applicant: _____
Gender: □ Male □Female Date of Birth: _____
Address: _____

To Child's Health Care Provider: This form should be completed and approved by the child's diabetes nurse educator, endocrinologist, or primary care provider/physician. Your cooperation in supplying the following information about an applicant for the Town of Tolland Day Camp is greatly appreciated. The child will not be accepted without your approval of this form.
Date of most recent exam: _____

I have read the Diabetes Management Plan, attached to this form, and certify that it provides a complete regime of care for this child's safety during summer camp. I recognize that the child will be active at this camp and represent that this plan accounts for applicable varying activity levels. Any restrictions are noted below.
Have any complications or health been detected? Yes / No (Circle One)
If yes, please specify: _____
_____
_____
_____

Is the child emotionally and physically mature or responsible enough to independently manage his/her health concerns? Yes / No (Circle One)
If not, please explain the minimum level of medical licensure or training required for the child's safety (unless fully described in the Medical Management Plan):
_____
_____
_____

Do you have any specific concerns regarding the management of this child's safety or health at camp not fully described in the Medical Management Plan? _____
If yes, please explain: _____

_____
Do you recommend any limitation on child's activity while at camp beyond those described in the Medical Management Plan? Yes / No (Circle One)
If yes, please describe: _____

_____

I certify that the information above is correct to the best of my knowledge and agree to answer questions and provide management guidance to the Town's summer camp program as requested at the sole cost and expense of the parent/legal guardian of the child.

Primary Health Care Provider's Name: _____
Address: _____

Phone: _____
Health Care Provider Signature: _____

Parents/Guardians Name: _____
Address: _____
Phone: _____
Parents/Guardian Signature: _____

YOUTH CAMP HEALTH EXAM/RECORD
FOR CAMPERS AND STAFF
Physical Exams Are Valid For 3 Years
From Date of Last Examination
Please Return Completed Form to Camp

☐ Camper
☐ Staff

Name _____ Date of Birth _____ Phone _____

Guardian _____ Address _____

Emergency Contact _____ Telephone _____

Date of Arrival at Camp: _____ Departure Date: _____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

Date of Exam _____

_____ May participate in all camp activities
_____ May participate except for: _____

Medical information pertinent to routine care and emergencies: _____

Is this individual taking prescription medication? ☐YES ☐NO

If yes, indicate prescription: _____

Does the individual have allergies? ☐YES ☐NO Explain: _____

Is the individual on a special diet? ☐YES ☐NO Explain: _____

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Polio		
Tetanus					

Comments: _____

Print name of medical care provider: _____

Medical care provider's address: _____

Medical care provider's: City/Town _____ ST _____ Zip Code _____

_____
Signature of Physician, APRN or PA

_____
Date Form Signed

_____
Telephone Number

Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student _____ Date of Birth___/___/___ Today's Date___/___/___

Address of Child/Student _____ Town_____

Medication Name/Generic Name of Drug_____ Controlled Drug? ☐ YES ☐ NO

Condition for which drug is being administered: _____

Specific Instructions for Medication Administration _____

Dosage_____ Method/Route_____

Time of Administration _____ If PRN, frequency_____

Medication shall be administered: Start Date: ____/____/____ End Date: ____/____/____

Relevant Side Effects of Medication _____ ☐ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs_____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number (____) _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____ Date ____/____/____

School Nurse Signature (if applicable) _____

Parent/Guardian Authorization:

☐ I request that medication be administered to my child/student as described and directed above

☐ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)

☐ I have administered at least one dose of the medication with the exception of emergency medications to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature_____ Relationship_____ Date ____/____/____

Parent /Guardian's Address _____ Town_____ State_____

Home Phone # (____) _____-_____ Work Phone # (____) _____-_____ Cell Phone # (____) _____-_____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: ☐ YES ☐ NO _____
Signature Date

Parent/Guardian authorization for self-administration: ☐ YES ☐ NO _____
Signature Date

School nurse, if applicable, approval for self-administration: ☐ YES ☐ NO _____
Signature Date

****

Today's Date _____ Printed Name of Individual Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink or electronic) _____

Note: This form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)

Medication Administration Record (MAR)

Name of Child/Student_____ **Date of Birth** _____/_____/_____

Pharmacy Name _____ **Prescription Number** _____

Medication Order_____

Date	Time	Dosage	Remarks	Was This Medication Self Administered?	Signature of Person Observing or Administering Medication
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

*Medication authorization form must be used as either a two-sided document or attached first and second page.

☐ **Authorization form is complete**

☐ **Medication is appropriately labeled**

☐ **Medication is in original container**

☐ **Date on label is current**

Person Accepting Medication (print name) _____ **Date** ____/____/____