Bethel
SCHOOLS

Dear Parents,

A law has been enacted in Washington that requires children with life-threatening conditions to have a medication or treatment order on file prior to attending school. This law, called Substitute House Bill 2834, took effect on June 13, 2002.

The medication or treatment order must address the life-threatening condition and it must be on file with the school prior to the child attending school. Under the law, "life-threatening condition" means a health condition that will put the child in danger of death during the school day if a medication or treatment order is not in place. In addition, our school nurses will be responsible for putting a nursing care plan in place. The law provides that a child may not attend school in the absence of a medication or treatment order if the child has a life-threatening condition that might require medical services to be provided at school.

Having reviewed the information you provided regarding your child's health, it appears that your child has a life-threatening condition that requires a medication or treatment order.

At the start of every school year you will need new medication order forms filled out by your health care provider for the next school year to comply with Substitute House Bill 2834, commonly known as the "Life Threatening Condition" law. The following new forms are included for your convenience:

- Diet Prescription for Meals at School
- Health Care Provider Orders for Students with Diabetes in Washington State Schools. This needs to be completed by doctor and parent and brought to the school at least three days before the first day of school attendance.

Please have your physician complete the Health Care Provider Orders for Students with Diabetes in Washington State Schools and sign the parent permission portion of the form. The Diet Prescription needs to be completed by the doctor and parent also. Return these forms to your child's school nurse as soon as possible.

The school nurse will need the diabetes orders at least three days prior to school starting. Upon receipt of the information from your health care provider, the school nurse will contact you to develop an appropriate nursing plan. She will then need to train the staff. Your child may not be able to start school on the first day of school if the orders are not at school three days prior to school starting.

Sincerely,

School Nurse

516 176th Street East • Spanaway, Washington 98387 • 253.800.2000 • bethelsd.org

Bethel Public Schools Nutrition Services
Diet Prescription for Meals at School

Student Name: ____________________________ Date of Birth: _________ Age: ____

Name of School: ____ Grade: ______

Section A: To be completed by parent or guardian. Please check box(es) and sign below:

☐ I understand that if my child's medical or health needs change, it is my responsibility to notify my child's school nurse/health clerk and have a new Diet Prescription for Meals at School form completed.

☐ I give Nutrition Services permission to speak with the Physician or Authorized Medical Authority named below to discuss the dietary needs described below.

________________________________ ___________________ _____________

Parent/Guardian Signature | Home Phone Number | Date Signed

Section B: To be completed by child's Physician / recognized Medical Authority (if describing a disability).

Does the child have a disability? ☐ Yes ☐ No

If yes, describe the major life activity affected by the disability _______________

____

Does the child have a non-disabling medical condition? ☐ Yes ☐ No

If yes, describe the medical condition ______________________________________

____

Does the child have special nutritional or feeding needs? ☐ Yes ☐ No

If yes, describe the specific need ____

____

If you answered YES to any of the questions above, complete Section C and return to the nurse/health clerk at the child's school.

Section C: PHYSICIAN REQUEST Diet Prescription:
(To be completed by the child's Physician or a recognized Medical Authority).

Note: For any food item to be omitted from diet, a substitute **must** be listed.

Foods to Omit:	Foods to Substitute:
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________

Please attach additional instructions if necessary.

I certify that the student noted above needs special school meals prepared as described above because of the student's disability or chronic medical condition.

____ _____________________

Health Care Provider Signature | Date Signed

Name: ___________________________ Office Phone: _____________ Fax:_____________
Type or Print

SCHOOL DIABETES ORDERS – INSULIN PUMP

Student photo here

Healthcare Provider to Complete Annually

NAME:_______________________________ DOB:________ SCHOOL:__________ GRADE:____

Start date: End date: school year ☐ Last day of school ☐ Other:

<u>LOW</u> BLOOD GLUCOSE (BG) MANAGEMENT

1. If BG is below 70 or having symptoms, give______grams fast-acting carbohydrate (i.e. 4 glucose tabs, 4 oz juice).
2. Recheck BG in 15 minutes and repeat carbohydrate treatment if BG still < 80 or if child continues to be symptomatic.
3. Once BG is > 80, may follow with 10-15 gram carb snack, or meal if time.

If unconscious, unresponsive, difficulty swallowing, or evidence of seizure: <u>Phone 911 immediately.</u> Do NOT give anything by mouth. ☐ If nurse or trained PDA is available, administer Glucagon (______mg SC or IM)

School nurse to notify provider's office of repeated hypoglycemia trends (i.e. more than 2-3 lows per week).

<u>HIGH</u> BLOOD GLUCOSE (BG) MANAGEMENT

1. Correction with Insulin
   - ☐ If BG is over______for______hours after last bolus or carbohydrate intake, student should receive correction bolus of insulin per insulin administration orders; pump will account for insulin on board(IOB).
   - ☐ Never correct for high blood sugars other than at mealtime, unless consultation with student's Healthcare Provider or as set up by 504 plan.
2. Ketones: Test urine ketones if ☐ BG > 300 two times over the course of_______hrs or mins, or ☐ Never. Call parent if child is having moderate or large ketones.
3. No exercise if having nausea or abdominal pain, or if ketones are tested and found positive (mod or lg).
4. Encourage student to drink plenty of water and provide rest if needed.

BLOOD GLUCOSE TESTING

BG to be tested: ☐ Before meals and for symptoms of low or high BG, or as set up by the 504plan

Extra BG testing: ☐ before exercise, ☐ before PE, ☐ before going home, ☐ other: ____________________

Blood glucose at which parents should be notified: Low__________mg/dL or High__________mg/dL

Notify the parents if repeated hypoglycemia, abdominal pain, nausea/vomiting, fever, if hypoglycemic before going home, or if there is a refusal of care by the child.

INSULIN ADMINISTRATION at *Mealtime/Snacks* ☐ Apidra® ☐ Humalog® ☐ Novolog® Pump Brand: ________

Insulin to Carb Ratio:_____unit:_____grams Carb
BG Correction Factor:_____unit:_____mg/dL >_____mg/dL
Basal Rates: basal rates adjusted by parent and HCP

Pre-meal BG target: ☐ 70-150 or ☐ Other:__________
Insulin dosing to be given: ☐ before, or ☐ after meal
☐ insulin & syringe should be used for pump malfunction
☐ after meal dosing when before meal BG <______mg/dL

☐ Parent/caregiver authorized to adjust insulin within______percent for carbs, BG level, or anticipated activity
☐ Licensed medical personnel authorized to adjust the insulin dose by +/- 0 to 5 units after consultation with parent.

STUDENT'S SELF-CARE *Healthcare provider and parents discuss and check box for ability level*

1.	Totally independent management	☐	**6.**	Student administers insulin bolus independently **<u>or</u>**	☐
2.	Student tests independently **<u>or</u>**	☐		Student consults with nurse/parent/PDA for insulin dose **<u>or</u>**	☐
	Student needs verification of number by staff **<u>or</u>**	☐		Student self-boluses with verification of the number by designated staff **<u>or</u>**	☐
	Assist/Testing to be done by school nurse/PDA/parent	☐		Student self-boluses with nurse supervision only **<u>or</u>**	☐
3.	Student counts carbohydrates independently **<u>or</u>**	☐		Bolus to be done by school nurse/PDA/parent	☐
	Student consults with nurse/parent/PDA or designated staff for carbohydrate count	☐	**7.**	Student needs assistance with infusion pump site change, pump programming and pump troubleshooting by nurse/parent/PDA	☐
4.	Student self-treats mild hypoglycemia	☐			
5.	Student tests and interprets own ketones **<u>or</u>**	☐	**8.**	Wears Continuous Glucose Monitor (CGM); further management per IHP. Insulin and hypoglycemia management per orders based on blood glucose reading only	☐
	Student needs assistance with interpreting ketones	☐			

DISASTER PLAN & ORDERS

Parent is responsible for providing and maintaining "disaster kit" and to notify school nurse. In case of disaster:
Use above BG correction scale + carb ratio coverage for disaster insulin dosing every 3-4 hrs.
If Lantus or Levemir long-acting insulin is available, may administer 80% of their usual dose.
If long-acting insulin is not available, then administer rapid-acting insulin every 3-4 hrs as indicated by BG levels.

Healthcare Provider Signature:______________________ Print Name:______________________ Date:________
Parent Signature:______________________ Print Name:______________________ Date:________
School Nurse Signature:______________________ Print Name:______________________ Date:________

Student photo here

SCHOOL DIABETES ORDERS – INJECTION (PEN/SYRINGE)

Healthcare Provider to Complete Annually

NAME:______________________ DOB:________ SCHOOL:__________ GRADE:____

Start date: End date: school year ☐ Last day of school ☐ Other:

LOW BLOOD GLUCOSE (BG) MANAGEMENT

1. If BG is below 70 or having symptoms, give______grams fast-acting carbohydrate (i.e. glucose tabs, juice).
2. Recheck BG in 15 minutes and repeat carbohydrate treatment if BG still < 80 or if child continues to be symptomatic.
   School nurse to notify provider's office of repeated hypoglycemia trends (i.e. more than 2-3 lows per week).
3. Once BG is > 80, may follow with 10-15 gram carb snack, or meal if time.

If unconscious, unresponsive, difficulty swallowing, or evidence of seizure: Phone 911 immediately. Do NOT give anything by mouth. ☐ If nurse or trained PDA is available, administer Glucagon (_____mg SQ or IM)

HIGH BLOOD GLUCOSE (BG) MANAGEMENT

1. Correction with Insulin
   - ☐ If BG is over target range______for______hours after last bolus or carbohydrate intake, student should receive correction dose of insulin per insulin orders, but only cover with carb ratio at the next meal time.
   - ☐ Never correct for high blood sugars other than at mealtime, unless consultation with student's Healthcare Provider or as set up by 504 plan.
2. Ketones: Test urine ketones if ☐ BG > 300 two times over the course of_______hrs or mins, or ☐ Never. Call parent if child is having moderate or large ketones.
3. No exercise if having nausea or abdominal pain, or if ketones are tested and found moderate or large.
4. Encourage student to drink plenty of water and provide rest if needed.

BLOOD GLUCOSE TESTING

BG to be tested: ☐ Before meals and for symptoms of low or high BG, or as set up by the 504 plan

Extra BG testing: ☐ before exercise, ☐ before PE, ☐ before going home, ☐ other: ____________________

Blood glucose at which parents should be notified: Low__________mg/dL or High__________mg/dL

Notify the parents if repeated hypoglycemia, abdominal pain, nausea/vomiting, fever, if hypoglycemic before going home, or if there is a refusal of care by the child.

INSULIN ADMINISTRATION at *Mealtime* ☐ Apidra® ☐ Humalog® ☐ Novolog®

Insulin to Carb Ratio:_____unit:______grams Carb

BG Correction Factor:_____unit:______mg/dL >____mg/dL

Pre-meal BG target: ☐ 70-150, or ☐ Other: _______

Insulin dosing to be given: ☐ before, or ☐ after meal

☐ after meal dosing when before meal BG <_____mg/dL

☐ Parent/caregiver authorized to adjust insulin within______percent for carbs, BG level, or anticipated activity

☐ Licensed medical personnel authorized to adjust the insulin dose by +/- 0 to 5 units after consultation with parent/caregiver

STUDENT'S SELF-CARE *Healthcare provider and parents discuss and check box for ability level*

#	Item	☐
1.	Totally independent management	☐
2.	Student tests independently **or**	☐
	Student needs verification of number by staff **or**	☐
	Assist/Testing to be done by school nurse/PDA/parent	☐
3.	Student counts carbohydrates independently or	☐
	Student consults with nurse/parent/PDA or designated staff for carbohydrate count	☐
4.	Student self-treats mild hypoglycemia	☐
5.	Student tests and interprets own ketones **or**	☐
	Student needs assistance with interpreting ketones	☐
6.	Student administers insulin injection independently **or**	☐
	Student consults with nurse/parent/PDA for insulin dose	☐
	Student self-injects with verification of the number by designated staff **or**	☐
	Student self-injects with nurse supervision only **or**	☐
	Injection to be done by school nurse/PDA/parent	☐
7.	Wears Continuous Glucose Monitor (CGM); further management per IHP. Insulin and hypoglycemia management per orders based on blood glucose reading only	☐

DISASTER PLAN & ORDERS

Parent is responsible for providing and maintaining "disaster kit" and to notify school nurse. In case of disaster:

Use above BG correction scale + carb ratio coverage for disaster insulin dosing every 3-4 hrs.

If Lantus or Levemir long-acting insulin is available, may administer 80% of their usual dose.

If long-acting insulin is not available, then administer rapid-acting insulin every 3-4 hrs as indicated by BG levels.

Healthcare Provider Signature:________________________ Print Name:____________________ Date:________

Parent Signature:________________________ Print Name:____________________ Date:________

School Nurse Signature:________________________ Print Name:____________________ Date:________