Madison County Schools

School Health Division
301 Highland Park Dr.
Richmond, KY 40475
(859) 387-6630

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 wil help us work with your student to minimize unnecessary restrictions, feelings of being treated differently, and possible absenteeism.

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 nus 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 (includes injectable and nasal routes), with completed parent/guardian statement and signature**

We are looking forward to meeting the medical needs of your student!

Please call the District Health Coordinator at 859-387-6630 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, cafeteria staff, and bus driver.

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

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

Allergies: _____

Please attach a current photo of your child here.

Bus # A.M. _____ Bus # P.M. _____ Walker ☐ Car Rider ☐

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 (Includes Nasal or injection)? ____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 peanut butter 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 or Nasal Powder) per Physician order.
3. Observe and monitor until EMS arrives.
4. When improved, give REGULAR soda, apple juice or other fast acting carbohydrate as tolerated. Avoid giving orange juice if Glucagon was administered due to possible nausea and vomiting.

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**
- The School Nurse or trained diabetes personnel should check for urine ketones if ordered by Physician.
  ✓ If ketones are elevated, contact Parent/Guardian for direction.
- 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 Clinic

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 to the school nurse and trained diabetes personnel to perform and carry out the diabetes care tasks as outlined in the above physician's orders. ☐ Yes ☐ No

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 diabetes 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 orders. 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 INJECTION 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 INJECTION

To be completed by the student's Physician and returned to School Health Clinic:

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 may not be 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: _____

PHYSICIAN & PARENT/GUARDIAN AUTHORIZATION FOR GLUCAGON (BAQSIMI NASAL POWDER) 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 BAQSIMI NASAL POWDER

To be completed by the student's Physician and returned to School Health Clinic:

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

ALLERGIES: _____

STUDENT'S TYPICAL REACTION: _____

_____

ACTION TO BE TAKEN:

☐ **I order the administration of Baqsimi (glucagon) nasal powder 3mg for treatment of severe hypoglycemia. I understand that since the School Nurse may not be 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 Baqsimi (glucagon) nasal power 3 mg 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 may 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:*** _____