

Cincinnati Children's Diabetes Center

Insulin Dose Verification for a Student with Diabetes

Parent/guardian to complete information below:

Student Name: _____ Date of Birth: _____ School Year: _____

School Name and Address: _____ Grade: _____

School Nurse/Personnel: _____

School Phone: (____) _____ School Fax: (____) _____

Insulin: ☐ Insulin lispro (Humalog® or Admelog®) ☐ Insulin aspart (Novolog®) ☐ Insulin glulisine (Apidra®)

Insulin Administration: ☐ Syringe/Vial ☐ Pen ☐ Pump

Insulin dose:

☐ Carbohydrate ratio for breakfast: 1 unit for _____ grams of carbohydrates

☐ Carbohydrate ratio for lunch: 1 unit for _____ grams of carbohydrates

☐ Correction target BG: _____ mg/dL

☐ Correction factor: 1 unit for every _____ mg/dL above correction target

☐ Other: _____

Parent/Guardian Name (please print) Date (____) _____
Parent/Guardian Phone Number

Parent/Guardian Signature _____ or ☐ Verbal Notification by Parent/Guardian for Dose Changes

Attention School Personnel: Fax form to the CCHMC Diabetes Center for provider approval of doses above.

Provider's Signature Date

Cincinnati Children's Hospital Diabetes Center Providers:

- | | | |
|--|--|---|
| ☐ Erin Atwood, MD | ☐ Nana-Hawa Yayah Jones, MD | ☐ Nat Nasomyont, MD |
| ☐ Ryan Brady, MD | ☐ Jennifer Kelly, APRN-CNP | ☐ Chris Osborn, APRN-CNP |
| ☐ Jeremy Brown, MD | ☐ Mansa Krishnamurthy, MD | ☐ LeAnne Sancrainte, MD |
| ☐ Mandi Cafasso, APRN-CNP | ☐ Andrew Lavik, MD | ☐ Lisa Schaaf, APRN-CNP |
| ☐ Sarah Corathers, MD | ☐ Sarah Lawson, MD | ☐ Amy Shah, MD |
| ☐ Nancy Crimmins, MD | ☐ Faith Lindsay, MD | ☐ Nicole Sheanon, MD |
| ☐ Lawrence Dolan, MD | ☐ Sonia Rodas Marquez, MD | ☐ Sarah Swauger, MD |
| ☐ Deborah Elder, MD | ☐ Gamal Mashali, MD | ☐ Amanda Sylvester, APRN-CNP |
| ☐ Janise Felblinger, APRN-CNP | ☐ Nancy Morwessel, APRN-CNP | ☐ Siobhan Tellez, APRN-CNP |
| ☐ Jonathan Howell, MD | ☐ Gajanthan Muthuvel, MD | ☐ Karishma Tilton, APRN-CNP |

Cincinnati Children's Diabetes Center
3333 Burnet Ave, Cincinnati, OH 45229-3039
Phone: (513) 636-3005 Fax: (513) 636-9677
Email: diabetescallcenter@cchmc.org

KENTON COUNTY SCHOOL DISTRICT

SCHOOL: _____ PHONE: _____ FAX: _____

For any questions related to this form, please contact the school nurse at the above number.

ADMINISTRATION of MEDICATION for STUDENTS WITH DIABETES

Dear Parent/Guardian,

In order to administer insulin at school, this form must be completed and signed by your child's physician. As parent/guardian, your signature is also required.

All medications are kept in the first aid room or the main office and must be in the original container with label affixed. Your child's name must be on the prescription label. Parents are responsible for providing all diabetic care supplies for their student, including snacks for treating low glucose levels.

The purpose of these procedures is to make sure that your child receives the proper medication/dosage and that the school personnel responsible for its administration can administer it safely, knowing the expected reactions to this medication.

A new form or a CCHMC Insulin Dose Order for Nurse-Assisted Insulin Administration in Ky Schools will be required for any changes in medication orders.

This form may be faxed to the school by your doctor to the number listed above.

The duration of this form is for one school year only. SCHOOL YEAR _____.

Please complete all sections of this form. Student's Name: _____

Date of Birth: _____ Grade: _____ ALLERGIES: _____

NAME OF MEDICATION:

Type of Insulin: () insulin lispro (Humalog®) () insulin aspart (Novolog®) () insulin glulisine (Apidra®)
() other specify _____

ROUTE: () Insulin Syringe () Insulin Pen () Insulin Pump

DOSAGE/DIRECTIONS:

Carbohydrate Ratio for food: 1 unit for _____ grams of carbohydrates.

Correction Target BG: _____ mg/dl.

Correction Factor: 1 unit for every _____ mg/dl above correction target.

TIME ADMINISTERED: () Lunch or with any food intake () Blood Glucose Correction
() other specify _____

***This student is: () self care () supervision only () dependent for diabetic care needs.

Is a CGM used? If yes, what type? _____ Please note only the DexComG5/G6 or FreeStyle Libre is FDA approved for blood sugar level checks. Students using other types of CGM will need BS checks before insulin is administered and other designated times.

FOR SEVERE HYPOGLYCEMIA, UNCONSCIOUSNESS OR SEIZURE

MEDICATION: () GLUCAGON () GVOKE () additional GVOKE repeated in 15 min if no response
GLUCAGON/GVOKE DOSAGE: Administer _____ mg intramuscularly.

() BAQSIMI 3mg Intranasal () additional Baqsimi 3mg dose repeated in 15 minutes if no response

*** () Student may self-carry GLUCAGON/GVOKE/BAQSIMI

POSSIBLE SIDE EFFECTS OR REACTIONS: _____

During school hours, I understand that teachers, assistants, nurses or other trained school personnel may be assisting/administering these medications according to district policies and the specified physician's order. Schools have established individual procedures for where and when the students receive their daily medicines and the student has the ultimate responsibility of reporting daily for their medication.

No medications will be sent home with students unless it is medication they are permitted to self carry. Parents or guardians must pick up all unused or discontinued medications from the school or they will be discarded.

I also give permission for administration of this medication or assistance by trained school personnel accompanying my child on a field trip or school related function in Kentucky and/or other states. In the case of field trips or school related functions, slight adaptations to the time that the medication is administered may also be necessary.

I hereby release the Kenton County Board of Education and its employees from any claims or liabilities connected with its reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance.

Parent's Signature _____

Parent's Phone _____

Date _____

Physician's Signature _____

Physician's Phone _____

Date _____

Print Physician's Name _____

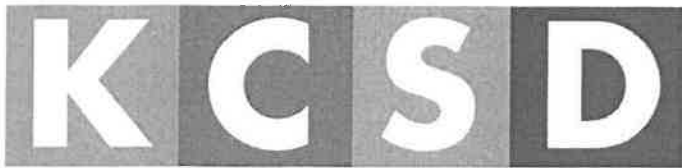
Physician's Address _____

Fax Number _____

School Nurse Signature _____

Date Received in Nurse's Office _____

8/2020



Kenton County School District | *It's about ALL kids.*

THE KENTON COUNTY BOARD OF EDUCATION

1055 EATON DRIVE, FORT WRIGHT, KENTUCKY 41017

TELEPHONE: (859) 344-8888 / FAX: (859) 344-1531

WEBSITE: www.kenton.kyschools.us

Dr. Henry Webb, Superintendent of Schools

I/We the parent(s)/guardian(s) of _____ request that Health Office personnel, School Nurse and Non-licensed Health Technician if applicable, follow/monitor my child's/student's Continuous Glucose Monitor (CGM) using the appropriate iPhone app. **I acknowledge and agree that the Kenton County School District (KCS D) can properly train and delegate appropriate unlicensed assistive personnel, who do not have the accessibility of this app, to care for the diabetic needs of my child/student using methods that are more traditional.** I agree that I will provide a device for my child/student that will allow transmission of the CGM information to be followed by appropriate school personnel. I/We understand this CGM app is a tool to promote self-care and independence. As parents/guardians we agree that we will be following my child's CGM and will set the notifications/alarms for unsafe blood glucose levels.

I acknowledge and agree to the following:

1. The Health Office might not be staffed by personnel who know how to use the app.
2. Health Office use of CGM "Follow" app does not mean that the Health Office takes sole responsibility for my child's/student's blood glucose levels. He/She still needs to report to the Health Office when symptomatic or he/she sees high or low glucose levels on their receiver/phone that requires intervention. If my student does not act accordingly to alarms, I understand he/she will be called to the health room.
3. The iPhone used to monitor my child/student in the Health Office will not be accessible after school hours and will remain in the Health Office.
4. Using this "Follow" app is a resource the Kenton County School District is offering to parents/students to assist in diabetic management. We are not guaranteeing the availability of this resource.
5. As the parent/guardian, I/we will set up the device for it to be followed and will invite Health Office staff to follow my child's/student's CGM.
6. Inappropriate use of iPhone while at school may cause child/student to lose phone privileges and inability to follow CGM. This includes frequent disruption caused by parent/guardian texting or calling students or school personnel regarding glucose monitoring.
7. I understand that KCS D internet connectivity may not always be available.
8. Supplies of snacks, drinks, and glucagon is the parent's/guardian's responsibility

I understand I have the right to suspend the use of the "Follow" app at any time, at which time KCS D will initiate/resume addressing the diabetic needs of my child/student using traditional methods of blood glucose monitoring. By signing and dating this document, I understand and agree with the terms listed above.

Parent/Guardian print name

Parent/Guardian signature

Date

Parent/Guardian print name

Parent/Guardian signature

Date

Kenton County Board of Education

Board Members: Carl Wicklund, Chairperson Karen L. Collins, Vice Chairperson Joshua Crabtree, Esq. Carla Egan Jessica Jehn
"The Kenton County Board of Education provides *Equal Education & Employment Opportunities.*"

1/7/2020