HUNTERDON CENTRAL REGIONAL HIGH SCHOOL

Healthcare Provider Orders For School/School Diabetes Medical Management Plan

Student's Name:_____ School Year: 20_____to 20_____ Grade:_____

Physical Condition: _____ Diabetes Type I Student's Usual symptoms of Hypoglycemia _____
_____ Diabetes Type 2 Student's Usual symptoms of Hyperglycemia _____

TASK **ACTION(S) (Check all that apply/Fill in the blanks)**

Blood Glucose Testing
Name of Glucose Meter
_____

_____for signs/symptoms of low blood sugar (report to school nurse)
_____for signs/symptoms of high blood sugar (report to school nurse)
_____ every day before lunch
_____other (specify; i.e. before or after PE, sport, etc.)_____
_____notify parent/guardian immediately for blood sugar <_____mg/dl and /or >_____mg/dl
_____student will notify parent/guardian of blood glucose results done at school
_____student may test in classroom and keep daily blood glucose log with them
_____**OR** student should test in health office, keep daily log in health office
_____student to have glucose meter at all times-one with student and one in health office
_____student/parent will supply health office with back-up diabetic supplies (see diabetic supply list)

Urine Ketone Testing

_____for blood sugar >_____mg/dl
_____for acute illness, i.e. vomiting, fever, etc.
_____student must have unlimited access to restroom and drinking fountain/water bottle and should drink _____ oz of fluid every _____ min. if ketones are present
_____notify parent/guardian immediately for _____ ketones (NOTE: if parent/guardian cannot be reached and the student has _____ ketones and is vomiting, contact paramedics for transport to E.R.)
_____notify parent/guardian daily of any ketone results done at school
_____other (specify) _____

Meal Planning

_____mid-morning snack at _____ a.m.
_____mid-afternoon snack at _____ p.m.
_____other (specify) _____
_____snacks should be taken (specify): _____Classroom _____Nurse's Office Other_____
_____student to carry a snack/glucose tabs at all times
_____student is independent in calculating carbohydrates and insulin coverage

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TASK	**ACTION(S) Check all that apply/Fill in the blanks**
Activity	_____no restrictions unless ketones are present; see above _____student to disconnect insulin pump during gym and/or sport _____Medical ID must be worn at all times including during gym/sports/etc. _____student may attend field trips with written parental permission if a parent or nurse is unavailable
Insulin at School	_____student is capable of the proper method of self-administration of Insulin without school nurse supervision _____**OR** all Insulin doses must be supervised or administered by the school nurse
Injections/Pre-lunch	_____administer _____Insulin subcutaneously before lunch as follows: Insulin/Carb ratio:_____ **OR *insulin sliding scale***: type of insulin_____ Dose_____ >_____BS level; Dose_____ >_____BS level; Dose_____ >_____BS level; Dose_____ >_____BS level; Dose_____ >_____BS level; Dose_____ >_____BS level _____if blood sugar > 300 at any other time of the day, please call the office for assistance
Pumps-Basal/Bolus Name of Insulin Pump _____	_____student has an Insulin infusion pump with _____ Insulin and shall be permitted to wear and attend to the pump as needed during school and school sponsored activities _____Basal rate during school hours _____ _____Bolus Rates: Meal Bolus (Insulin/Carb ratio): _____ Correction Bolus: _____ _____other (specify) _____
Hypoglycemia/Glucagon	_____treat all blood sugar < _____mg/dl with _____grams of rapid-acting carbohydrate followed by meal/snack _____for severe hypoglycemia (or suspected severe hypoglycemia) when the student is unconscious or unable to swallow, give _____mg Glucagon I.M. or S.Q. AND contact parent/guardian and paramedics immediately _____student requires a Glucagon delegate, School nurse may train volunteer in administration of Glucagon (no school employee, including school nurse, bus driver, bus aide, or any other agent of a board of education, shall be held liable for any good faith act or omission with provision of N.J.S.A 18A:40-12-11-21)
Other	_____the student is capable of and has been instructed in the self-management and self-care of their diabetes _____the student has been instructed in proper hand washing and preparation of injection sites _____the student has been instructed in proper needle disposal and preventing blood exposure to others _____List oral diabetic medications (if any)_____ _____School Nurse has permission to speak with the prescribing physician regarding the information Listed above

Healthcare provider's Name (Please Print): _____ Doctor's Stamp:

Healthcare provider's Signature: _____ Date:_____

Telephone Number: _____

Parent Signature: _____ Student Signature:_____ Date: _____

HUNTERDON CENTRAL REGIONAL HIGH SCHOOL
Health Office
Hunterdon Central Regional High School
84 Route 31
Flemington, NJ 08822
Phone: 908-284-7304/7143/7140/7235 Fax: 908-284-7311/7312

Authorization for Medication
ONLY ONE MEDICATION PER FORM

State law requires a signed prescription by a physician that includes the information below OR completion of the form below. If a prescription is faxed, the original must be forwarded to the Health Office.

Name_____ Grade_____ Date_____

Diagnosis__Diabetes – Type 1_____ Allergies_____

Medication_GLUCAGON EMERGENCY KIT_____

Dosage_I mg_ Time(s)_PRN for BS <☐ & unable to take PO glucose___ Route__I.M.

Possible Side Effects__nausea, vomiting, hypersensitivity, bronchospasm_____

Termination date_end of each school year__(Note: State law requires that medication be renewed each school year).

Student is free of contagious disease and physically fit to attend school.
The student would not be able to attend school unless the medication is given during school hours.

_____ _____ _____
Physician's Signature Printed Name of Physician Date

Parent/ Guardian Consent for Giving Medication During School

I request and give my consent for the School Nurse to dispense the medication prescribed by the physician on this form.

A prescription medication must be delivered to the School Nurse in the original pharmacy container labeled with the student's name, date of prescription, name of medication, dosage and the prescribing physician's name. If the medication is an over the counter medicine, it must be in the original box.

I give permission for the information on this form to be shared with the appropriate staff members, coaches, and chaperones, etc for the safety and welfare of my child.

I give permission for the school nurse to train a glucagon delegate for my child in the event that the school nurse is not physically present at the scene. I understand that no school employee, including a school nurse, bus driver, bus aide, or any other officer or agent of a board of education, shall be held liable for any good faith act or omission consistent with the provisions of N.J.S.A. 18A:40-12-11-21.

I give permission for the school nurse to speak with the prescribing physician regarding the medication listed above, if necessary.

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

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Name_____ Grade_____ Date_____

Diagnosis_Diabetes Type 1 – Pump Failure___ Allergies_____

Medication_____Insulin_____

Dosage_____ Time(s)_____Route_____

Possible Side Effects__hypoglycemia; pruritis; rash; dry mouth; blurred vision_____

Termination date_____(*Note: State law requires that medication be renewed each school year*).

Student is free of contagious disease and physically fit to attend school.
The student would not be able to attend school unless the medication is given during school hours.

_____ _____ _____
Physician's Signature Printed Name of Physician Date

Parent/ Guardian Consent for Giving Medication During School

I request and give my consent for the School Nurse to dispense the medication prescribed by the physician on this form.

A prescription medication must be delivered to the School Nurse in the original pharmacy container labeled with the student's name, date of prescription, name of medication, dosage and the prescribing physician's name. If the medication is an over the counter medicine, it must be in the original box.

I give permission for the information on this form to be shared with the appropriate staff members, coaches, and chaperones for the safety and welfare of my child.

I give permission for the school nurse to speak with the prescribing physician regarding the medication listed above, if necessary.

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

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DIABETES SUPPLIES

Parents are responsible for providing all diabetic supplies. The following is a list of typical supplies:

INSULIN SUPPLIES
Insulin
Insulin syringes OR
Insulin pen with cartridge loaded
Insulin pen needles OR
Insulin pump supplies
Alcohol wipes

BLOOD GLUCOSE TESTING SUPPLIES
Blood glucose meter and manufacturer's instructions
Test strips (with code information)
Lancet device
Lancets
Logbook to record blood sugar and amounts of insulin (student to carry if approved by MD)

FOOD SUPPLIES
Snack foods
Low blood sugar (hypoglycemia supplies: glucose tablets, juice and carbohydrate/protein snack)
Water

OTHER
Urine ketone strips
Glucagon kit

HUNTERDON CENTRAL REGIONAL HIGH SCHOOL

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Contact Information

Student's Name:_____ Gender:_____

Date of Birth:_____ Date of Diabetes Diagnosis_____

Grade:_____

Mother/Guardian:_____

Address:_____

Telephone home:_____ work:_____cell:_____

Email Address:_____

Father/Guardian:_____

Address:_____

Telephone home:_____ work:_____cell:_____

Email Address:_____

Student's Physician/Health care provider:

Name:_____

Address:_____

Telephone:_____ Emergency Number:_____

Other Emergency Contacts:

Name:_____Relationship:_____Telephone:_____

Name:_____Relationship:_____Telephone:_____

Name:_____Relationship:_____Telephone:_____

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DIABETES MEDICAL MANAGEMENT UPDATE

Date:

Dear Parent or Guardian,

In 2009 the New Jersey Legislature amended N.J.S.A 18A:40-12 adding provisions to enhance the medical management of students with Diabetes in the school. This amendment requires additional information to be provided to the school to care for your child.

Please have your physician complete the following information on the attached forms to supplement the diabetic management plan that we have in place for your child. The forms for the physician include the Heathcare Provider Orders for School, Glucagon Emergency Medication, and if appropriate the Diabetes Type 1 Pump Failure form.

In addition please review, update, and sign the enclosed care plan and Quick Reference Emergency Plan. Please indicate which symptoms your child usually experiences in episodes of hyperglycemia and hypoglycemia. Return all forms to the appropriate health office.

Please note that state law requires that medication be renewed each year. If you have any questions, please contact the appropriate health office.

9/10 health office 284-7140, 284-7304 Fax 284-7311
11/12 health office 284-7143, 284-7235 Fax 284-7312

_____

School Nurse:
Jennifer Amato RN
Lauren Larsen RN
Janet Jeans RN
Cathy Stenger RN