Columbus City Schools
Health, Family and Community Services
Columbus Ohio 43215

Health forms for students with

Diabetes

Please complete packet and return to nurse at child's school

What's in this packet?

1) Parent Letter – parent keeps

2) Release of Information - allows the doctor to talk to the school nurse if there are any questions

3) Diabetes Questionnaire – parent completes, explains how your child is affected by and manages their diabetes

4) Diabetes Management Agreement – parent signs giving consent for care at school and introduces how care will be provided at school

5) Guidelines for Medicines at School – parent reference

6) Diabetes Management at School – Healthcare Provider letter – A letter to give to your child's doctor or healthcare provider

7) Diabetes Medical Management Plan – doctor completes, the form provides the school with medical orders needed to care for your child while at school

8) Prescribed Insulin Authorization Form – doctor completes if they prefer this format for prescribing diabetes medication

Questions? Please call your school nurse.

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This policy is applicable in all district programs and activities. Rev. 8/24

Columbus City Schools
Health, Family and Community Services

DIABETES MANAGEMENT AT SCHOOL

Dear Parent/Guardian of _____: Date:_____

Columbus City Schools provides nursing services that promote students ability to learn. Our goals are to:

- Assist students in learning how to take care of their health.
- Ensure a safe school environment.
- Promote good control of a student's health condition so they are ready to learn.

To help us meet the above goals:

1. All school nurses in Columbus City Schools are registered nurses.
2. The school nurses work closely with the student's parents/guardians and their Healthcare Providers to assure access to necessary resources.
3. The district also has a Diabetes Resource Nurse with advanced training to assist other school nurses, school personnel, students with diabetes, and their parents/guardians and to collaborate with the student's healthcare provider.

To assist your student at school and promote diabetes management, the forms below *are required each school year*. Please give the completed and signed forms below to the school nurse prior to starting school:

- ***Diabetes Management - Parent Agreement*** – Parent permission for the school to provide diabetes care
- ***Diabetes Questionnaire*** - Parent/Guardian completes
- ***Release of Information –*** Parent/Guardian completes

Your student's healthcare provider needs to provide you or the school with the **Insulin/Diabetes Medication Orders/Diabetes Medical Orders for School**–which are needed prior to attending school.

To follow medical orders and in the best interest of your student's health, your student can NOT be in school unless we have ALL diabetes related paperwork, medical orders AND ALL necessary supplies checked below:

- ☐ 8- Fast acting sugar sources (15 gm glucose tablets, juice, etc) to treat low blood sugar
- ☐ 8 - Carbohydrate/protein snacks
- ☐ Insulin vial or insulin pen cartridge in Pharmacy box
- ☐ Insulin syringes or pen needles
- ☐ Blood glucose meter
- ☐ Blood glucose test strips
- ☐ Lancet device and Lancets
- ☐ Urine Ketone testing strips
- ☐ Insulin Pump Supplies for back-up (if pump is ordered for student)
- ☐ Glucagon Kit
- ☐ Other:_____

Please contact the school nurse with any questions or concerns. Thank you for your help in obtaining the necessary orders.

Your student's School Nurse is: _____

Phone number: _____ Days at school: _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

Date:

Student Full Name:		**Birth Date:**	
School Name:		**School Phone:**	
Requested by: Name, Title		**School Fax:**	

☐ **Fax Info to School** ☐ **Email Info to:** _____

In order to release any confidential information regarding your student, Columbus City Schools is required by law to have your written permission as this information is protected under the Family Educational Rights and Privacy Act (FERPA). Please sign this form to indicate the agencies or individuals that Columbus City Schools may receive information from or release information to regarding your student. Please keep a copy for your records. This signed authorization will be valid for one year from the date of your signature. If you wish to revoke this consent, please provide written notice to your student's school.

I understand the requested information below will be used by the Columbus City School staff for educational and health care planning and service delivery at school.

Provider Name and Address	Provider Fax #	Provider Phone #

Dates Range of Records Requested: From Date: _____ To Date: _____

☐ Medical Info/Records: **specified below** ☐ Psychological Information/Records ☐ Immunization Records

☐ TB Test Results/Records ☐ Speech and/or Hearing Evaluation ☐ School Health Records

Specific Information Requested for educational and health care planning and service delivery at school :

I understand any release of information pertaining to substance abuse, mental health or HIV related records will be done only if needed to better meet the educational and school health needs of the student named above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above-mentioned entity. Release of alcohol and drug abuse information is protected by Federal Confidentiality Rules (42 CFR Part 2) without written consent of the person to whom it pertains or as otherwise permitted. Federal rules also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52 FR 21809, June 9, 1987: 52 FR 41997, November 2, 1987).

Authorization for Redisclosure: Under federal law, CCS may not redisclose the information identified above to any other party without prior consent.

_____ _____

Parent/Guardian or Adult Student Signature **Date**

_____

Printed Name of Parent/Guardian or Adult Student

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PR-10 PARENTAL CONSENT TO SHARE HEALTH INFORMATION FOR THE OHIO MEDICAID SCHOOL PROGRAM

CHILD'S INFORMATION

CHILD'S NAME _____

DATE OF BIRTH ____/_____/____ DISTRICT NAME _____

Ohio school districts have the opportunity to receive federal Medicaid dollars through a program called the Ohio Medicaid School Program (MSP). Through this program, school districts can receive Medicaid dollars for therapy services such as Speech, Audiology, Physical Therapy, Occupational Therapy, Nursing, Psychology, Counseling, and Social Work services. In the process of billing Medicaid for these services, billing information must be shared with the Ohio Department of Medicaid. For Medicaid billing purposes, schools must obtain a one-time signed Parental Consent to Share Health Information for the Ohio School Medicaid Program. After this one-time written consent, you will receive an annual notice of this consent.

Schools request this consent for all students who receive therapy services, even students who may not be currently enrolled in Medicaid. Some health information shared is specific to your student, while other information is related to all students within the entire school district. Schools can use this health information to help reduce costs for services that the district must deliver pursuant to the Individuals with Disabilities Education Act (IDEA). This student specific health information is protected and will be accessed only by people authorized to do so by the school's Medicaid contract.

Your consent is voluntary. You have the right to withdraw your consent at any time (34 CFR Part 99 and Part 300.) You are not required to enroll in Medicaid. If your school does bill Medicaid, you will not be required to incur any out-of-pocket expenses such as a deductible or co-pay, decreased lifetime coverage, increased premiums or the discontinuation of benefits, or result in you paying for services.

Regardless of whether you grant consent, refuse consent, or revoke your consent, your child will still be provided with an evaluation and/or the services as identified by the school district at no cost to you.

____ I understand and agree to give permission to share my child's *specific* health information in order for the school to access Medicaid.

____ I do not give permission to share my child's *specific* health information in order for the school to access Medicaid.

Parent (printed) Name _____

Parent Signature _____

Date _____/_____/_____

Please contact **Healthcare Billing Services, Inc**. at **(740) 639-4218** with questions or if you feel you have incurred a personal cost for these services.

Student: _____

DOB: _____ Student ID: _____

School: _____

Grade: _____ Room: _____ School Year: _____

DIABETES QUESTIONNAIRE

Complete & Return to the School Nurse as soon as possible. The information is needed to assist your student.

Person to Contact:	Relationship:	Work/Cell Phone:	Home Phone:
1.			
2.			

Preferred Communication Method ☐ phone ☐ written ☒ in person ☐ email: _____

Health Provider Name	Phone:	Fax:

Student is diagnosed with: ☐ Type 1 ☐ Type 2 Other: _____ Age at Diagnosis: _____

Does the student take insulin: ☐ at home ☐ at school ☐ none

Does the student wear a medical alert bracelet/necklace: ☐ Yes ☐ No

What is the student's blood glucose (BG) target range? _____ mg/dl to _____

Does the student check their BG? ☐ at home ☐ at school ☐ none

(Completed Medical Management Plan with medication orders is required from healthcare provider)

When does student check BG at home: ☐ before each meal ☐ before physical activity ☐ with symptoms of high BG ☐ after physical activity ☐ with symptoms of low BG ☐ other: _____

Does the student test urine for ketones? ☐ at home ☐ at school ☐ none

If yes, when does student check for urine ketones? When BG is greater than _____

What BG level is considered low for the student? below _____ What has been their lowest BG? _____

How often does the student typically experience low BG? ☐ daily ☐ weekly ☐ monthly ☐ other _____

When does student typically have low BG: ☐ mid AM ☐ before lunch ☐ afternoon ☐ not often ☐ after exercise ☐ Other _____

If student takes the bus, how long is bus ride? _____

Please check the student's usual signs/symptoms of low blood glucose:

☐ hunger or "butterfly feeling"	☐ irritable	☐ difficulty with speech
☐ shaky/trembling	☐ weak/drowsy	☐ anxious
☐ dizzy	☐ pale	☐ confused/disoriented
☐ sweaty	☐ severe headache	☐ loss of consciousness
☐ rapid heartbeat	☐ impaired vision	☐ seizure activity
☐ inappropriate crying/laughing	☐ difficulty with coordination	☐ Other _____

Does the student recognize these signs/symptoms? ☐ Yes ☐ No

How are low BG levels treated at home? Be specific. State amount of food, beverage, Glucagon, etc.:

_____

Does the student need daily snacks at school? ☐ Yes ☐ No **If yes, what and when:** _____

ALL SNACKS AND SUPPLIES used at school MUST be provided by the family.

What would you like done about birthday treats and/or party snacks? _____

In the past year, how often has the student been treated for **severe low** BG? _____ times

In the past year, how often has the student been treated for **severe high** BG? _____ times

In the past year, has the student been seen for diabetes care:

☐ In the emergency room ☐ overnight in the hospital

NOTES/COMMENTS:

_____

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Please indicate the student's skill level for the following:

Skill	Does alone	Adult Help	Adult Performs	Comments
Checks blood glucose				
Reads meter and records				
Counts carbs for meals/snack				
Calculate carb & correction dose				
Determines total insulin dose				
Interpret sliding scale - if has one				
Draw up/dial insulin dose				
Selects insulin injection site				
Gives insulin injection				
Checks urine ketones				
Pump Skills				

Does the student use an insulin to carbohydrate ratio with meals at home? ☐ Yes ☐ No Ratio: _____

Does the student use an insulin adjustment for high or low BG at home? ☐ Yes ☐ No

Insulin routine at home, if applicable

Name of Insulin:	Units or Ratio:	Time:

Typical carbs at:
Breakfast -
Lunch -
Dinner -
Other -
Other -

Check Method

☐ Pen
☐ Syringe/vial
☐ Pump

Other medication taken on a regular basis:

Name	By (mouth, injection, etc.)	Dose	Time of day

As needed medication:

Name	By (mouth, injection, etc.)	Dose	Time of day

Please list side effects of the student's medications that may affect their learning and/or behavior:

A Diabetes Medical Management Plan and medication orders from the student's healthcare provider must be completed yearly. ALL insulin, medication and diabetes related supplies MUST be brought to the school by the family; for health and safety reasons, a student cannot attend school without them. All medication must be in the original labeled container.

What action do you want school staff to take if the student does not respond to treatment/medication?

_____

Is the student compliant with their diabetes medical management at home? ☐ Yes ☐ No ☐ Sometimes

Comments: _____

Has the student received diabetes education? ☐ Yes ☐ No If yes, where: (check **all** that apply)

☐ by healthcare provider ☐ at support group ☐ community agency

☐ at camp ☐ other _____

Please add anything else you would like school personnel to know about the student's diabetes (or any health condition).

_____

Information provided by _____ _____ _____

Name Relationship to Student Date

I authorize reciprocal release of information related to the student's diabetes between the school nurse and the healthcare provider.

_____ _____

Parent/Guardian Signature Date

5-2018

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Columbus City Schools
Health, Family and Community Services
Columbus, OH 43215

Diabetes Management at School – Agreement

Student Name: _____ **School Year:** _____-_____

School: _____ **Birth date:** _____ **Grade:** _____

PARENT/GUARDIAN TO COMPLETE:

I _____, request that the specialized health care service prescribed by the student's healthcare provider be provided for the student. I authorize the school to appoint qualified designated trained staff to ensure the prescribed treatment is provided in the absence of the school nurse. I agree to immediately notify school personnel of any change in either the student's treatment regimen or the authorizing healthcare provider.

THE FOLLOWING INFORMATION IS NECESSARY FOR COLUMBUS CITY SCHOOL STUDENTS REQUIRING PRESCRIBED MEDICATION IN SCHOOL; **PARENT must sign this form and ensure the school has the Medical Management orders from the Healthcare Provider.**

1. I request permission for the above student to use medication according to the healthcare provider's medication order as part of the Diabetes Medical Management Plan for school.
2. I assume responsibility for the safe delivery of the medication **AND SUPPLIES** to school, either by myself or by the student.
3. I will notify the school immediately if there is any change in the student's Medical Management Plan.
4. I authorize Columbus City School Health Services personnel to communicate with the student's healthcare providers as necessary concerning the medical management of the student at school.
5. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

In addition:

1. I am responsible to assure the student regularly monitors blood glucose and is compliant with medication regimen as prescribed.
2. I am to maintain regular appointments with the prescribing healthcare provider and the student.
3. This agreement will last for only one academic school year.

_____

Signature of Parent or Guardian **Date**

_____

Home Telephone **Cell Phone** **Work Telephone**

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Guidelines for Medications at School

Students needing to take medication during school hours must follow these guidelines:

- **Provide the school nurse with a completed Medication Authorization Form signed by both the parent/guardian and the healthcare provider.**
- **Medications cannot be at school without the form and signatures of both doctor and parents. Medications cannot be held until the mediation authorization form arrives.**
- **A new Medication Authorization Form is required each school year AND when there is a change in medication or dose.**
- **All medication must be in the original container in which it was dispensed by the healthcare provider or pharmacy and be labeled with the correct dose and instructions. The medication cannot be expired.**
  - The label must match what is on the Medication Authorization Form.
  - Students taking a medication at both school and home can request 2 separate labeled bottles from the pharmacy to divide the pills to have some at home and school.
  - Students using an inhaler, epinephrine pen or other emergency medications at school can request 2 prescriptions from the healthcare provider in order to have a supply at home and school.

- **Medication must be brought to school by the parent or guardian. Bus drivers cannot be responsible for medications on the bus.**

- **School personnel cannot give over-the-counter medications unless prescribed by a healthcare provider. A Medication Authorization Form is required.**

  - Prescribed over the counter medications follow the same guidelines as stated above for prescribed medications. (Over the counter medications include pain medication such as Tylenol, cough medicine, eye drops, ointments.)
  - Over the counter medications must be in the original container and not expired.
  - A label must be attached to the medication which includes: the student's name, name of medication, dosage, strength, route, time of administration and expiration date. Label must match the Medication Authorization Form.

- **Medications ordered three times a day or less, unless time is specified, may not need to be taken at school.** The medication should be given before school, after school and at bedtime.

All unused medication must be picked up by the parent/guardian on the last day of student attendance or it will be discarded.

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Columbus City Schools

DIABETES MEDICAL MANAGEMENT PLAN FOR SCHOOL Year: _____ - _____

Student: _____ DOB: _____ Grade: _____ Room: _____

Student ID: _____ School: _____

Type of Diabetes: ☐ Type 1 ☐ Type 2 ☐ Pre-Diabetes ☐ Other _____

Date of diagnosis _____

Blood Glucose Monitoring

Blood glucose (BG) target range: _____ - _____ mg/dl

☐ Blood glucose testing times: _____

☐ No BG testing at school

☐ Only at student's discretion

☐ For suspected hypo or hyperglycemia and as needed

☐ When testing BG, the student: ☐ needs assistance ☐ needs supervision ☐ is independent

Diabetes Medication

☐ No insulin at school

☐ Oral diabetes medication at school: _____

Medication – Dose -- Time

☐ Insulin at school: ☐ Humalog ☐ Novolog ☐ Other _____

Insulin delivery device: ☐ Syringe and vial ☐ Insulin pen ☐ Insulin pump ☐ CGM: _____

Insulin dose at school:

☐ Breakfast _____ units of insulin per _____ grams of carbohydrate

☐ Lunch _____ units of insulin per _____ grams of carbohydrate

Other: _____ (Snacks)

☐ Correction for high glucose: _____ units of insulin for every _____ mg/dl above _____ mg/dl

(Correction bolus is given with meals or as directed for by prescribing physician)

If scale applicable

Blood Glucose Value (mg/dl)	Units of Insulin

Note: Meal bolus and correction bolus equals the total insulin dose.

☐ Ketone coverage: _____

☐ Round Insulin dose to nearest: (circle) Half / Whole Unit

Additional Considerations:

☐ Plan for pre-activity: _____

☐ Plan for after school activities: _____

☐ Extra food allowed ☐ Parent/guardian's discretion ☐ Student's discretion

Hypoglycemia

Low Blood Glucose < _____ mg/dl

☐ Self-treatment of mild lows ☐ Assistance for all lows

☐ Immediately treat with 15 g of fast-acting carbohydrate (e.g., 4 oz juice, 3-4 glucose tabs, 5 oz regular pop)

☐ Recheck BG in 15 minutes; repeat 15 grams of fast-acting carbohydrate if BG remains < target

☐ If more than 1 hour until next meal or snack, student should have a 15-gram carbohydrate, protein, fat snack

☐ If student participating in additional exercise or activity before the next meal, provide an additional 15 gm carb choice

☐ If student is using an insulin pump:

Severe Hypoglycemia

If the child is unconscious or having seizures due to low blood glucose the school nurse or trained staff per protocol will immediately administer **Glucagon: Type: _____ Dose: _____ per directions**

☐ Immediately after administering the Glucagon, turn the child onto their side. Vomiting is a common side effect.

☐ Notify parent and EMS per protocol

Hyperglycemia

High Blood Glucose ≥ _____ mg/dl

☐ Check ketones when blood glucose > _____ mg/dl or student is sick

☐ Use correction coverage insulin orders when blood glucose is _____ mg/dl

☐ Unlimited water and bathroom pass

☐ Notify parent immediately of blood glucose > _____ mg/dl or if student is vomiting

☐ If student is using an insulin pump, follow DKA prevention protocol

Insulin Pump Instructions

Note: Insulin/carb ratio and correction factor noted above. Additional directions:

Is there a temporary Basal Rate before gym: ☐ Yes ☐ No

Hyperglycemia Treatment:

Hyperglycemia/ Sensitivity Factor: 1 unit of insulin will decrease the BG by _____ mg/dl

If BG has not dropped or is higher, check tubing, insulin cartridge or pump may be malfunctioning. Call parent if needed.

Student is fully instructed and should be responsible for: giving boluses & changing the infusion site: ____Yes ____ No

Hypoglycemia Treatment:

Special Occasions

☐ Arrange for appropriate monitoring and access to supplies on all field trips and school related events.

_____ _____

Signature of Physician/ Licensed Prescriber Date

_____

Print name of Physician/ Licensed Prescriber

_____ _____ _____

Clinic Address Phone Fax

Returned to: _____ _____ _____

Licensed School Nurse Phone Fax

Columbus City Schools
Health, Family and Community Services
Columbus, Ohio 43215

Prescribed Insulin Authorization

Student Name: _____ **DOB**: ___/___/___ Room/Grade:_____**Today's Date**_____

Student Address: _____ Name of school:_____

School Nurse: _____ School Phone: _____ School Fax: _____

Diagnosis: ☐ Diabetes Type I ☐ Diabetes Type 2 ☐ Pre-diabetes ☐ Other _____

Type of Insulin: ☐ insulin lispro (Humalog®) ☐ insulin aspart (Novolog®) ☐ Other _____

Administration Method: ☐ syringe/vial or pen ☐ pump

Insulin Dose and Time:

☐ Carbohydrate ratio for (circle) Breakfast / Lunch / All meals: 1 unit for _____ grams of carbohydrates

☐ Carbohydrate ratio for Snacks 1 unit for_____ grams of carbohydrates

☐ Correction Target BG: _____ mg/dL

☐ Insulin correction factor: ____ unit(s) for every _____ mg/dL above correction target BG

☐ Insulin for ketone coverage: _____

☐ Round Insulin dose to nearest: (circle) Half / Whole Unit

☐ Other (ie: Pump information, CGM, sliding scale): _____

_____

_____ _____

Parent/Guardian Signature Date Parent/Guardian Phone Number

Below completed by healthcare provider:

Beginning Date:_____ Expiration Date: _____

Possible Adverse Reactions:_____

Special Instructions: _____

Healthcare Provider Signature: _____ Date: _____

Healthcare Provider Printed Name: _____

_____

Address Telephone Fax

Or Stamp: