School Year: _____

Model Laboratory School

SCHOOL HEALTH DIVISION
521 Lancaster Avenue
Richmond, KY 40475
Office: 859-622-8575
Fax: 859-622-6658

PARENT PACKET - DIABETES

Dear Parent/Guardian:

You have informed us that your student has a medical concern. Enclosed are forms, which need to be completed by both the Parent/Guardian and student's Physician. These forms are necessary in order for the School Nurse or appropriately trained school personnel to perform or administer specific medical treatment or procedures. This information will help us work with your student to minimize unnecessary restrictions, feelings of being treated differently, and possibly absenteeism.

Please send a current picture of your student in order for the student to be easily identified. This information will be distributed to appropriate school personnel on a need-to-know basis and may include bus drivers, substitute teachers, cafeteria staff, and others who work with your student daily.

To help your student, please let us know of any changes in your student's medical condition or emergency daytime phone numbers.

The following need to be returned to the School Nurse:

- **Health Care Plan for Diabetes**
- **Physician Order for Diabetes Care & Parent/Guardian Statement**
- **Physician Order for Glucagon & Parent/Guardian Statement**

Please note: Effective July 15, 2014, KRS 158.838 was amended to require at least one school employee at each school who has met requirements of KRS 156.502 be on duty during the entire school day to **administer or assist with the self administration of insulin.**

We are looking forward to a great year with your student!

Please call the School Health Services program at 622-8575 if you have any questions.

HEALTH CARE PLAN FOR DIABETES

School Year: _____

Note: This will be shared with the appropriate school personnel such as the Principal, student's teachers, and cafeteria staff.

Name:_____ **Date:** ____ / ____ / ____

DOB: ___ / ___ / ___ **Grade:**_____ **School:**_____

Allergies: _____

Please attach a current photo of your child here.

Emergency Contact Information:

Parent/Guardian:_____Work Phone:_____ Home:_____

Parent/Guardian:_____Work Phone:_____ Home:_____

Emergency Contact: _____ Phone:_____

Doctor:_____ Phone: _____ Hospital: _____

Location of Diabetic Snacks:_____

Location of Glucose Meter: _____

GLUCAGON ORDERED? _____ Yes _____ No *LOCATION OF GLUCAGON*____ _____

HOW TO TREAT LOW BLOOD SUGAR

SIGNS AND SYMPTOMS OF LOW BLOOD SUGAR (HYPOGLYCEMIA):

- The student complains about feeling "low."
- The student exhibits some of all of the following symptoms:
  - Hungry
  - Shaky
  - Unable to Concentrate
  - Lethargic
  - Moist Skin, Sweating
  - Weakness
  - Pale
  - Poor Coordination
  - Combative
  - Dizzy
  - Other _____

IF BLOOD SUGAR IS _____ or less OR if signs of low blood sugar are present:

1. Give one of the following fast-acting carbohydrates:
   - 4 oz. (1/2 cup) Apple or Orange Juice
   - 4 oz. REGULAR soda – NOT diet!
   - Honey Packet
   - Half Tube of Cake Icing
   - Or: _____
2. Contact the School Nurse: **DO NOT LEAVE THE STUDENT ALONE OR SEND TO OFFICE ALONE**
3. Observe the student for 10 to 15 minutes and check for improvement:
   - Student feels/appears OK and
   - Blood Sugar is > _____ when re-checked.
4. If student continues to feel poorly or Blood Sugar is LESS THAN _____, repeat steps 1 through 3 until Blood Sugar is greater than _____.
5. If the student improves, have him/her eat one of the following:
   - Lunch or Snack – Whichever is due within the hour OR
   - Pre-packaged snack such as cheese crackers if lunch or snack is not scheduled within the hour.

Reviewed by: _____*RN* *Date:* _____

HEALTH CARE PLAN FOR DIABETES

School Year: _____

IF STUDENT IS ***UNABLE*** TO PARTICIPATE IN CARE:

1. If student is having symptoms such as:
   ☐ Unable to Swallow ☐ Uncooperative ☐ Combative ☐ Unconsciousness ☐ Seizures

   Place student on his/her side and have someone else call Parent/Guardian and 911.

   Keep student safe if he/she has seizure activity by moving furniture, etc.

2. GIVE **GLUCAGON** INJECTION per Physician order.

3. Observe and monitor until EMS arrives.

HOW TO TREAT **HIGH** BLOOD SUGAR

SIGNS AND SYMPTOMS OF HIGH BLOOD SUGAR (HYPERGLYCEMIA):

- The student with hyperglycemia will exhibit the following symptoms:
  - Excessive Thirst
  - Frequent Urination
  - Personality/Behavior Change
  - Nausea
  - Blurry Vision
  - Fatigue
  - Inability to Concentrate
  - Other _____

- If the student exhibits any of the symptoms listed above, check the student's Blood Glucose.

IF BLOOD GLUCOSE IS HIGHER THAN_____, OR THE ABOVE SYMPTOMS ARE PRESENT:

- Encourage the student to drink water.
- Allow free access to the bathroom.
- **Notify School Nurse**

- If the student is **VOMITING** or **LETHARGIC**, call the Parent/Guardian OR call for medical assistance if Parent/Guardian or emergency contact cannot be reached.

EMERGENCY CONTACT LIST	TRAINED SCHOOL PERSONNEL
1. _____	
Relation: _____ **Phone:** _____	**1.** _____ **Rm:** _____
2. _____	
Relation: _____ **Phone:** _____	**2.** _____ **Rm:** _____
3. _____	
Relation: _____ **Phone:** _____	**3.** _____ **Rm:** _____

Reviewed by: _____*RN* *Date:* _____

School: _____ **School Year:** _____

PHYSICIAN ORDER FOR DIABETES CARE *(or attach your agency's standard orders)*

To be completed by the student's Physician and returned to School Health: Confidential FAX (859) 622-6658 *or by mail:* Model Laboratory School, 521 Lancaster Ave, Richmond, Ky 40475.

STUDENT'S NAME: _____ **Date of Birth:** _____

ALLERGIES: _____

BLOOD SUGAR MONITORING NEEDED DURING SCHOOL HOURS:

☐ **Before Meal** ☐ **2 Hours after Meal**

☐ **Before Snack** ☐ **Other (Explain):** _____

***Can Student perform his or her own Blood Sugar Checks?** ☐ **Yes** ☐ **No**

INSULIN:

Type of Insulin to be administered at school: _____

☐ **Pen** ☐ **Pump**

☐ **Insulin Units to Carbohydrate Ratio:** _____

Correction Factor: _____

_____

CAN STUDENT GIVE OWN INJECTIONS? ☐ **Yes** ☐ **No**

CAN STUDENT CALCULATE CARBS & DETERMINE CORRECT AMOUNT OF INSULIN? ☐ **Yes** ☐ **No**

CAN STUDENT DIAL CORRECT DOSE OF INSULIN? ☐ **Yes** ☐ **No**

IF PUMP, CAN STUDENT EFFECTIVELY TROUBLESHOOT PROBLEMS? ☐ **Yes** ☐ **No**

I ORDER THE TESTING OF URINE FOR KETONES IF BLOOD GLUCOSE IS > _____

Additional Instructions: _____

I give permission for this student to check his/her own Blood Sugar, calculate his/her own carb intake, then determine and administer the appropriate amount of insulin INDEPENDENTLY. If student is deemed independent on the aforementioned procedures, the School Nurse or trained personnel WILL NOT oversee the student's actions. ☐ **Yes** ☐ **No**

X _____ _____

(Physician's Signature) Date

_____ _____

(Physician's Name - Printed) Telephone Number

PARENT/GUARDIAN STATEMENT

☐ I, the undersigned Parent/Guardian of _____, **authorize a School Nurse or "trained staff member" to administer** the above medication to my student per Physician instructions. I agree to furnish the necessary prescribed medication and agree to notify the School Nurse immediately of any changes. I agree to pick up any unused medication within two weeks of the last day of school, or it shall be destroyed.

☐ I, the undersigned Parent/Guardian of _____ give consent for ****my student to self-administer** the above medication(s). I understand the Madison County Board of Education Medication Policies & Procedures (09.2241) are readily available for me to read. I hereby agree to release and hold the school staff free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from such treatment. I have read this Consent and understand all its terms. I sign it voluntarily and with full knowledge of its significance.
I agree to notify the School Nurse immediately if there is any change in my student's status or Physician's orders. The School Nurse reserves the right to monitor the student periodically throughout the year.

X _____ _____ / _____ / _____

(Parent/Guardian Signature) **Date**

Home Phone: _____ **Work:** _____ **Cell:** _____

Reviewed by: _____*RN* *Date:* _____

School: _____ **School Year:** _____

PHYSICIAN & PARENT/GUARDIAN AUTHORIZATION FOR GLUCAGON MEDICATION ADMINISTRATION

The Board of Education of Madison*County has adopted a procedure wherein a member of the staff of the school the student is attending will administer either an injection or prescribed drug in the event of a crisis. The undersigned understands that the staff member administering the above care is not a trained health professional, but is trained by the School Nurse per state law and that this individual will undertake to do his or her best to comply with the recommended procedure as developed by the student's Physician in the case of a life-threatening emergency wherein immediate intervention is required by school personnel.*

The undersigned Parent/Guardian does hereby consent to the intervention of school personnel in accordance with the instructions contained in the attached letter from the student's Physician. Additionally, the undersigned agrees to hold school personnel harmless for any injuries resulting from the emergency care unless the injury was caused by the volunteer's negligence.

PHYSICIAN ORDER FOR GLUCAGON

To be completed by the student's Physician and returned to School Health: Confidential FAX (859) 622-6658 *or by mail:* Model Laboratory School, 521 Lancaster Ave., Richmond, KY 40475.

STUDENT'S NAME: _____ **Date of Birth:** _____

ALLERGIES: _____

STUDENT'S TYPICAL REACTION: _____

_____

ACTION TO BE TAKEN:

☐ **I order the administration of Glucagon for treatment of severe hypoglycemia. I understand that since the School Nurse is not present in the school at all times, the School Nurse will be teaching unlicensed staff from the school to administer the drug if needed.**

Please administer Glucagon/Glucagen 1 mg by IM injection for Blood Sugar below _____ or unconsciousness. Must follow with a snack and contact Parent/Guardian.

COMMENTS: _____

_____

* **Madison** ***County Public Schools' Protocol requires notification of EMS and Parent/Guardian when Glucagon is administered.***

X _____ _____
(Physician's Signature) Date

_____ _____
(Physician's Name - Printed) Telephone Number

* ***PLEASE NOTE: The School Nurse is NOT always in the school building and trains non-medical staff to administer medication.***

PARENT/GUARDIAN STATEMENT

☐ I, the undersigned parent/guardian of _____, request that a *trained staff member administer the above medication to my student per Physician instructions. I agree to furnish the necessary prescribed medication and agree to notify the School Nurse immediately of any changes. I understand the Madison County Board of Education Medication Policies & Procedures (09.2241) are readily available for me to read. I sign this voluntarily and with full knowledge of its significance. I agree to pick up any unused medication within two weeks of the last day of school, or it shall be destroyed.

I agree to notify the School Nurse immediately if there is any change in my student's status or Physician's orders.

* ***Parent/Student are responsible to have medication available at school.***

X _____ _____ **/** _____ **/** _____
(Parent/Guardian Signature) **Date**

Home Phone: _____ **Work:** _____ **Cell:** _____

Reviewed by: _____***RN*** ***Date:*** _____

School Year: _____

ROLES & RESPONSIBILITIES
IN THE MANAGEMENT OF STUDENTS WITH DIABETES

The School Nurse will work with the student, family, student's Physician, and school system personnel as a team to help the diabetic student achieve his or her optimal level of health. The following are responsibilities of each party:

PARENTS/GUARDIANS

1. Provide all necessary equipment for the management of their child's diabetes such as glucose-testing equipment, urine ketone test strips, insulin administration equipment, a used sharps container, and glucagon. A record book may also be provided by the parent/guardian in which blood sugar, carbohydrate counts, and insulin can be recorded for home use, but the School Nurse will also record this information on Madison County Health Department flow sheets which will be kept in the student's permanent chart.
2. Provide snacks to be kept at school.
3. If ordered by the physician, ensure Glucagon is taken to the front office at the beginning of the school year or when the child is newly diagnosed as diabetic. The Glucagon should be picked up by the parent/guardian at the end of the school year.
4. Effective treatment for hypoglycemic episodes should be available at school (e.g., glucose tablets, juice).
5. Complete Healthcare Plan for Diabetes packet and return as soon as possible to the School Nurse.
6. Inform the School Nurse immediately if any changes are made to the Healthcare Plan for Diabetes by the student's health care team.
7. Maintain current telephone numbers where they can be reached in an emergency.

SCHOOL NURSE

1. Identify and maintain current list at school of diabetic students.
2. Send out Diabetic packet prior to the start of the school year for known diabetics and encourage prompt return from the parent/guardian.
3. Develop an Individual Health Plan for each diabetic in the school, which will be reviewed at least annually and as needed to keep current with the Physician's orders.
4. Maintain communication with health care team as needed to revise health care plan.
5. Maintain proper documentation.
6. Maintain skills so that they are up to date with the current trends in diabetic management.
7. Train the appropriate staff within the building about diabetes management and ensure they are fully aware of their role.
8. Perform and/or oversee blood glucose checks and/or insulin administration to students who cannot perform these tasks independently.
9. Work with the student and team to help the pupil achieve the greatest level of independence as appropriate.
10. Notify parent/guardian when supplies are low – (e.g., lancets, Insulin, blood glucose strips, alcohol pads).
11. Ensure Insulin and Glucagon have not expired.
12. Dispose of sharps container in appropriate manner – Return to Health Department.

HEALTH-CARE TEAM (PHYSICIAN, DIABETES NURSE EDUCATOR, DIETICIAN, SOCIAL WORKER, ETC.)

1. Complete Diabetic Health sheet, which will provide the orders needed for the School Nurse to develop the Diabetic Care Plan.
2. Maintain communication with School Nurse as needed to maintain and revise the Healthcare Plan for Diabetes.

STUDENT

1. Adhere to meal plan.
2. Perform blood glucose tests and record in appropriate log if able.
3. Be available for School Nurse to administer treatment – blood glucose check and/or insulin injection.
4. Be an active participant in the health care plan.
5. IF ABLE - Notify a teacher or School Nurse immediately if symptoms of hyperglycemia or hypoglycemia are present.
6. Have a source of carbohydrate to correct hypoglycemia readily available.
7. Participate in school activities without unnecessary restrictions as deemed appropriate by the student and health care team.
8. "Participate in caring for his or her diabetes equipment in a responsible manner."

School Year: _____

ROLES & RESPONSIBILITIES
IN THE MANAGEMENT OF STUDENTS WITH DIABETES

TEACHERS

1. Participate in the development of the health care plan as appropriate.
2. Be aware of the symptoms of hypoglycemia and hyperglycemia and act appropriately.
3. Attend training offered by the School Nurse at the beginning of the school year or when a student is newly diagnosed with diabetes.
4. Allow student free access to bathroom and water when blood sugar is >200.
5. Provide information for any substitute teacher regarding the health care plan of a student with diabetes.
6. Notify School Nurse of upcoming field trips.
7. If student has Glucagon in the front office, ensure it accompanies him or her on ALL field trips.
8. Help the student comply with meal and snack requirements.
9. Accompany student to School Nurse's office or front office if feeling hyperglycemic or hypoglycemic.

PRINCIPALS/ADMINISTRATORS

1. Attend training on Glucagon offered by the School Nurse at the beginning of the school year if school has known diabetics OR when a student is newly diagnosed as diabetic
2. Be aware of students who have diabetes in the school and where their healthcare plan is located

FOOD SERVICE STAFF

1. Be informed about the management of diabetes and the roles of foods and snacks.
2. Know the symptoms of hyperglycemia and hypoglycemia and appropriate treatment for hypoglycemia.
3. Be able to provide School Nurse with carbohydrate count of school menu offerings.
4. Be aware of a student's diabetes health care plan as it relates to food and snacks and accommodate the medical needs of the pupil.

SPECIAL AREA TEACHERS AND COACHES

1. Be aware of the student's health care plan and attend training offered by the School Nurse.
2. Know the symptoms of hyperglycemia and hypoglycemia and how to treat as outlined by the healthcare plan.
3. Be aware of the student's healthcare plan as it relates to sports and exercise and follow accordingly.
4. Encourage the student to participate in physical activities.

Madison County School District School Health Program

Permission Form for Prescribed and Over the Counter Medication

TO BE COMPLETED BY SCHOOL PERSONNEL

School:_____Date form received:_____

I/we acknowledge receipt of this Physician's Statement and Parent Authorization._____

Student Name:_____Student age: _____Date of Birth:_____

Grade:_____Homeroom/Classroom:_____

TO BE COMPLETED BY PARENT / GUARDIAN

************(MUST BE IN CHILD SPECIFIC, CURRENT, ORIGINAL PHARMACY LABELED CONTAINER)************

Name of medication: _____Reason for medication:_____

ALLERGIES:_____ Any OTHER Condition(s):_____

Form of medication/treatment:_____

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

Instructions (Schedule and dose to be given at school:_____

_____

Start: ☐ Date form received ☐ Other, as specified:_____

Stop: ☐ End of school year ☐ Other date/duration:_____

☐ **For episodic/emergency events only**

Restrictions and/or important side effects: ☐ No restrictions

☐ Yes. Please describe:_____

_____

Special storage requirements: ☐ None ☐ Refrigerate

Other Instrructions:_____

Parent or Guardian Signature_____Date:_____

Health Care Provider Name_____

Address:_____ Phone:_____ FAX:_____

I give permission for (name of child)_____ is to receive the above stated medication at school according to standard school policy. I release the School Board and its employees from any claims or liability connected with its reliance on this permission.

(Parent/guardians to bring the medication in its original container.)

Date:_____Signature:_____ Relationship:_____

Home phone:_____ Work phone:_____ Emergency or CELL phone:_____

TO BE COMPLETED BY Health Care Provider

♦♦♦For Self-Administration or EMERGENCY ♦♦♦For Self-Administration or EMERGENCY ♦♦♦For Self-Administration or EMERGENCY♦♦♦

This student is capable, responsible, and demonstrated self-administration of the above medication:

☐ **Yes - Unsupervised** ☐ **Yes-Supervised** ☐ **No**

This student may carry this medication: ☐ **Yes** ☐ **No** **Any restriction(s):_____**

The school nurse will delegate and train designated school personnel to give the above stated emergency medication if necessary.

Please indicate if you have provided additional information:

☐ On the back side of this form ☐ As an attachment

Signature:_____Date_____

Physician or Authorized Provider

******Over the counter medications can be given no more than 3 consecutive days without written orders from health care provider.** **MCBE 1 (7-2014)**

Adapted from the Academy of Pediatrics