Welcome!

Thank you for registering to participate with the Raleigh Parks, Recreation and Cultural Resources Department. The City is committed to providing all participants with an exceptional experience! The City has received your request for accommodation, and it is important that we engage you as a partner in the process to make participation as seamless and successful as possible. In order to make sure that our program is compatible with your support needs, we would like to provide you with more detailed information about our program considerations. In addition, to make sure that the City can safely and meaningfully accommodate the needs, we are requesting additional information from you and the treating physician. We would also like to further explain the steps and process for designing an accommodation to best meet your support needs, in consideration of safety and available Department resources.

PRCR Program Considerations

The Raleigh Parks, Recreation and Cultural Resources Department boasts more than 200 parks including features like amusements, art centers, athletic facilities, community centers, lakes, nature preserves, off-leash dog parks, playgrounds, swimming pools, historic homes, and open spaces. PRCR programs occur throughout all parks and facilities, on our greenways, and at non-City locations. The City cannot control environmental conditions at activities conducted off-site. Participants should plan accordingly and must notify staff in advance if alternative activities would be safer or more appropriate.

Program Activities & Requirements: programs have various activities such as free choice play, active activities in a large room/gym/outdoors, passive/quiet activities, arts and crafts, recreational sports, games, field trips, food and food experiences, and specialty programs. Programs may involve a high level of gross motor skills and physical mobility/activity including climbing, balancing, stopping, kneeling, crouching crawling, jumping/hopping, standing, walking, running, and physical contact between participants. Programs may involve a high level of fine motor skills as appropriate for the specific program content. In addition, participants should exhibit a moderate level of expressive and receptive communication skills and a moderate level of appropriate social skills, such as turn taking and peer cooperation.

Program Environment & Spaces: programs may be held in a variety of spaces such as a room inside a community/art/etc. center, outdoor tennis/basketball/volleyball court, baseball/softball/open field, playground, picnic shelter, gymnasium (with or without air condition), pool, etc. There may be multiple transitions between various spaces, environments and activities during the program. Some programs travel to various field trip locations, some greater than 50 miles away from the base program location. For trips, transportation may be provided by PRCR vehicles or by a charter bus. Participants may be exposed to a variety of indoor spaces both air conditioned and not air conditioned, and outdoor spaces in different weather conditions and temperatures. there are specific activities and spaces that will be loud (music, shouting, etc.) and some activities that will be in dim lighting (movies, video games, etc.).

Staffing: All programs operate under the direction of a full time staff that provides oversight and support to the program and instructors/staff. Some programs are instructed directly by full time staff, while other are instructed by part time staff. Staffing ratios and plans are unique and individualized per program. All

program instructors are trained in City policies and procedures, and at least 1 staff with the program/facility is certified in First Aid and CPR. While there will be at least one or two staff members with First Aid and CPR certification with the program at all times, no staff members are required to have medical training or certifications above First Aid and CPR.

Needed Information

The Medical Management Plan (MMP) – please work with the treating physician to complete this form in its entirety. It is acceptable for a parent/guardian/participant to fill out the form as long as the physician reviews and signs it. The City will rely on this form in order to make reasonable attempts to make accommodations and provide an opportunity to meaningfully participate in program activities. Because the City has no staff with medical training or experience specific to particular limitations and needs, Parks, Recreation and Cultural Resources staff must rely on the MMP in order to safely supervise the participant. The MMP must be returned to the City at least two weeks before the start of the program. However, in order to allow as much time as possible for development of a support plan, to allocate available resources, and to provide additional training, the City would like to receive the MMP back from you as far in advance as possible. The form is attached to this letter and includes an overview for the physician.

Next Steps

- PRCR staff will review the MMP once it is received to determine whether PRCR resources are adequate to safely accommodate.

- If we are able to accommodate, PRCR staff will contact you and will work with the participant/parent/guardian to develop an appropriate support plan. Medical accommodations are the most successful when we work directly with the treating physician and the participant/parent/guarding to develop the support plan and offer training for the program staff. Effective communication between the City and the participant/parent/guardian will be essential to the development of a care plan that accurately reflects the care needs. After the support plan has been developed, PRCR staff will work with you to verify how staff will implement the procedures.

- We will work collectively to schedule and conduct appropriate training for the staff that will be working to provide support. The City asks that you be available during the training to share with staff any pertinent information, and to partner with any appropriate medical staff to provide information about any equipment or situations that may be unique.

Please let us know as you have questions. We look forward to serving you in our programs!

Sincerely,

Laurel Heizelman, CPRP
Inclusion Manager
Specialized Recreation and Inclusion Services
919-996-2149

Nikki Speer-Raleigh, ADAC, LRT/CTRS
Program Director
Specialized Recreation and Inclusion Services
919-996-6835

Dear Physician:

One of your patients has registered to participate in a City of Raleigh Parks, Recreation and Cultural Resources Department program or event, and we have been requested to provide support for care. Please review the program considerations below and discuss the specific program with your patient. Then, please complete the attached Medical Management Plan (MMP) in full. This record will remain in the participant's file so that we may assist with their medical care and needs. The completed MMP will be valid for 1 calendar year from the date of your signature, unless there are changes in their condition.

PRCR Program Considerations

The Raleigh Parks, Recreation and Cultural Resources Department boasts more than 200 parks including features like amusements, art centers, athletic facilities, community centers, lakes, nature preserves, off-leash dog parks, playgrounds, swimming pools, historic homes, and open spaces. PRCR programs occur throughout all parks and facilities, on our greenways, and at non-City locations. The City cannot control environmental conditions at activities conducted off-site. Participants should plan accordingly and must notify staff in advance if alternative activities would be safer or more appropriate.

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First Aid and CPR certification with the program at all times, no staff members are required to have medical training or certifications above First Aid and CPR.

If you have any questions regarding the MMP or more specific program considerations, please contact us.

Sincerely,

Laurel Heizelman, CPRP
Inclusion Manager
Specialized Recreation and Inclusion Services
919-996-2149
Laurel.heizelman@raleighnc.gov

Nikki Speer-Raleigh, LRT/CTRS
Program Director
Parks, Recreation and Cultural Resources Dept.
919-996-6835
Nikki.speer@raleighnc.gov

Parks, Recreation and Cultural Resources
RALEIGH
parks.raleighnc.gov

Medical Management Plan (Diabetes)

This plan is designed for participants under the age of 18 or those over the age of 18 who may need support managing their condition. It should be completed by the participant's personal health care team, including the parent/guardian. It should be reviewed with relevant Parks, Recreation and Cultural Resources staff and copies should be kept in a place that can be accessed easily by authorized personnel. This plan is valid for one year from the physician's signature unless condition or care changes.

Participant's Name:_____ Date of Birth: _____

Date of Diagnosis: _____ ☐ type 1 ☐ type 2 ☐ Other: _____

Program:_____ Location: _____

Program 2 (if applicable):_____ Location: _____

Additional Programs and Locations: _____

CONTACT INFORMATION

Guardian: _____

Address: _____

Telephone: Home_____ Work_____ Cell: _____

Email Address: _____

Guardian:_____

Address: _____

Telephone: Home_____ Work_____ Cell:_____

Email Address: _____

Participant's Physician/Health Care Provider:

Address: _____

Telephone: _____

Email Address:_____ Emergency Number: _____

Other Emergency Contact:

Name:_____ Relationship:_____

Telephone: Home _____ Work_____ Cell:_____

This following is a general meal schedule for the City of Raleigh camps. This may differ depending on the program, age of participant, or the weekly schedule. Please confirm with program for more specific times. Please consider these times when deciding when to check blood glucose and when to administer insulin.

The following may occur between:

9:00 AM - 10:00 AM: Morning snack

11:30 AM - 12:30 PM: Lunch

2:00 PM - 3:00 PM: Afternoon snack

CHECKING BLOOD GLUCOSE

Target range of blood glucose: ☐ 70-130 mg/dL ☐ 70-180 mg/dL ☐ Other: _____

Preferred site of testing: ☐ Fingertip ☐ Forearm ☐ Thigh ☐ Other: _____

Please indicate when check BG (a row left blank indicates no action is required):

		When?		Method?	
		__ min. Before*	**__ min. After***	**Finger Prick**	**CGM**
Routine	AM Snack				
	Lunch				
	PM Snack				
	Physical Activity (playground, gym games, outdoor play, etc)				
	Before Bus Ride				
	Swimming				
Special Circumstance	Special Food Activity				
	CGM alert				
	Signs/Symptoms of illness				
	Signs/Symptoms of low blood glucose				
	Signs/Symptoms of high blood glucose				
	After a correction dose				

*Please specify how many minutes before or after

Brand/Model of blood glucose meter: _____

Note: The fingertip should always be used to check blood glucose level if hypoglycemia is suspected.

Participant's self-care blood glucose checking skills:

☐ Independently checks own blood glucose.

☐ May check blood glucose with supervision.

☐ Requires trained diabetes personnel to check blood glucose .

Continuous Glucose Monitor (CGM): ☐ Yes ☐ No
Brand/Model:_____
Alarms set for: ☐ ____mg/dL (low) and ☐ ____mg/dL (high)

Note: If participant has symptoms or signs of hypoglycemia, hyperglycemia, or illness, check fingertip blood glucose level regardless of CGM.

HYPOGLYCEMIA TREATMENT

Participant's usual symptoms of hypoglycemia (list below):

_____

_____

Give a quick-acting glucose product equal to_____grams of carbohydrate if blood glucose level is less than_____mg/dL.

BG determined by: ☐ Finger Prick ☐ Continuous Glucose Monitor (select one)

Please list quick-acting glucose products that will be provided by the parent:

_____

_____

Repeat treatment if blood glucose level is less than_____mg/dL after_____minutes of first treatment.

BG determined by: ☐ Finger Prick ☐ Continuous Glucose Monitor (select one)

Additional treatment: _____

Follow physical activity and sports orders (see page 8).

If the participant is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movements), give:

☐ Glucagon: ☐ 1 mg ☐ 1/2 mg Route: ☐ Intramuscular ☐ Other: _____

Site for glucagon injection: ☐ Arm ☐ Thigh ☐ Other: _____

☐ Call 911 (Emergency Medical Services) and then the participant's parents/guardian.

☐ Contact participant's health care provider.

HYPERGLYCEMIA TREATMENT

Participant's usual symptoms of hyperglycemia (list below):

_____

_____

Check for ketones when blood glucose levels are greater than____mg/dL, every____hours.

BG determined by: ☐ Finger Prick ☐ Continuous Glucose Monitor

Check for ketones by: ☐ Blood ☐ Urine

Additional treatment for ketones: _____

_____

Give correction dose of insulin* when blood glucose levels are greater than_____mg/dL AND at least_____hours since last insulin dose

BG determined by: ☐ Finger Prick ☐Continuous Glucose Monitor

Parents/guardian authorization should be obtained before administering a correction dose ☐ Yes ☐ No

**For insulin pump users: see additional information for participant with insulin pump (pg. 5).*

Give extra water and/or non-sugar-containing drinks (not fruit juices):_____ounces per hour.

Follow physical activity and sports orders (see page 8).

- Notify parents/guardian of onset of hyperglycemia.
- If the participant has symptoms of a hyperglycemia emergency, including dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy, or depressed level of consciousness: Call 911 (Emergency Medical Services) and the participant's parents/
  guardian.
- Contact participant's health care provider.

Please continue onto next page

PLEASE CHECK WHICH INSULIN THERAPY IS USED AND THEN CONTINUE TO THAT SPECIFIC PAGE.

☐ Insulin pump (continue on this page)
☐ Syringe (continue to page 6)
☐ Insulin pen (continue to page 6)

Insulin will be administered ☐ BEFORE ☐ AFTER meal (Please select one).

Will snacks need to be covered or are they "free"? Please specify the carbohydrate limit on free snacks, if there is a blood glucose range for free snacks, etc.

_____

_____

_____

INFORMATION FOR PARTICIPANT WITH INSULIN PUMP

General Information:

Brand/Model of pump: _____
Type of insulin in pump: _____
Basal rates during program: _____
Type of infusion set:_____

Participant's self-care pump skills:	**Independent?**
Count carbohydrates	☐ Yes ☐ No
Bolus correct amount for carbohydrates consumed	☐ Yes ☐ No
Calculate and administer correction bolus	☐ Yes ☐ No
Calculate and set basal profiles	☐ Yes ☐ No
Calculate and set temporary basal rate	☐ Yes ☐ No
Change batteries	☐ Yes ☐ No
Disconnect pump	☐ Yes ☐ No
Troubleshoot alarms and malfunctions	☐ Yes ☐ No
Reconnect pump to infusion set**	☐ Yes ☐ No
Prepare reservoir and tubing**	☐ Yes ☐ No
Insert infusion set**	☐ Yes ☐ No

Pump Failure:

For blood glucose greater than_____mg/dL that has not decreased within _____ hours after correction, consider pump failure or infusion site failure.

Please indicate how you would like PRCR staff to respond:

☐ Notify parents/guardian
☐ Give insulin by syringe*
☐ Give insulin by insulin pen*

*For pump failure: please complete instructions for carb calculation and correction dose on pages 6 and 7.

**For infusion site failure: If participant is not independent, parent/guardian is responsible for inserting new infusion set and/or replacing reservoir.

Physical Activity for Insulin Pump Users

Swimming:
May the pump get wet? ☐ Yes ☐ No
Instructions:_____

Water Activities: (Participant will be dressed in normal day clothes – ie: water play, boating, etc.)
May the pump get wet? ☐ Yes ☐ No
Instructions:_____

Other: Please list other times participant may disconnect from pump (sports activities, specific games, swimming, etc):

_____

_____

If disconnecting:
Set a temporary basal rate ☐ Yes ☒ No _____ % temporary basal for_____hours

INFORMATION FOR PARTICIPANT WITHOUT PUMP OR FOR PUMP FAILURE

Type of insulin therapy during program:
☐ Adjustable Insulin Therapy
☐ Fixed Insulin Therapy
☐ No insulin

Adjustable Insulin Therapy
Name of insulin:_____

Carbohydrate Coverage

Morning Snack (9-10 am): 1 unit of insulin per_____grams of carbohydrate
☐ No coverage for snack
☐ Carbohydrate coverage only
☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and_____hours since last insulin dose.
☐ Other: _____

Lunch (11:30 am- 12:30 pm): 1 unit of insulin per_____grams of carbohydrate
☐ Carbohydrate coverage only
☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and_____hours since last insulin dose.
☐ Other: _____

Afternoon Snack (2-3 pm): 1 unit of insulin per_____grams of carbohydrate

☐ No coverage for snack
☐ Carbohydrate coverage only
☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and_____hours since last insulin dose.
☐ Other: _____

Correction Dose Calculation For Participants Without Pump

Blood Glucose Correction Factor/Insulin Sensitivity Factor = _____

Target blood glucose =_____mg/dL

Participant's self-care insulin administration skills:

☐ Yes ☐ No Independently calculates and gives own injections.
☐ Yes ☐ No May calculate/give own injections with supervision.
☐ Yes ☐ No Requires trained diabetes personnel to calculate/give injections.

Participant's self-care nutrition skills:

☐ Yes ☐ No Independently counts carbohydrates.
☐ Yes ☐ No May count carbohydrates with supervision.
☐ Yes ☐ No Requires trained diabetes personnel to count carbohydrates.

Fixed Insulin Therapy

Name of insulin:_____

☐ _____Units of insulin given pre-lunch daily
☐ _____Units of insulin given pre-snack daily
☐ Other: _____

Parental Authorization to Adjust Insulin Dose:

☐ Yes ☐ No Parents/guardian are authorized to increase or decrease correction dose scale, insulin-to-carbohydrate ratio and fixed insulin dose.

OTHER INFORMATION

Other times to give snacks and content/amount:_____

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

Special event/party food permitted: ☐ Parents/guardian discretion
☐ Participant discretion

OTHER DIABETES MEDICATIONS

Name:_____Dose:_____Route:_____Times given: ____
Name:_____Dose:_____Route:_____Times given: ____

PHYSICAL ACTIVITY AND SPORTS

Special instructions for physical activity/sports (please specify if blood glucose must be above a certain level before physical activity, if a "free" carbohydrate snack should be given and when - ie. before/during/after activity; at a certain blood glucose level, etc.):

_____
_____
_____

If most recent blood glucose is less than_____mg/dL, participant can participate in physical activity when blood glucose is corrected and above_____mg/dL

BG determined by: ☐ finger prick ☐Continuous Glucose Monitor (please select one)

Avoid physical activity when:

☐ Blood glucose is greater than_____mg/dL

BG determined by: ☐ finger prick ☐Continuous Glucose Monitor (please select one)

☐ Blood glucose is greater than_____mg/dL AND ketones are moderate to large

BG determined by: ☐ finger prick ☐Continuous Glucose Monitor (please select one)

Special instructions for swimming (please specify if blood glucose must be above a certain level before swimming, if a "free" carbohydrate snack should be given and when - ie. before/during/after swimming; at a certain blood glucose level, etc.):

_____
_____
_____

Bus Rides:

☐ Participant's blood glucose level must be_____mg/dL or greater in order to ride the bus

For participants with a CGM:

During swimming activities, may the CGM get wet? ☐ Yes ☐ No

During water activities where the participant is dressed in normal day clothes, may the CGM get wet? ☐ Yes ☐ No

(Additional information for participant on insulin pump is in the insulin section on page 6.)

Additional information or special instructions for care:

_____
_____
_____
_____

SIGNATURES: PHYSICIAN

As the treating physician of (child's name:)_____, I have reviewed the program description, likely environmental conditions, and physical requirements of (program name:)_____. In my judgment, I believe (child's name:) _____ may safely participate in (program name:) _____ and that the physical limitations of (child's name:) _____ may be successfully met by non-medical personnel. Therefore, I _____, approve this Medical Management Plan and acknowledge that the procedures outlined in this plan may be performed by non-medical personnel.

_____

Participant's Physician/Health Care Provider Name

_____ _____

Participant's Physician/Health Care Provider Signature Date

I intend and agree that typing my name above constitutes my electronic signature, which acknowledges my consent to the terms set forth herein. I intend that my electronic signature have the same legal force and effect as a written signature. I consent to using electronic means by which to provide written authorization for the Medical Management Plan and procedures for the above referenced child, and further agree that I have provided the written authorization as required by law.

SIGNATURES: PARENT/GUARDIAN

I, (parent/guardian:)_____ give permission to the personnel of the City of Raleigh Parks, Recreation and Cultural Resources Department to perform and carry out the care tasks as outlined in (participant:)_____'s Medical Management Plan.

I understand and acknowledge that the City of Raleigh is not a healthcare provider, and that this document contains protected health information regarding (child's name). I freely authorize disclosure of this information to the City of Raleigh for the purposes stated herein, and I understand that the information used or disclosed herein may be subject to re-disclosure, and that disclosure of this information may mean that this information is no longer protected by Federal privacy regulations. I expressly consent to the release of the information contained in this Medical Management Plan to all program staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the PRCR staff and/or qualified health care professional to contact my child's physician/health care provider. I understand that any action already taken in reliance on this authorization cannot be reversed.

_____

Participant's Parent/Guardian Name

_____ _____

Participant's Parent/Guardian Signature Date

I intend and agree that typing my name above constitutes my electronic signature, which acknowledges my consent to the terms set forth herein. I intend that my electronic signature have the same legal force and effect as a written signature. I consent to using electronic means by which to provide written authorization for the Medical Management Plan and procedures for the above referenced child, and further agree that I have provided the written authorization as required by law.

Diabetes Management Procedures

***To be completed by the parent/guardian.**

I acknowledge that the ability of PR&CR staff to successfully implement (child's name:)_____'s MMP depends on the timeliness and accuracy of the information provided herein. I further acknowledge that PRCR staff will rely upon the information provided herein in order to make reasonable efforts to:

- Provide care consistent with the most current approved MMP.
- Provide accurate, timely information about the scheduled activities and program environment.
- Train staff on all procedures outlined in the DMMP who will be responsible for providing care.
- Ensure trained diabetes personnel are with the participant/on-site at all times during the program.
- Train all other staff in the program how to recognize signs/symptoms of high/low blood glucose and to communicate any concerns to trained diabetes personnel.
- Document care provided as it is given using approved documentation.
- Provide adequate space as needed for diabetes care.
- Provide appropriate storage, access, and disposal for diabetes medication and equipment.
- Communicate with the parent/guardian as outlined in the communication protocol.

☐ _____

☐ _____

Parent/Guardian will:

☐ Provide information regarding the most current approved MMP and any future updates or changes to the plan (when possible at least 2 weeks in advance).

☐ Participate in training staff of the Raleigh Parks, Recreation and Cultural. Resources Department as requested to review equipment and/or procedures that are specific to the participant.

☐ Provide adequate meals/snacks with carbohydrate counts clearly labeled.

☐ Provide clear instructions for how program provided meals/snacks should be handled.
☐ Provide all medication and medical equipment needed to implement the approved MMP in the program.
☐ Perform any site changes that may be needed for participants with a CGM/Insulin Pump.
☐ Communicate with Raleigh Parks, Recreation and Cultural Resources as outlined in the communication protocol.
☐ _____
☐ _____

Medication storage/access:

The following medications will be provided to the program in accordance with the approved MMP and have the following storage/access requirements:

Medication: _____

Storage: _____

Access: ☐ On-site (access in less than 10 minutes, ie. stored in office)
☐ Immediate (medication must be with participant at all times)

Medication: _____

Storage: _____

Access: ☐ On-site (access in less than 10 minutes, ie. stored in office)
☐ Immediate (medication must be with participant at all times)

Medication: _____

Storage: _____

Access: ☐ On-site (access in less than 10 minutes, ie. stored in office)
☐ Immediate (medication must be with participant at all times)

Communication protocol:

I request that Parks, Recreation and Cultural Resources staff contact the parent/guardian immediately in the following circumstances:

☐ Any time the participant's emergency action plan is activated for high or low blood glucose
☐ Any time there is suspected pump failure or infusion site failure
☐ For authorization to give a correction dose
☐ For any circumstance compromising PRCR's ability to provide care
☐ _____
☐ _____

Parks, Recreation and Cultural Resources will contact the parent/guardian:

☐ To discuss special program circumstances that could impact care (examples include field trips, overnights, program provided food)
☐ _____
☐ _____

Parent/Guardian will contact PRCR:

☐ Any time the participant's MMP or management procedures need to be updated
☐ Any time changes in the participant's medical condition could cause care during the program to be problematic
☐ Any time the participant will be absent from the program
☐ _____
☐ _____

Additional information or responsibilities:

_____

_____

_____

Signatures:

_____

Parent/Guardian Name (Print)

_____

Parent/Guardian Signature Date

I intend and agree that typing my name above constitutes my electronic signature, which acknowledges my consent to the terms set forth herein. I intend that my electronic signature have the same legal force and effect as a written signature. I consent to using electronic means by which to provide written authorization for the Medical Management Plan and procedures for the above referenced child, and further agree that I have provided the written authorization as required by law.

Acknowledged and received by:

_____ _____

PRCR Authorized Representative Date