# MAMARONECK
Union Free School District
Mamaroneck, NY 10543


## Diabetes Letter to parents

Dear Parent/Guardian,

Our records indicate that your child has diabetes. Our hope is that your child will have the best possible school year. It is important that we have the necessary supplies and proper authorization to provide appropriate care. At the beginning of each school year, please provide the following forms to the Health Office and needed supplies:

1. DIABETES MEDICATION ADMINISTRATION FORM –completed by your Physician & Parent
2. DIABETES EMERGENCY ACTION PLAN –completed by your Physician
3. DIABETES INFORMATION FORM – completed by the Parent/Guardian
4. CONSENT TO RELEASE MEDICAL INFORMATION- completed by the Parent/Guardian
5. MEDICATION PERMISSION SHEETS FOR INSULIN and GLUCAGON- completed by your Physician
6. ATTESTATION and PARENT PERMISSION REQUIRED FOR INDEPENDENT MEDICATION CARRY AND USE - completed by your Physician and the Parent/Guardian

Your child's supplies should be labeled and include:

- Blood glucose meter and batteries
- Lancet device/lancets
- Test strips
- Insulin
- Pump supplies
- Syringes and/or Insulin pen with cartridges/needles
- Glucagon kit for emergency ( check expiration date)
- Glucose tablets or gel
- Ketone sticks
- Snacks and juice

All diabetic students are expected to carry a small bag with needed supplies in the event of an evacuation or needed medical assistance when they are not in the nurse's office.

Students with diabetes will not be permitted to attend school until Physicians orders for the current school year are in place. This applies even at the High School where some students are independent with their care.

Please inform the school nurse of any changes in your child's health condition or medication schedule.

Thank you,

Attach student photo here

# DIABETES MEDICATION ADMINISTRATION FORM [PART A]

Provider Medication Order Form – Office of School Health – **Mamaroneck Union Free School District**

| **Student** Last Name | First Name | MI | **Date of birth** | ☐ Male ☐ Female | |
|---|---|---|---|---|---|
| **School** | | | | **Grade** | **Class** |

## HEALTH CARE PRACTITIONER COMPLETES BELOW

☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Non-Type 1/Type 2 Diabetes ☐ Other Diagnosis: _____

Recent A1C: Date ____/____/_____ Result ____.____%

**Orders written will be for the current school year, September through August.**

## EMERGENCY ORDERS

**Severe Hypoglycemia**

Administer **Glucagon** and **call 911**

**Glucagon:** ☐ 1 mg ☐ ____ mg SC/IM

**GVOKE:** ☐ 1 mg ☐ ____mg SC/IM

**Baqsimi:** ☐ 3 mg Intranasal

Give PRN: unconscious, unresponsive, seizure, or inability to swallow EVEN if bG is unknown. Turn onto left side to prevent aspiration.

**Risk for Ketones or Diabetic Ketoacidosis (DKA)**

☐ Test **ketones** if bG >____ mg/dl, or if vomiting, or fever > 100.5F

**OR**

☐ Test ketones if bG >____ mg/dl for the 2nd time that day (at least 2 hrs. apart), or if vomiting or fever > 100.5F

- If small or trace give water; re-test ketones & bG in 2 hrs or ___ hrs
- If ketones are moderate or large, give water:
  Call parent and Endocrinologist; ☐ **NO GYM**
  If ketones and vomiting, unable to take PO and MD not available, **CALL 911**

☐ Give insulin correction dose if > 2 hrs or ____ hours since last insulin.

## SKILL LEVEL

**Blood Glucose (bG) Monitoring Skill Level**

☐ Nurse / adult must check bG.

☐ Student to check bG with adult supervision.

☐ Student may check bG without supervision.

**Insulin Administration Skill Level**

☐ Nurse-Dependent Student: nurse must administer medication

☐ Supervised student: student self-administers, under adult supervision

☐ Independent Student: Self-carry / Self-administer *(MUST Initial attestation)*

I attest that the **independent** student demonstrated the ability to self-administer the prescribed medication effectively for school, field trips, & school/sponsored events _____ PROVIDER INITIALS

**NOTE: Trip nurse not required for supervised or independent students.**

## BLOOD GLUCOSE MONITORING *[See Part B for CGM readings]*

Specify times to test in school (must match times for treatment and/or insulin) ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN

**Hypoglycemia**: *Check all boxes needed. Must include at least one treatment plan.*

☐ For bG < _____mg/dl give _____ gm rapid carbs at: ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN

Repeat bG testing in 15 or ____ min. If bG still < _____mg/dl repeat carbs and retesting until bG > _____ mg/dl.

☐ For bG < _____mg/dl give _____ gm rapid carbs at: ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN

Repeat bG testing in 15 or ____ min. If bG still < _____mg/dl repeat carbs and retesting until bG > _____ mg/dl.

☐ For bG < _____mg/dl pre-gym, **no gym** ☐ For bG < _____mg/dl ☐ Pre-gym; ☐ PRN; treat hypoglycemia then give snack.

☐ T2DM - no bG monitoring or insulin in school

15 gm rapid carbs = 4 glucose tabs = 1 glucose gel tube = 4 oz.

*Insulin is given before food unless noted here:* ☐ Give insulin after: ☐ Breakfast ☐ Lunch ☐ Snack

**Mid-range Glycemia:** *Insulin is given before food unless noted here:* ☐ Give insulin after: ☐ Breakfast ☐ Lunch ☐ Snack ☐ Give snack before gym

**Hyperglycemia:** *Insulin is given before food unless noted here:* ☐ Give insulin after: ☐ Breakfast ☐ Lunch ☐

Snack ☐No Gym For bG >_____mg/dl ☐ Pre-gym and/or ☐ PRN

☐For bG >_____ mg/dl PRN, Give insulin correction dose if > 2 hrs or ____ hrs. since last insulin For bG meter reading "**High**" use bG of 500 or____ mg/dl.

☐**Check bG or Sensor Glucose (sG) before dismissal**

☐ Give correction dose pre-meal and carb coverage after meal

☐For sG or bG values <_____mg/dl treat for hypoglycemia if needed, and give _____ gm carb snack before dismissed

☐For sG or bG values <_____mg/dl treat for hypoglycemia if needed, and do not send on bus/mass transit, parent to pick up from school.

## INSULIN ORDERS

**Name of Insulin*:**

_____

* May substitute Novolog with Humalog/Admelog

☐ No Insulin in School

☐ No Insulin at Snack

**Delivery Method:**

☐ Syringe/Pen

☐ Pump *(Brand)*:

_____

☐ Smart Pen – use pen Suggestions

**Insulin Calculation Method:**

☐ Carb coverage **ONLY** at: ☐ Breakfast ☐ Lunch ☐ Snack

☐ Correction dose **ONLY** at:☐ Breakfast ☐ Lunch ☐ Snack

☐ Carb coverage **plus** correction dose when bG > Target **AND** at least 2 hrs or ___ hrs. since last insulin at

☐ Breakfast ☐ Lunch ☐ Snack

Correction dose calculated using: ☐ ISF **or** ☐ Sliding Scale

☐ Fixed Dose *(see Other Orders)*

☐ Sliding Scale *(See Part B)*

☐ If gym/recess is immediately following lunch, subtract ___ gm carbs from lunch carb calculation.

**Insulin Calculation Directions:** *(give number, not range)*

Target bG = _____ mg/dl

Insulin Sensitivity Factor (ISF):

1 unit decreases bG by _____ mg/dl

(time:_____ to _____)

1 unit decreases bG by _____ mg/dl:

(time:_____ to _____)

*If only one ISF, time will be 8am to 4pm if not specified.*

Insulin to Carb Ratio (I:C):

Bkfast **OR** time:_____ to _____

1 unit per _____ gms carbs

Snack **OR** time: _____ to _____

1 unit per _____ gms carbs

Lunch **OR** time:_____ to _____

1 unit per _____ gms carbs

Lunch followed by gym

1 unit per _____ gms carbs

**Carb Coverage:**

# gm carb in meal = X units insulin
# gm carb in I:C

**Correction Dose using ISF:**

bG – Target bG = X units insulin
ISF

Round DOWN insulin dose to closest 0.5 unit for syringe/pen, or nearest whole unit if syringe/pen doesn't have ½ unit marks; unless otherwise instructed by PCP/Endocrinologist. Round DOWN to nearest 0.1 unit for pumps, unless following pump recommendations or PCP/Endocrinologist orders.

**For Pumps** - Basal Rate in school:

__:__ AM/PM to __:__ AM/PM _____ units/hr

__:__ AM/PM to __:__ AM/PM _____ units/hr

__:__ AM/PM to __:__ AM/PM _____ units/hr

☐ Student on FDA approved hybrid closed loop pump-basal rate variable per pump.

☐ Suspend/disconnect pump for gym

☐ Suspend pump for hypoglycemia not responding to treatment for _____ min.

**Additional Pump Instructions:**

☐ Follow pump recommendations for bolus dose *(if not using pump recommendations, will round down to nearest 0.1 unit)*

☐ For bG > _____ mg/dl that has not decreased in ____ hours after correction, consider pump failure and notify parents.

☐ For suspected pump failure: SUSPEND pump, give insulin by syringe or pen, and notify parents.

☐For pump failure, only give correction dose if >____ hrs since last insulin.

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS FORMS CANNOT BE COMPLETED BY A RESIDENT Rev 4/20

**HEALTH CARE PRACTITIONERS: COMPLETE 'PART B' AND SIGN ➔**

# DIABETES MEDICATION ADMINISTRATION FORM [PART B]

Provider Medication Order Form – Office of School Health – **Mamaroneck Union Free School District**

## CONTINUOUS GLUCOSE MONITORING (CGM) ORDERS

☐ Use CGM readings - For CGM's used to replace finger stick bG readings, only devices FDA approved for use and age may be used within the limits of the manufacturer's protocol. (sG = sensor glucose).

**Name and Model of CGM:**_____

For CGM used for insulin dosing: finger stick bG will be done when: the symptoms don't match the CGM readings; if there is some reason to doubt the sensor (i.e. for readings <70 mg/dl or sensor does not show both arrows and numbers)

☐ CGM to be used for insulin dosing and monitoring - **must be FDA approved for use and age**

**sG Monitoring** Specify times to check sensor reading ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN *[if none checked, will use bG monitoring times]*
For sG <70mg/dl check bG and follow orders on DMAF, unless otherwise ordered below.
Use CGM grid below OR ☐ See attached CGM instruction

| CGM reading | Arrows | Action ☐ use < 80 mg/dl instead of < 70 mg/dl for grid action plan |
|---|---|---|
| sG < 60 mg/dl | Any arrows | Treat hypoglycemia per bG hypoglycemia plan; Recheck in 15-20 min. If still < 70 mg/dl check bG. |
| sG 60-70 mg/dl | and ↓, ↓↓, ↘ or → | Treat hypoglycemia per bG hypoglycemia plan; Recheck in 15-20 min. If still < 70 mg/dl check bG. |
| sG 60-70 mg/dl | and ↑, ↑↑, or ↗ | If symptomatic, treat hypoglycemia per bG hypoglycemia plan; if not symptomatic, recheck in 15-20 minutes. If still <70 mg/dl check bG. |
| sG >70 mg/dl | Any arrows | Follow bG DMAF orders for insulin dosing |
| sG ≤ 120 mg/dl pre-gym or recess | and ↓, ↓↓ | Give 15 gms uncovered carbs. If gym or recess is immediately after lunch, subtract 15 gms of carbs from lunch carb calculation. |
| sG ≥ 250 | Any arrows | Follow bG DMAF orders for treatment and insulin dosing |

☐ For student using CGM, wait 2 hours after meal before testing ketones with hyperglycemia.

## PARENTAL INPUT INTO INSULIN DOSING

☐ Parent(s)/Guardian(s) (*give name*), _____, may provide the nurse with information relevant to insulin dosing, including dosing recommendations. Taking the parent's input into account, the nurse will determine the insulin dose within the range ordered by the health care practitioner and in keeping with nursing judgment.

Please select **one** option below:

**1.** ☐ Nurse may adjust calculated dose up or down up to __ units based on parental input and nursing judgment.

**2.** ☐ Nurse may adjust calculated dose up by ___% or down by ___% of the prescribed dose based on parental input and nursing judgment

**MUST COMPLETE: Health care practitioner can be reached for urgent dosing orders at: (_____) _____ - _____**
If the parent requests a similar adjustment for > 2 days in a row, the nurse will contad the health care practitioner to see if the school orders need to be revised.

## SLIDING SCALE

Do NOT overlap ranges (e.g. enter 0-100, 101-200, etc.). If ranges overlap, the lower dose will be given. Use pre-treatment bG to calculate insulin dose unless other orders.

| | bG | Units Insulin | | bG | Units Insulin |
|---|---|---|---|---|---|
| ☐Lunch | Zero -___ | _____ | ☐Other Time _____ | Zero -___ | _____ |
| ☐Snack | ___-___ | _____ | | ___-___ | _____ |
| ☐Breakfast | ___-___ | _____ | ☐Snack | ___-___ | _____ |
| ☐Correction Dose | ___-___ | _____ | ☐Breakfast | ___-___ | _____ |
| | ___-___ | _____ | ☐Correction Dose | ___-___ | _____ |
| | ___-___ | _____ | | ___-___ | _____ |
| | ___-___ | _____ | | ___-___ | _____ |

## OPTIONAL ORDERS

☐ Round insulin dosing to nearest whole unit: 0.51-1.50u rounds to 1.00u.
☐ Round insulin dosing to nearest half unit: 0.26-0.75u rounds to 0.50 u (must have half unit syringe/pen).
☐ Use sliding scale for correction AND at meals ADD: ___ units for lunch; ___ units for snack; ___ units for breakfast (sliding scale must be marked as correction dose only).
☐ Long acting insulin given in school – Insulin Name:_____
Dose:_____ units Time _____ or ☐Lunch

### SNACK ORDERS

☐ Student may carry and self-administer snack
Snack time of day: _____ AM / PM ☐ Pre-gym Snack
Type & amount of snack:

**OTHER ORDERS:**

### HOME MEDICATIONS

| Medication | Dose | Frequency | Time | Route |
|---|---|---|---|---|
| Insulin: | | | | |
| Other: | | | | |

## ADDITIONAL INFORMATION

Is the child using altered or non-FDA approved equipment? ☐ Yes or ☐ No [*Please note that New York State Education laws prohibit nurses from managing non-FDA devices. Please provide pump-failure and/or back up orders on DMAF Part A Form.*]

By signing this form, I certify that I have discussed these orders with the parent(s)/guardian(s).

| | | |
|---|---|---|
| **Health Care Practitioner Name** LAST FIRST | Signature | Date ___/___/_____ |
| (**Please print and check one:** ☐ MD, ☐ DO, ☐ NP, ☐ PA) | | |
| Address | Tel. (___)___-____ | Fax. (___)___-____ |
| NYS License # **(Required)** E-mail | **CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with diabetes.** | |

## PARENTS/GUARDIANS FILL BELOW

### BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to the nurse giving my child's prescribed medicine, and the nurse/trained staff checking their blood sugar and treating their low blood sugar based on the directions and skill level determined by my child's health care practitioner. These actions may be performed on school grounds or during school trips.
2. I also consent to any equipment needed for my child's medicine being stored and used at school.
3. I understand that:
   - I must give the school nurse my child's medicine, snacks, equipment, and supplies and must replace such medicine, snacks, equipment and supplies as needed. OSH recommends the use of safety lancets and other safety needle devices and supplies to check my child's blood sugar levels and give insulin.
   - **All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired medicine for my child's use during school days.**
     - Prescription medicine must have the original pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's health care practitioner's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
   - I must **immediately** tell the school nurse about any change in my child's medicine or the health care practitioner's instructions.
   - OSH and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
   - By signing this Medication Administration Form (MAF), I authorize OSH to provide diabetes-related health services to my child. These services may include but are not limited to a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
   - The medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse a new MAF (whichever is earlier). When this medication order expires, I will give my child's school nurse a new MAF written by my child's health care practitioner. OSH will not need my signature for future MAFs.
   - OSH and the Department of Education (DOE) are responsible for making sure that my child can safely test his or her blood sugar.
   - This form represents my consent and request for the diabetes services described on this form. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Student Accommodation Plan. This plan will be completed by the school.
   - For the purposes of providing care or treatment for my child, OSH may obtain any other information they think is needed about my child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.

### FOR SELF-ADMINISTRATION OF MEDICINE (INDEPENDENT STUDENTS ONLY):

- I certify/confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing and giving them the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school. The school nurse will confirm my child's ability to carry and give them medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.
- I consent to the school nurse or trained school staff giving my child Glucagon if prescribed by their health care provider if my child is temporarily unable to carry and take medicine. **This does not include nasal Glucagon as New York State does not endorse training non-licensed personnel to administer nasal Glucagon at this time.**

**NOTE: It is preferred that you send medication and equipment for your child on a school trip day and for off-site school activities.**

| Student Last Name | First Name | MI | Date of birth ___/___/_____ |
|---|---|---|---|
| School | | | |
| Print Parent/Guardian's Name | SIGN HERE Parent/Guardian's Signature for Parts A & B | | Date Signed ___/___/_____ |
| Parent/Guardian's Email | | | |
| Parent/Guardian's Address | | | |
| Telephone Numbers: Daytime (____)____-_____ | Home (____)____-_____ | Cell Phone (____)____-_____ | |
| Alternate Emergency Contact's Name | Relationship to Student | Contact Telephone Number (____)____-_____ | |

# DIABETES

## Mamaroneck Union Free School District
## EMERGENCY ACTION PLAN

Student's name: _____ DOB: _____ Grade/class: _____

School: ☐Central ☐Chatsworth ☐ Mamaroneck Avenue ☐ Murray ☐Hommocks ☐High School ☐ Other _____

PHOTO ID

○ Type 1 ○ Type 2 **Insulin Brand:** _____

Mother/Guardian: _____ (H) _____
(C): _____ (W) _____
Father/Guardian: _____ (H) _____
(C): _____ (W) _____
Emergency contact: _____ (H) _____
(C): _____ (W) _____

Endocrinologist: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

**Insulin Pump:** ☐ Yes ☐ No **If Yes Type of Pump** _____

**Student's Location of Diabetic Supplies:** _____

**Glucagon location:** _____

**Signs of LOW BLOOD SUGAR (hypoglycemia) include:**
The student with hypoglycemia (low blood sugar) may exhibit the following symptoms:

| | | | | |
|---|---|---|---|---|
| HUNGRY | SHAKY | UNABLE TO CONCENTRATE | LETHARGIC | WEAK |
| SLEEPY | COMBATIVE | CONFUSED OR DISORIENTED | SWEATY | OTHER: _____ |
| PALE | DIZZY | POOR COORDINATION | IRRITABLE | |

THE SEVERITY OF SYMPTOMS CAN CHANGE QUICKLY. ALL ABOVE SYMPTOMS CAN POTENTIALLY PROGRESS TO A LIFE-THREATENING SITUATION!

**ACTION (How to Treat Low Blood Sugar):**

*If the student complains of feeling "low" or exhibits symptoms of hypoglycemia but is conscious, cooperative and can swallow:*

1. Please see attached **Diabetes Medication Administration Form** for instructions
2. Check the blood glucose in 15 minutes. If still low refer to **Diabetes Medication Administration Form** for further instructions

*If student is unresponsive, having a seizure, or unable to swallow, contact the school nurse or trained diabetes personnel who will give glucagon as ordered in the physician's orders.*

1. Turn the student on his or her side and keep the airway open.
2. Call 911 (inform paramedic that student is a diabetic).
3. Inform building administration that 911 has been called.
4. Call parent/guardian.

**Emergency Medications for Low Blood Sugar:**

Glucagon ordered? ☐ Yes ☐ No IF GLUCAGON IS GIVEN, CALL 911. NOTIFY PARENTS.

GLUCAGON CAN ONLY BE ADMINISTERED BY SCHOOL NURSE OR TRAINED SCHOOL PERSONNEL.

**Do not hesitate to administer glucagon or call 911, even if parents cannot be reached!**

**Signs of HIGH BLOOD SUGAR (hyperglycemia), that can impair the student's cognitive abilities, include:**
The student with hyperglycemia (high blood sugar) may 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 and contact the school nurse.**

**ACTION (How to Treat High Blood Sugar):**

1. If the student has any of the signs and symptoms above, see attached **Diabetes Medication Administration Form** for instructions
2. Allow free use of the bathroom.
3. Encourage the student to drink water or other sugar-free liquid.
4. Contact the school nurse or trained diabetes personnel to check urine for ketones and to administer insulin as ordered in the **Diabetes Medication Administration Form**
5. If the student is vomiting or lethargic, call 911 and parent.

INSULIN CAN ONLY BE ADMINISTERED BY A SELF-DIRECTED STUDENT OR A SCHOOL NURSE.

**Comments/Special Instructions:** _____

Signature of parent/guardian: _____ Date: _____

Signature of Health Care Provider: _____ Date: _____

Parent signature gives permission to speak to child's physician/practitioner and school staff as needed.

PARENT – PLEASE COMPLETE THE OTHER SIDE OF FORM

# DIABETES INFORMATION FORM

Dear Parent(s) or Guardian(s):

Please complete the information below and return to the school nurse as soon as possible. If any changes occur during the year, please notify your school nurse.

Name of student: _____ Grade/class: _____

**General History:**

- What type of diabetes was your child diagnosed with? ○ Type 1 ○ Type 2
- Age your child was diagnosed with diabetes? _____
- What signs/symptoms did your child have when diagnosed: _____
- Medications child takes at home including, insulin type:

| Please circle: | Name of medication/insulin | Dose | How often |
|---|---|---|---|
| Injection Pen Pump | _____ | _____ | _____ |
| Injection Pen Pump | _____ | _____ | _____ |

  Basal rate during school hours for pump: _____
- Normal range of blood sugar for your child: From: _____ to _____
- How often does your child test his/her blood sugar? _____
- When was the last time your child saw the endocrinologist? _____
- Last HgbA1C Level: _____
- Last hospitalization/ER visit: _____
  - Why? _____
- Does your child have any ALLERGIES (food, medication, etc.)? ○ Yes ○ No

  What happens to your child when he/she eats this or comes into contact with this?

  _____
- Following a LOW BLOOD SUGAR attack has your child ever been given:

  ○ Glucagon ○ Glucose Tabs/Gel ○ Other medication: _____
- Please list/check which symptoms your child has when he/she is having a low blood sugar reaction:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Hungry | | Shaky | | Unable to concentrate | | Irritable |
| | Sleepy | | Combative; angry | | Confused; disoriented | | Sweaty |
| | Weak | | Dizzy | | Poor coordination | | Other: |

- Does your child test for ketones when his/her blood sugar is high? ○ Yes ○ No
- Last vision/ eye exam by MD: _____
- Does your child need assistance performing blood glucose testing: ○ Yes ○ No
- Please tell me about your child's understanding of his/her diabetes: _____
- Does child exercise regularly : _____ Have a well-balance diet: _____ Suffer from frequent Illnesses: _____
- Additional information/instructions: _____

**Please alert the school nurse for changes in insulin dosages or medication dosages.**
**Thank you for help in providing the best care for your child.**

Signature of parent/guardian: _____ Date: _____

PLEASE COMPLETE THE OTHER SIDE OF FORM

**MAMARONECK**

PUBLIC SCHOOLS

1000 W. Boston Post Rd.

Mamaroneck NY 10543

914-220-3000

## CONSENT TO RELEASE MEDICAL INFORMATION

School: Central ❍ Chatsworth ❍ Mamaroneck Avenue ❍ Murray
❍ Hommocks ❍ High ❍ Other _____

Date: _____

Name of physician/practitioner: _____

Street Address: _____

City/Town; State; Zip: _____

Phone: _____

Name of student: _____

Date of birth: _____

To: Physician/practitioner

Please release any medical documentation and/or other information on the above named patient to the school nurse, and/or the school physician as maybe requested by a representative of the District's Health Office.

_____ _____

Parent's signature Date

PARENT SIGNATURE DENOTES PERMISSION TO SHARE INFORMATION WITH STAFF ON A NEED-TO-KNOW BASIS.

# MAMARONECK UNION FREE SCHOOL DISTRICT

## *INSULIN* Medication Permission Sheet
## at School/School - Sponsored Events

### To Be Completed By Parent

Student Name: _____ DOB: _____

Grade: _____ Teacher/Counselor_____ School: _____

I request the school nurse give the medication listed on this plan; trained staff may assist my child to take his/her own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

_____ _____
**Parent/Guardian Signature** **Date**

_____ _____
**Email** **Phone Where We Can Reach You** ☐ **Check if Cell**

**Parent signature gives permission to speak to student's physician/ practitioner and school staff as needed**

### To Be Completed By Health Care Provider-Valid for School Year

**Diagnosis: Diabetes: Type**_____

**Medication: INSULIN NAME:**_____

**Dose: See Diabetes Medication Administration Form Attached**

☐ **Independent Carry and Use Attestation Attached (Required for Independent Carry and Use)**
NYS law requires both provider attestation that the student has demonstrated he/she can effectively self- administer inhaled respiratory rescue medications, epinephrine auto-injector, Insulin, glucagon and diabetes supplies or other medications which require rapid administration along with parent/guardian permission delivery to allow this option in school. Check this box and attach the attestation to this form to request this option.

_____ _____
**Name/Title of Prescriber** (Please Print) **Date**

_____ _____
**Prescriber's Signature** **Phone**

Stamp

## PLEASE RETURN TO THE SCHOOL NURSE

9/17

# MAMARONECK UNION FREE SCHOOL DISTRICT

## *Glucagon* Medication Permission Sheet
## at School/School - Sponsored Events

### To Be Completed By Parent

Student Name: _____ DOB: _____

Grade: _____ Teacher/Counselor_____ School: _____

I request the school nurse give the medication listed on this plan; trained staff may assist my child to take his/her own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

_____ _____

**Parent/Guardian Signature** **Date**

_____ _____

**Email** **Phone Where We Can Reach You** ☐ **Check if Cell**

**Parent signature gives permission to speak to student's physician/ practitioner and school staff as needed**

### To Be Completed By Health Care Provider-Valid for School Year

**Diagnosis: Diabetes: Type**_____

**Medication: Glucagon**

**Dose:** ☐ **1 mg** ☐ ___**mg** **Route: SC/IM injection** **Time: PRN Severe Hypoglycemia**

**Recommendations: Give PRN unconsciousness, unresponsiveness, seizure, or inability to swallow EVEN if BG is unknown. Turn onto left side to prevent aspiration. Call 911 if administered; call parent/guardian; call administrator**

☐ **Independent Carry and Use Attestation Attached (Required for Independent Carry and Use)**

NYS law requires both provider attestation that the student has demonstrated he/she can effectively self- administer inhaled respiratory rescue medications, epinephrine auto-injector, Insulin, glucagon and diabetes supplies or other medications which require rapid administration along with parent/guardian permission delivery to allow this option in school. Check this box and attach the attestation to this form to request this option.

_____ _____

**Name/Title of Prescriber (Please Print)** **Date**

_____ _____

**Prescriber's Signature** **Phone**

Stamp

## PLEASE RETURN TO THE SCHOOL NURSE

# MAMARONECK UNION FREE SCHOOL DISTRICT

## ATTESTATION AND PARENT PERMISSION
## REQUIRED FOR INDEPENDENT MEDICATION CARRY AND USE

**Directions for the Health Care Provider:** This form must be used as an addendum to a medication permission sheet, it is an attestation for a student to independently carry and use his/her medication as required by NYS law. A **provider order** and **parent/guardian permission** are needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

**Student Name:** _____ **DOB:** _____

**Health Care Provider Permission for Independent Use and Carry**

I attest that this student has demonstrated to me that he/she can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school- sponsored activity. Staff intervention and support is needed only during an emergency. This order applies to the medications checked below:

This student is diagnosed with:

- ❑ Allergy and requires Epinephrine Auto-injector
- ❑ Allergy and requires Antihistamine
- ❑ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ❑ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- ❑ _____ which requires rapid administration of _____
  (State Diagnosis) (Medication Name)

Signature: _____ Date: _____

**Parent/Guardian Permission for Independent Use and Carry**

I agree that my child can use his/her medication effectively and may carry and use this medication independently at any school/school-sponsored activity. Staff intervention and support is needed only during an emergency.

Signature: _____ Date: _____

STAMP

**PLEASE RETURN TO THE SCHOOL NURSE**

4/16