



Health forms for students with **Diabetes**

Please complete packet and return to nurse at child's school

What's in this packet?

- 1) Parent Letter – parent keeps
- 2) Release of Information - allows the doctor to talk to the school nurse if there are any questions
- 3) Diabetes Questionnaire – parent completes, explains how your child is affected by and manages their diabetes
- 4) Diabetes Management Agreement – parent signs giving consent for care at school and introduces how care will be provided at school
- 5) Guidelines for Medicines at School – parent reference
- 6) Diabetes Management at School – Healthcare Provider letter – A letter to give to your child's doctor or healthcare provider
- 7) Diabetes Medical Management Plan – doctor completes, the form provides the school with medical orders needed to care for your child while at school
- 8) Prescribed Insulin Authorization Form – doctor completes if they prefer this format for prescribing diabetes medication

Questions? Please call your school nurse.



Dear Parent/Guardian of _____:

Date: _____

Columbus City Schools provides nursing services that promote students ability to learn. Our goals are to:

- Assist students in learning how to take care of their health.
- Ensure a safe school environment.
- Promote good control of a student’s health condition so they are ready to learn.

To help us meet the above goals:

1. All school nurses in Columbus City Schools are registered nurses.
2. The school nurses work closely with the student’s parents/guardians and their Healthcare Providers to assure access to necessary resources.
3. The district also has a Diabetes Resource Nurse with advanced training to assist other school nurses, school personnel, students with diabetes, and their parents/guardians and to collaborate with the student’s healthcare provider.

In order to assist your child at school and promote diabetes management, the forms below are required each school year. Please give the completed and signed forms below to the school nurse prior to starting school:

- *Diabetes Management - Parent Agreement* – Parent permission for the school to provide diabetes care
- *Diabetes Questionnaire* - Completed by parent/guardian
- *Diabetes Medical Management Plan* – Completed by the healthcare provider

In the best interest of your child’s health and safety - your child can NOT be in school unless we have ALL diabetes related paperwork, medical orders AND ALL necessary supplies listed below.

Supplies that must be provided in order for school personnel to follow medical orders include:

- | | |
|--|---|
| <input type="checkbox"/> 8- Fast acting sugar sources (15 gm glucose tablets, juice, etc) to treat low blood sugar | <input type="checkbox"/> Blood glucose meter |
| <input type="checkbox"/> 8 - Carbohydrate/protein snacks | <input type="checkbox"/> Blood glucose test strips |
| <input type="checkbox"/> Insulin vial or insulin pen cartridge in Pharmacy box | <input type="checkbox"/> Lancet device and Lancets |
| <input type="checkbox"/> Insulin syringes or pen needles | <input type="checkbox"/> Urine Ketone testing strips |
| | <input type="checkbox"/> Insulin Pump Supplies for back-up (if pump is ordered for student) |
| | <input type="checkbox"/> Glucagon Kit |
| | <input type="checkbox"/> Other: _____ |

We are looking forward to helping your child be successful in school. Please feel free to contact me with any questions or concerns.

Your child’s School Nurse is: _____

Phone number: _____

Days at school: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

CHILD'S NAME: _____

DATE OF BIRTH: _____ STUDENT #: _____

I hereby give consent for the exchange of the information as checked below concerning the above-named child between the party indicated and Columbus City Schools.

_____ Obtain Information From: _____

_____ Release Information To: _____

_____ Medical Information/Records

_____ TB Test Results/Records

_____ Immunization Records

_____ Achievement and Aptitude Test Scores

_____ Psychological Information/Records

_____ Grades and Attendance

_____ Speech and/or Hearing Evaluation

_____ Individual Education Plan (IEP), if in Special Education

_____ Other Information, as specified: _____

This information to be used for:

Parent/Guardian Signature

Date

Student: _____
DOB: _____ Student ID: _____
School: _____
Grade: _____ Room: _____ School Year: _____

**DIABETES
QUESTIONNAIRE**



Complete & Return to the School Nurse as soon as possible. The information is needed to assist your student.

Person to Contact:	Relationship:	Work/Cell Phone:	Home Phone:
1. _____	_____	_____	_____
2. _____	_____	_____	_____
Preferred Communication Method	<input type="checkbox"/> phone <input type="checkbox"/> written <input checked="" type="checkbox"/> in person	<input type="checkbox"/> email:	_____
Health Provider Name	Phone:	Fax:	_____

Student is diagnosed with: Type 1 Type 2 Other: _____ Age at Diagnosis: _____

Does the student take insulin: at home at school none

Does the student wear a medical alert bracelet/necklace: Yes No

What is the student's blood glucose (BG) target range? _____ mg/dl to _____

Does the student check their BG? at home at school none

(Completed Medical Management Plan with medication orders is required from healthcare provider)

When does student check BG at home: before each meal before physical activity
 with symptoms of high BG after physical activity
 with symptoms of low BG other: _____

Does the student test urine for ketones? at home at school none

If yes, when does student check for urine ketones? When BG is greater than _____

What BG level is considered low for the student? _____ below _____ What has been their lowest BG? _____

How often does the student typically experience low BG? daily weekly
 monthly other _____

When does student typically have low BG: mid AM before lunch afternoon
 not often after exercise Other _____

If student takes the bus, how long is bus ride? _____

Please check the student's usual signs/symptoms of low blood glucose:

<input type="checkbox"/> hunger or "butterfly feeling"	<input type="checkbox"/> irritable	<input type="checkbox"/> difficulty with speech
<input type="checkbox"/> shaky/trembling	<input type="checkbox"/> weak/drowsy	<input type="checkbox"/> anxious
<input type="checkbox"/> dizzy	<input type="checkbox"/> pale	<input type="checkbox"/> confused/disoriented
<input type="checkbox"/> sweaty	<input type="checkbox"/> severe headache	<input type="checkbox"/> loss of consciousness
<input type="checkbox"/> rapid heartbeat	<input type="checkbox"/> impaired vision	<input type="checkbox"/> seizure activity
<input type="checkbox"/> inappropriate crying/laughing	<input type="checkbox"/> difficulty with coordination	<input type="checkbox"/> Other _____

Does the student recognize these signs/symptoms? Yes No

How are low BG levels treated at home? Be specific. State amount of food, beverage, Glucagon, etc.:

Does the student need daily snacks at school? Yes No **If yes, what and when:** _____

ALL SNACKS AND SUPPLIES used at school MUST be provided by the family.

What would you like done about birthday treats and/or party snacks? _____

In the past year, how often has the student been treated for **severe low** BG? _____ times

In the past year, how often has the student been treated for **severe high** BG? _____ times

In the past year, has the student been seen for diabetes care:
 In the emergency room overnight in the hospital

NOTES/COMMENTS: _____

Please indicate the student's skill level for the following:

Skill	Does alone	Adult Help	Adult Performs	Comments
Checks blood glucose				
Reads meter and records				
Counts carbs for meals/snack				
Calculate carb & correction dose				
Determines total insulin dose				
Interpret sliding scale - if has one				
Draw up/dial insulin dose				
Selects insulin injection site				
Gives insulin injection				
Checks urine ketones				
Pump Skills				

Does the student use an insulin to carbohydrate ratio with meals at home?

Yes No Ratio: _____

Does the student use an insulin adjustment for high or low BG at home?

Yes No

Insulin routine at home, if applicable

Name of Insulin:	Units or Ratio:	Time:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Typical carbs at:
Breakfast -
Lunch -
Dinner -
Other -
Other -

Check Method
<input type="checkbox"/> Pen
<input type="checkbox"/> Syringe/vial
<input type="checkbox"/> Pump

Other medication taken on a regular basis:

Name	By (mouth, injection, etc.)	Dose	Time of day
_____	_____	_____	_____

As needed medication:

Name	By (mouth, injection, etc.)	Dose	Time of day
_____	_____	_____	_____

Please list side effects of the student's medications that may affect their learning and/or behavior:

A Diabetes Medical Management Plan and medication orders from the student's healthcare provider must be completed yearly. ALL insulin, medication and diabetes related supplies MUST be brought to the school by the family; for health and safety reasons, a student cannot attend school without them. All medication must be in the original labeled container.

What action do you want school staff to take if the student does not respond to treatment/medication?

Is the student compliant with their diabetes medical management at home? Yes No Sometimes

Comments: _____

Has the student received diabetes education? Yes No If yes, where: (check **all** that apply)

- by healthcare provider at support group community agency
 at camp other _____

Please add anything else you would like school personnel to know about the student's diabetes (or any health condition).

Information provided by _____
Name Relationship to Student Date

I authorize reciprocal release of information related to the student's diabetes between the school nurse and the healthcare provider.

Parent/Guardian Signature _____ Date _____ 5-2018



Diabetes Management at School – Agreement

Student Name: _____ School Year: _____ - _____

School: _____ Birth date: _____ Grade: _____

PARENT/GUARDIAN TO COMPLETE:

We (I), _____, request that the specialized health care service prescribed by the student's healthcare provider be provided for the student. We (I) authorize the school to appoint a qualified designated person(s) to ensure the prescribed treatment is provided in the absence of the school nurse. We (I) agree to immediately notify school personnel of any change in either the student's treatment regimen or the authorizing healthcare provider.

THE FOLLOWING INFORMATION IS NECESSARY FOR COLUMBUS CITY SCHOOL STUDENTS REQUIRING PRESCRIBED MEDICATION IN SCHOOL; **PARENT must sign this form and ensure the school has the Medical Management orders from the Healthcare Provider.**

1. I request permission for the above student to use medication according to the healthcare provider's medication order as part of the Diabetes Medical Management Plan for school.
2. I assume responsibility for the safe delivery of the medication **AND SUPPLIES** to school, either by myself or by the student.
3. I will notify the school immediately if there is any change in the student's Medical Management Plan.
4. I authorize Columbus City School Health Services personnel to communicate with the student's healthcare providers as necessary concerning the medical management of the student at school.
5. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

In addition:

1. I am responsible to assure the student regularly monitors blood glucose and is compliant with medication regimen as prescribed.
2. I am to maintain regular appointments with the prescribing healthcare provider and the student.
3. This agreement will last for only one academic school year.

Signature(s) of Parent or Guardian

Date

Home Telephone

Cell Phone

Work Telephone



Guidelines for Medications at School

Students needing to take medication during school hours must follow these guidelines:

- **Provide the school nurse with a completed Medication Authorization Form signed by both the parent/guardian and the healthcare provider.**

- **A new Medication Authorization Form must be completed each school year AND when the medication or dose has changed.**

- **All medication must be in the original container in which it was dispensed by the healthcare provider or pharmacy and be labeled with the correct dose and instructions.**
 - The label must match what is on the Medication Authorization Form.
 - Students taking a medication at both school and home can request 2 separate labeled bottles from the pharmacy to divide the pills to have some at home and school.
 - Students using an inhaler, epinephrine pen or other emergency medications at school can request 2 prescriptions from the healthcare provider in order to have a supply at home and school.

- **School personnel cannot give over-the-counter medications unless prescribed by a healthcare provider. A Medication Authorization Form must be completed.**

Prescribed over the counter medications follow the same guidelines as stated above for prescribed medications. (Over the counter medications include pain medication such as Tylenol, cough medicine, ointments.)

- **Medications ordered three times a day or less, unless time is specified, may not need to be taken at school.** The medication should be given before school, after school and at bedtime.

- ***All unused medication must be picked up by the parent/guardian on the last day of school or it will be discarded.***



EFFECTIVE DIABETES MANAGEMENT AT SCHOOL

Dear Healthcare Provider:

Columbus City Schools provides nursing services that promote students ability to learn. Our goals are to:

- Assist students in learning how to take care of their health.
- Ensure a safe school environment.
- Promote good control of a student's health condition so they are ready to learn.

Methods:

1. To help meet the above goals, all school nurses in Columbus City Schools are registered nurses.
2. The school nurses work closely with the student's parents/guardians and their Healthcare Providers to assure access to necessary resources.
3. The district also has a Diabetes Resource Nurse with advanced training to assist other school nurses, school personnel, individual students with diabetes, and their parents/guardians and to collaborate with the student's healthcare provider.

Documentation Requirements: In order to help address student needs and promote effective management, the following information is required each year from the healthcare provider; **we understand some medical plans can be obtained from healthcare provider's websites:**

- A written Medical Management Plan for diabetes care at school including directives for treating hypo/hyperglycemia
- Insulin/Medication Orders

In the best interest of the students health and safety – the student may NOT be in school unless we have ALL diabetes related paperwork, medical orders AND ALL necessary diabetes supplies.

Necessary Supplies: The nurses will work with the students' parents/guardians to assure that adequate supplies, as listed in the student's diabetes management plan, are provided at school:

- Glucose treatment sources and snacks to treat low blood sugar.
- Insulin and injection equipment and supplies
- Blood glucose meter, strips, lancets and other supplies
- Insulin Pump Supplies for back-up (if pump is ordered for student)
- Ketone testing strips and equipment
- Glucagon (if ordered)

We are looking forward to assisting your patient and their parents/guardians with their health care needs to assure optimal school health, safety and academic success. Please feel free to contact me at _____ with any questions or concerns. Thank you.

Sincerely,

School Nurse _____

School: _____

Rev.5/17



Columbus City Schools

DIABETES MEDICAL MANAGEMENT PLAN FOR SCHOOL

Year: _____ - _____

Student: _____ **DOB:** _____ **Grade:** _____ **Room:** _____
Student ID: _____ **School:** _____
Type of Diabetes: Type 1 Type 2 Pre-Diabetes Other _____
Date of diagnosis _____

Blood Glucose Monitoring

Blood glucose target range: _____ - _____ mg/dl

- Blood glucose testing times: _____
- No blood glucose testing at school Other _____
- Only at student's discretion
- For suspected hypo or hyperglycemia and as needed
- Testing BG, the student: needs assistance needs supervision is independent
- Test blood glucose prior to dismissal and other times as needed

Diabetes Medication

- No insulin at school
 - Oral diabetes medication at school: _____
- | | | | | | | |
|--|---|--------------------------------------|---------------------------------------|---|--|--|
| | | | | Medication – Dose -- Time | | |
| <input type="checkbox"/> Insulin at school | <input type="checkbox"/> Humalog | <input type="checkbox"/> Novolog | <input type="checkbox"/> Lantus | <input type="checkbox"/> Other _____ | | |
| Insulin delivery device: | <input type="checkbox"/> Syringe and vial | <input type="checkbox"/> Insulin pen | <input type="checkbox"/> Insulin pump | <input type="checkbox"/> Continuous Glucose Monitor | | |
- Insulin dose at school:
- Breakfast _____ units of insulin per _____ grams of carbohydrate
 - Lunch _____ units of insulin per _____ grams of carbohydrate
 - Other: _____
 - Correction for high glucose: _____ units of insulin for every _____ mg/dl above _____ mg/dl
 (Correction bolus is given with meals or as directed for by prescribing physician)

If scale applicable

Blood Glucose Value (mg/dl)	Units of Insulin

Note: Meal bolus and correction bolus equals the total insulin dose.

Meal Plan

- Student follows insulin carb ratio as stated on page 1.
- OR – Meal plan prescribed (see below) 1 Carbohydrate choice = _____ Grams of carbohydrate
- Breakfast: # of carbohydrate choices = _____
- Lunch: # of carbohydrate choices = _____
- Snacks: # of carbohydrate choices = _____
- Plan for pre-activity: _____
- Plan for after school activities: _____
- Extra food allowed Parent/guardian's discretion Student's discretion

Hypoglycemia

Low Blood Glucose < _____ mg/dl

- Self-treatment of mild lows Assistance for all lows
- Immediately treat with 15 g of fast-acting carbohydrate (e.g., 4 oz juice, 3-4 glucose tabs, 5 oz regular soda)
- Recheck blood glucose in 15 minutes and repeat 15 grams of carbohydrate if blood glucose remains < target
- If more than 1 hour until next meal or snack, student should have a 15-gram carbohydrate, protein, fat snack
- If student will be participating in additional exercise or activity before the next meal, provide an additional carb choice
- If student is using an insulin pump:

Severe Hypoglycemia

If the child is unconscious or having seizures due to low blood glucose the school nurse or trained staff per protocol will immediately administer injection of: **Glucagon _____ mg (glucagon emergency kit) per directions**

- Immediately after administering the Glucagon, turn the child onto their side. Vomiting is a common side effect.
- Notify parent and EMS per protocol

Hyperglycemia

High Blood Glucose ≥ _____ mg/dl

- Check ketones when blood glucose > _____ mg/dl or student is sick
- Use correction scale insulin orders when blood glucose is _____ mg/dl
- Unlimited water and bathroom pass
- Notify parent immediately of blood glucose > _____ mg/dl or if student is vomiting
- If student is using an insulin pump, follow DKA prevention protocol

Insulin Pump Instructions

Note: Insulin/carb ratio and correction factor noted above. Additional directions:

Is there a temporary Basal Rate before gym: Yes No

Hyperglycemia Treatment:

Hyperglycemia/ Sensitivity Factor: 1 unit of insulin will decrease the BG by _____ mg/dl

If BG has not dropped or is higher, check tubing, insulin cartridge or pump may be malfunctioning. Call parent if needed.

Student is fully instructed and should be responsible for: giving boluses & changing the infusion site: ____ Yes ____ No

Hypoglycemia Treatment:

Special Occasions

- Arrange for appropriate monitoring and access to supplies on all field trips and school related events.

Signature of Physician/ Licensed Prescriber

Date

Print name of Physician/ Licensed Prescriber

Clinic Address

Phone

Fax

Returned to:

Licensed School Nurse

Phone

Fax



Prescribed Insulin Authorization

Student Name: _____ DOB: ___/___/___ Room/Grade: _____ Today's Date: _____

Student Address: _____ Name of school: _____

School Nurse: _____ School Phone: _____ School Fax: _____

Diagnosis: Diabetes Type 1 Diabetes Type 2 Pre-diabetes Other _____

Type of Insulin: insulin lispro (Humalog®) insulin aspart (Novolog®) Other _____

Administration Method: Syringe/vial Pen Pump
 Oral medication _____ Dose _____ Time _____

Insulin Dose and Time:

Carbohydrate ratio for (circle) Breakfast / Lunch / All meals: 1 unit for _____ grams of carbohydrates

Carbohydrate ratio for (circle) Breakfast / Lunch / All meals: 1 unit for _____ grams of carbohydrates

Carbohydrate ratio for Snacks 1 unit for _____ grams of carbohydrates

Correction Target BG: _____ mg/dL

Insulin correction factor, give: _____ unit(s) for every _____ mg/dL above correction target BG

Round Insulin dose to nearest unit: (circle) Half / Whole / Not applicable

Glucagon Administration: in case of seizure, unconsciousness, or unable to drink and/or eat give:

0.5 mg injection 1 mg injection as instructed for severe hypoglycemia

Other (ie: Pump information, sliding scale):

Parent/Guardian Signature _____ Date _____

Parent/Guardian Phone Number _____

Below completed by healthcare provider:

Beginning Date: _____ Expiration Date: _____

Possible Adverse Reactions: _____

Special Instructions: _____

Healthcare Provider Signature: _____ Date: _____

Healthcare Provider Printed Name: _____

Address _____

Telephone _____

Fax _____

Or Stamp _____