SAHUARITA UNIFIED SCHOOL DISTRICT #30

SCHOOL HEALTH SERVICES

Parent Information Packet: Diabetes Documentation Requested

To the parent of _____ Date: _____

While reviewing the *Student Health History Form* you completed for your child, it was noted you indicate he/she may have *Diabetes.*

In order to provide better health care services for your child in school, we need to know if this is currently an issue, and if your child requires special care and/or observation for this condition at school.

Please complete the section below and return to me at school, with appropriate documentation as requested. If you have any questions or concerns please feel free to contact me at any time. All medical information is confidential and will be shared only with teaching staff working directly with your child.

Thank you.

_____
School Health Staff

Please check the box next to the most appropriate statement for your child, sign the bottom of this page and return to the school health office.

Please note: If your child is not on an insulin pump (every day/consistently) and your child is unable to consistently and accurately draw and/or inject insulin with a vial and syringe, please ask your child's physician to provide a prescription for an insulin pen and insulin cartridges for school staff to assist the child with administering insulin. Insulin pens are safer and easier for non-licensed school staff to assist the child. Insulin pens utilize a "number dial" that measures and dispenses accurate insulin doses in half unit increments.

____ This is no longer a health concern.
____ My child DOES have Diabetes:

- Prepare your child. Discuss the medication plan, appropriate use of medications and how to handle symptoms.
- Keep school staff up-to-date on any changes in your child's care.
- PLEASE PROVIDE THE FOLLOWING DOCUMENTS **ANNUALLY** TO THE SCHOOL HEALTH OFFICE:
  - ☑ **Parent Diabetes Questionnaire** completed by parent/guardian
  - ☑ **Diabetes Medical Management Plan for School Form** (Injection or Pump) signed by an **Arizona Licensed Physician/Health Care Provider** and parent/guardian. Please note: If your child sees a physician at either the Angel Clinic or TMC One Diabetes Clinics, you may substitute this form with their printed diabetes orders for school.
  - ☑ **Please see school health staff if your child requires diabetes medications/supplies at school.**
  - ☑ **Consent for Administration of Medications for Students/Insulin** (Please see health staff if self-administration is requested)
  - ☑ **Consent for Administration of Medications for Students/Glucagon** (Please see health staff if self-administration is requested)
  - ☑ **Authorization to Administer Physician Prescribed Treatment/Procedure** signed by an **Arizona Licensed Physician/Health Care Provider**
  - ☑ **Permission for Release/Exchange of Student Records – Diabetic Student**
  - ☑ **Diabetic Supply List**

_____ _____ _____
Name of Parent and/or Guardian Signature Date

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Parent Diabetes Questionnaire pg 1/2

This questionnaire should be completed and signed by the students parents/guardians parents/guardian, however for it to be valid it MUST be accompanied by DIABETES MEDICAL MANAGEMENT PLAN signed and dated by a Licensed HealthCare Provider! . Both the Diabetes Questionnaire for Parents and Diabetes Medical Management Plan must be renewed ANNUALLY at the start of each school year. Information in this questionnaire will only be used by school staff if Physician Orders do not contradict parent information.

Student's Name: _____Date of Birth: _____
Grade: _____ Homeroom Teacher: _____
Address: _____
Diabetes Diagnosis Date: _____ ☐ Diabetes type 1 ☐ Diabetes type 2

Contact Information
Mother/Guardian: _____
Telephone: Home _____ Work _____ Cell_____
Father/Guardian: _____
Telephone: Home _____ Work _____ Cell _____
Student's Diabetes Management Doctor/Health Care Provider:
Name: _____ Phone Number _____ Fax _____

Student Meals
What time does student usually eat breakfast on school days? _____
Will student be buying breakfast at school? Yes No Will student be buying their lunch to school? Yes No
Will student be allowed to eat group snack at school? Yes No
If student forgets their food from home: Is the student allowed to eat school breakfast, snack, or lunch? Yes No

Please note, parents are responsible for providing carb counts and insulin dosages for all children who are not independent in doing so. For students buying their breakfast/lunch at school, carb count menu's may be provided upon request. If a young student will be buying lunch regularly, parents are requested to fill out a carb count menu for their child in advance, so parents are able to calculate carb counts for each days menu selection. For more information, please speak to health staff. Also note, students go to the cafeteria before some health assistants are on duty.

Blood Glucose Monitoring
Target range for blood glucose is ☐ **70-150** ☐ Other _____-_____
Times for blood glucose checks (*check all that apply*)
☐ Before Lunch ☐ Before Snack/Classroom Parties ☐ Before PE
☐ Before Boarding School Bus ☐ As Needed ☐ Other _____
Type of blood glucose meter student uses: _____

For Students Taking Oral Diabetes Medications
Type of medication: _____ Timing: _____
Other medications: _____ Timing: _____

Insulin Dosages and Administration by Syringe Injection
What Insulin will the student be receiving at school: _____
What is the students current Insulin to Carb Ratio? _____:_____
What is the students current Blood Glucose Correction Formula? : (Blood Glucose – _____/_____)
How Frequent is student to receive Blood Glucose Correction (maximum frequency i.e. every 2 hours if high):_____

Student Pump Abilities/Skills:

Perform Blood Glucose Testing	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently
Count Carbs and Calculate Carb Correction	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently
Calculate Corrective Insulin Bolus	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently
Draw Correct Insulin into Syringe	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently
Administer own Injections	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently

Parent Diabetes Questionnaire pg 2/2

Insulin Dosages and Administration by Pump
Type of pump: _____ Basal rates: _____
Type of insulin in pump: _____
Type of infusion set: _____
What is the students current Insulin to Carb Ratio? _____:_____
What is the students current Blood Glucose Correction Formula? : (Blood Glucose – _____/_____)

Student Pump Abilities/Skills:

Perform Blood Glucose Testing	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently
Count Carbs and Calculate Carb Correction	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently
Calculate Corrective Insulin Bolus	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently
Draw Correct Insulin into Syringe	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently
Calculate and set basal profiles	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently
Calculate and set temporary basal rate	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently
Disconnect pump at infusion set	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently
Reconnect pump at infusion set	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently
Prepare reservoir and tubing	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently
Troubleshoot alarms and malfunctions	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently

Exercise and Sports
Student should not exercise if blood glucose level is below _____ mg/dl or above _____ mg/dl or if moderate to large urine Ketones are present.

Hypoglycemia (Low Blood Sugar)
Usual symptoms of hypoglycemia: _____
Treatment of hypoglycemia: _____
Glucagon should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow.
Route _____, Dosage _____, site for glucagon injection: _____arm, _____thigh, _____other.
If glucagon is required, administer it promptly. Then, call 911 (or other emergency assistance) and the parents/guardian.

Hyperglycemia (High Blood Sugar)
Usual symptoms of hyperglycemia: _____
Treatment of hyperglycemia: _____
Urine should be checked for Ketones when blood glucose levels are above _____ mg/dl.
Treatment for Ketones:
_____

Supplies to be Kept at School (parents are responsible for providing and maintaining supplies)
_____Blood glucose meter, blood glucose test strips, batteries for meter
_____ Lancet device, lancets, gloves, etc.
_____Urine Ketone strips
_____Insulin pump and supplies
_____Insulin pen, pen needles, insulin cartridges
_____Fast-acting source of glucose
_____Carbohydrate containing snack
_____Glucagon emergency kit

Signatures
I give permission to the school nurse, trained diabetes personnel, and other designated staff members to perform and carry out the diabetes care tasks as outlined by _____'s attached Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all staff members and other adults who care for my child at school and who may need to know this information to maintain my child's health and safety.

_____ _____ _____
Name of Parent and/or Guardian Signature Date

SAHUARITA UNIFIED SCHOOL DISTRICT #30

SCHOOL HEALTH SERVICES

Diabetes Injection Therapy Medical Management Plan for School

Valid for 1 school year. To be completed and signed ANNUALLY by **Arizona Licensed Physician/Health Care Provider**

Student's Name:_____**D.O.B:**_____**Teacher:**_____ **School Year:** _____/_____

Blood Glucose Monitoring

Target range for blood glucose is:

☐ 70-150 ☐ 70-180 ☐ Other ____-_____

Blood Glucose Monitoring Schedule:

☐ Before lunch and snacks	☐ Before boarding school bus
☐ When student feels low/high/i	☐ Other schedule:
☐ Before PE/Exercise	_____

Insulin Injection:

- ☐ Insulin to be given at school will be either Humalog, Novolog, or Apidra
- ☐ Bolus for meal based on carbohydrate count
  Initial Insulin to Carb Ratio: 1 Unit Insulin: ____Carbs
- ☐ Correction or supplemental bolus for high glucose
  Initial Blood Sugar Correction Factor: _____ Unit for every _____>_____
- ☐ Note: Current doses may change over time. Please defer to parents for most current dose.

Low Blood Sugar (Blood Glucose less than 70)

- ☐ Give _____ Grams of fast acting Carbohydrates (default=15)
- ☐ Re-Test blood Glucose Level in 15 minutes
- ☐ If Blood Glucose still less than 70, Repeat Carbohydrate dose and re-check Blood Glucose in another 15 minutes.
- ☐ Give student a snack
  - Carbohydrates
  - Protein
- ☐ Notify parent.

Seizure, Unable to Swallow and/or Loss of Consciousness:

- ☐ Glucose gel, 1mg of glucagon IM or Sub-Q and call 9-1-1 (Glucagon be administered by anyone properly trained in administration of glucagon)

High Blood Sugar (Blood Glucose greater than _____)

- ☐ Give insulin correction bolus as outlined above. Insulin correction bolus should not be given more often than every _____ hours.
- ☐ Encourage student to drink water.
- ☐ If blood glucose level greater than _____mg/dl, have student check Ketones (default=250)
- ☐ No PE/Physical Activity if Blood Glucose level over _____

Ketones Moderate to Large

- ☐ Student should be sent home for treatment and monitoring.
- ☐ If the student is not taken home after 2 hours, the school nurse should consider calling 9-1-1 for transport to nearest healthcare facility.
- ☐ Student needs to drink as much water as he/she can (32 fl oz in 15 minutes).
- ☐ Rapid acting insulin doses need to be given every 2-3 hours and glucose levels checked every 2 hours per physician or parent guidelines until urine Ketones are clear.

I have instructed student in the proper way to complete the skills listed below and the student has demonstrated competence in completing the following Diabetes Maintenance Skills/Tasks, and I authorize student to complete the following tasks at school with Supervision or Independently:

Perform Blood Glucose Testing	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently
Count Carbs and Calculate Carb Correction	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently
Calculate Corrective Insulin Bolus	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently
Draw Correct Insulin into Syringe	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently
Administer own Injections	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently

Physician Authorizations:

- ☐ I authorize school nurse and/or designated school staff to assist student in monitoring blood glucose and administering Glucose, Glucagon, and Insulin as needed as outlined as above.
- ☐ I authorize school nurse and/or designated school staff to refer to the Information for School Personnel about Diabetes Mellitis instructions when assisting student in monitoring blood glucose and administering Glucose, Glucagon, and Insulin as needed.
- ☐ It is my professional opinion that he/she should be allowed to carry and use his/her Blood Glucose Testing Supplies by him/herself and school. (Right to carry may be revoked if student found to be irresponsible with medication at school).
- ☐ It is my professional opinion that he/she should be allowed to carry and use his/her Diabetes Medications (Glucose and Insulin) by him/herself and school. (Right to carry may be revoked if student found to be irresponsible with medication at school).

Arizona Licensed Physician/Healthcare Provider Signature authorizes the School Nurse, Health Assistant, Extended Resource Teacher, Health Inclusion Assistant, or Authorized Designee perform the above health care tasks as indicated.

Provider's Printed Name _____ **Phone:** _____

Provider's Signature: _____ **Date:** _____

Parent/Guardian's Name: _____ Phone Number: _____

Parent/Guardian's Signature_____ Date: _____

SAHUARITA UNIFIED SCHOOL DISTRICT #30

SCHOOL HEALTH SERVICES

Diabetes Pump Therapy Medical Management Plan for School

Valid for 1 school year. To be completed and signed ANNUALLY by **Arizona Licensed Physician/Health Care Provider**

Student's Name:_____**D.O.B:**_____**Teacher:**_____ **School Year:** _____/_____

Blood Glucose Monitoring

Target range for blood glucose is:

☐ 70-150 ☐ 70-180 ☐ Other ____-_____

Blood Glucose Monitoring Schedule:

☐ Before lunch and snacks	☐ Before boarding school bus
☐ When student feels low/high/ill	☐ Other schedule:
☐ Before PE/Exercise	_____

Insulin Bolus:

- ☐ Insulin to be given at school will be either Humalog, Novolog, or Apidra
- ☐ Bolus for meal based on carbohydrate count
  Initial Insulin to Carb Ratio: 1 Unit Insulin: ____Carbs
- ☐ Correction or supplemental bolus for high glucose
  Initial Blood Sugar Correction Factor: _____ Unit for every _____>____
- ☐ Note: Current doses may change over time. Please defer to parents for mo current dose.

Low Blood Sugar (Blood Glucose less than 70)

- ☐ Give _____ Grams of fast acting Carbohydrates (if blank, 15 Grams will be given)
- ☐ Re-Test blood Glucose Level in 15 minutes
- ☐ If Blood Glucose still less than 70, Repeat Carbohydrate dose and re-check Blood Glucose in another 15 minutes.
- ☐ Additional Instructions:
  _____
- ☐ Give student a snack
  - o Carbohydrates
  - o Protein
- ☐ Notify parent.

Seizure, Unable to Swallow and/or Loss of Consciousness:

- ☐ Disconnect insulin pump (Do not remove insertion set, just disconnect catheter tubing)
- ☐ Glucose gel, 1mg of glucagon IM or Sub-Q and call 9-1-1 (Glucagon to b administered by anyone properly trained in administration of glucagon)

High Blood Sugar (Blood Glucose greater than _____)

- ☐ Give insulin correction bolus as outlined above. Insulin correction bolus should not be given more often than every _____ hours. If BS high
- ☐ Encourage student to drink water.
- ☐ If blood glucose level greater than _____mg/dl, have student check Ketones (default=250)
- ☐ No PE/Physical Activity if Blood Glucose level over _____

Ketones Moderate to Large

- ☐ The parent should be contacted and student should be sent home for treatment and monitoring.
- ☐ If the student is not taken home after 2 hours, the school nurse should consider calling 9-1-1 for transport to nearest healthcare facility.
- ☐ While waiting for parents to pick up student, the student needs to drink as much water as he/she can (32 fl oz in 15 minutes).
- ☐ Rapid acting insulin doses need to be given every 2-3 hours and glucose levels checked every 2 hours per physician or parent guidelines until urine Ketones are clear.
- ☐ Other Instructions:
  _____

I have instructed student in the proper way to complete the skills listed below and the student has demonstrated competence in completing the following Diabetes Maintenance Skills/Tasks, and I authorize student to complete the following tasks at school with Supervision or Independently:

Perform Blood Glucose Testing	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently
Count Carbs and Calculate Carb Correction	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently
Calculate Corrective Insulin Bolus	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently
Draw Correct Insulin into Syringe	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently
Calculate and set basal profiles	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently
Calculate and set temporary basal rate	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently
Disconnect pump at infusion set	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently
Reconnect pump at infusion set	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently
Prepare reservoir and tubing	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently
Troubleshoot alarms and malfunctions	☐ Unable to perform task	☐ May complete task with Supervision	☐ May complete task independently

Physician Authorizations:

- ☐ I authorize school nurse and/or designated school staff to assist student in monitoring blood glucose and administering Glucose, Glucagon, and Insulin as needed as outlined as above.
- ☐ I authorize school nurse and/or designated school staff to refer to the Information for School Personnel about Diabetes Mellitis instructions when assisting student in monitoring blood glucose and administering Glucose, Glucagon, and Insulin as needed.
- ☐ It is my professional opinion that he/she should be allowed to carry and use his/her Blood Glucose Testing Supplies by him/herself and school. (Right to carry may be revoked if student found to be irresponsible with medication at school).
- ☐ It is my professional opinion that he/she should be allowed to carry and use his/her Diabetes Medications (Glucose and Insulin) by him/herself and school. (Right to carry may be revoked if student found to be irresponsible with medication at school).

Provider's Printed Name _____ **Phone:** _____

Provider's Signature: _____ **Date:** _____

Parent/Guardian's Name: _____ Phone Number: _____

Parent/Guardian's Signature_____ Date: _____

SAHUARITA UNIFIED SCHOOL DISTRICT #30

SCHOOL HEALTH SERVICES

MEDICINES/ADMINISTERING MEDICATIONS TO STUDENTS

CONSENT FOR ADMINISTRATION OF MEDICATIONS TO STUDENTS - INSULIN

Valid Up to 1 School Year

Student's Name:_____**D.O.B:**_____**Teacher:**_____ **Grade:** _____

When it is essential to a student's health that medication - prescription or over-the-counter (OTC) - be taken during school hours:

- Consent for Administration of Medications to Students Form must be completed.
- There must be a prescription from an Arizona Licensed Physician/ Health Care Provider stating the name of the patient, name of the medication, dosage and time to be given on the bottle. Instructions on this form must match the instructions on the pharmacy label.
- Medication must be in the original, non-expired prescription or OTC container, with complete pharmacy label and instructions.
    - Pharmacy label on prescription medication must include the patient name, name of medication, dosage, and times to be given.
    - For all OTC medications, an **Arizona Licensed Physician/Health Care Provider Co-Signature is required on this consent form.**
    - All medication must be FDA approved. No medications from outside the United States may be accepted.
- Parents must hand deliver medications to the school health office, and are responsible for assuring that the student does not run out of medication at school.
- Students may NOT carry any medications on campus other than epinephrine, rescue inhalers, or diabetic medication/supplies with written parent permission. Forms for students to carry and self-administer epinephrine auto-injectors and rescue inhalers are available from the health office.
- Parents must notify the school health office in writing if the medication is to be discontinued. All other changes in medication, dosage, or times is to be accompanied by a new Consent for Administration of Medications to Students Form.
- All unused medication must be picked up within 1 week of discontinuation and any medications remaining after 1 week or at the end of the school year will be destroyed by school health personnel.

Medication Name: Insulin/Type:_____ **Dosage:** _Per MD Orders_ **Times to be given:** _As Needed/Per MD Orders_

Is the medication to be given: __X__**Daily** __X__**As Needed** _Per MD Orders_____**Other (Please Describe)**

Start Date: _____ **End Date:** _X__End of School Year _____ (Other)

Prescribed by: _____ **Prescribers Phone #** _____

Reason for Medication:

_____

Known Food or Drug Allergies: _____

Please list all other medications student is currently taking: _____

I agree to the above medication administration requirements and I give permission to the School Nurse, Health Assistant, Extended Resource Teacher, Health Inclusion Assistant, or Authorized Designee to give the above medication to my child. I also give permission to the school health staff to share with the Arizona Licensed Physician/Health Care Provider who prescribed this medication, information relative to the prescribed medication administration e.g. effectiveness, adverse side effects, as he/she determines necessary for my child's health and safety.

Parent/Guardian Signature: _____ **Date:** _____

Arizona Licensed Physician/Healthcare Provider Signature authorizes administration by the School Nurse, Health Assistant, Extended Resource Teacher, Health Inclusion Assistant, or Authorized Designee of the above OTC FDA approved medication in the dosage, route, and frequency above.

Provider's Printed Name _____ **Phone:** _____

Provider's Signature: _____ **Date:** _____

For Health Staff Use Only: Initial Amount of Medication Received: _____ Date: _____

Date Medication Returned to Parent	Amount Returned	Parent Signature	Health Staff Initials

SAHUARITA UNIFIED SCHOOL DISTRICT #30

SCHOOL HEALTH SERVICES

MEDICINES/ADMINISTERING MEDICATIONS TO STUDENTS

CONSENT FOR ADMINISTRATION OF MEDICATIONS TO STUDENTS - GLUCAGON

Valid Up to 1 School Year

Student's Name:_____**D.O.B:**_____**Teacher:**_____ **Grade:** _____

When it is essential to a student's health that medication - prescription or over-the-counter (OTC) - be taken during school hours:

- Consent for Administration of Medications to Students Form must be completed.
- There must be a prescription from an Arizona Licensed Physician/ Health Care Provider stating the name of the patient, name of the medication, dosage and time to be given on the bottle. Instructions on this form must match the instructions on the pharmacy label.
- Medication must be in the original, non-expired prescription or OTC container, with complete pharmacy label and instructions.
    - Pharmacy label on prescription medication must include the patient name, name of medication, dosage, and times to be given.
    - For all OTC medications, an **Arizona Licensed Physician/Health Care Provider Co-Signature is required on this consent form.**
    - All medication must be FDA approved. No medications from outside the United States may be accepted.
- Parents must hand deliver medications to the school health office, and are responsible for assuring that the student does not run out of medication at school.
- Students may NOT carry any medications on campus other than epinephrine, rescue inhalers, or diabetic medication/supplies with written parent permission. Forms for students to carry and self-administer epinephrine auto-injectors and rescue inhalers are available from the health office.
- Parents must notify the school health office in writing if the medication is to be discontinued. All other changes in medication, dosage, or times is to be accompanied by a new Consent for Administration of Medications to Students Form.
- All unused medication must be picked up within 1 week of discontinuation and any medications remaining after 1 week or at the end of the school year will be destroyed by school health personnel.

Medication Name: Glucagon 1mg/vial Injection:_____ **Dosage:** _1 mg_ **Times to be given:** _As Needed/Per MD Orders_
Is the medication to be given: ____**Daily** __X__**As Needed** _Per MD Orders _____**Other (Please Describe)**
Start Date: _____ **End Date:** _X__End of School Year _____ (Other)
Prescribed by: _____ **Prescribers Phone #** _____
Reason for Medication: _____
Known Food or Drug Allergies: _____
Please list all other medications student is currently taking: _____

I agree to the above medication administration requirements and I give permission to the School Nurse, Health Assistant, Extended Resource Teacher, Health Inclusion Assistant, or Authorized Designee to give the above medication to my child. I also give permission to the school health staff to share with the Arizona Licensed Physician/Health Care Provider who prescribed this medication, information relative to the prescribed medication administration e.g. effectiveness, adverse side effects, as he/she determines necessary for my child's health and safety.

Parent/Guardian Signature: _____ **Date:** _____

Arizona Licensed Physician/Healthcare Provider Signature authorizes administration by the School Nurse, Health Assistant, Extended Resource Teacher, Health Inclusion Assistant, or Authorized Designee of the above OTC FDA approved medication in the dosage, route, and frequency above.

Provider's Printed Name _____ **Phone:** _____

Provider's Signature: _____ **Date:** _____

For Health Staff Use Only: Initial Amount of Medication Received:_____ Date:_____

Date Medication Returned to Parent	Amount Returned	Parent Signature	Health Staff Initials

SAHUARITA UNIFIED SCHOOL DISTRICT #30

SCHOOL HEALTH SERVICES

Authorization to Administer Physician Prescribed Treatment/Procedure – Diabetic Student

Valid for 1 school year. To be completed and signed ANNUALLY by **Arizona Licensed Physician/Health Care Provider**

Child's Name:_____ Date of Birth:_____
School: _____ Grade:_____

I, the undersigned, the parent/guardian of (student) _____ request that the following specialized physical health care treatment/procedure be administered to my child during school hours:

Physician Prescribed Treatment/Procedure:
Assist Student with Glucose Monitoring/Administration of Insulin/Administration of Glucagon and other Diabetes Related Tasks as Indicated

- ✓ I understand that I am responsible for providing current physician orders and all necessary supplies and equipment, labeled. The prescription must state child's full name, treatment to be provided by the school, directions to complete treatment including time, frequency, and duration of treatment, and physician signature.
- ✓ I am aware that there is not a school nurse available to complete this treatment/procedure; therefore this treatment/procedure will need to be completed by Unlicensed Assistive Personnel. I understand that the appointed qualified unlicensed assistive personnel who will perform the task will be indirectly supervised with intermittent direct supervision by the school nurse, a licensed professional nurse (RN).
- ✓ I understand that I am responsible for training the Unlicensed Assistive Personnel who are assigned to complete this treatment/procedure. A qualified school nurse will be present at the training, and will provide additional instruction as needed to ensure the Unlicensed Assistive Personnel are trained in the standards of care for the treatment/procedure.
- ✓ I understand that I am responsible for notifying my child's physician that the treatment/procedure will be completed by Unlicensed Assistive Personnel.
- ✓ I understand that I must notify the school immediately if my child's health status changes, diet changes, we change physicians, or the procedure is changed or canceled. We understand any changes must have a physician's signature.
- ✓ We understand that, whenever possible, the health maintenance tasks should be provided before or after school hours. This assures that the student receives maximum educational time.
- ✓ The school is authorized to provide emergency medical services for my child whenever the need for such services is necessary.

I authorize the school nurse, school health assistant, and the following Unlicensed Assistive Personnel to complete the specialized physical health care treatment/procedure as listed above:

School Health Assistant:

_____

Unlicensed Assistive Personnel:

_____

_____

Parent/Guardian Signature: _____ Date: _____

Arizona Licensed Physician/Healthcare Provider Signature authorizes the School Nurse, Health Assistant, Extended Resource Teacher, Health Inclusion Assistant, or Authorized Designee perform the above health care tasks as indicated.

Provider's Printed Name _____ Phone: _____

Provider's Signature: _____ Date: _____

Parent/Guardian's Name: _____ Phone Number: _____

Parent/Guardian's Signature_____ Date: _____

Please note: AZ Arizona Licensed Physician/Health Care Provider signature not required if indicated on Diabetes Management orders for school.

Permission for Release/Exchange of Student Records - Diabetic Student

Child's Name:_____ Date of Birth:_____
School: _____ Grade:_____

Your healthcare provider will require the release of information from below to share Protected Medical Information with Sahuarita Unified School District. Please sign and give the form to your healthcare provider and a copy to your school nurse to avoid delays.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ authorize my child's healthcare provider(s) listed below to release my child's _____ medical records to the district's medical officer, school nurse, physical (PT), occupational (OT), and/or speech therapists (ST):
Endocrinologist: Name _____ Phone _____ Fax _____
Pediatrician: Name _____ Phone _____ Fax _____

The healthcare provider may disclose the following protected health information: (check all that apply)

X Immunizations
X Health Appraisals
X Past/Current Medical condition and Its Impact on Attendance, School Programming, and/or PT, OT, ST needs
X Other: Diabetes Management

The Protected Health Information may be used, disclosed, or received for the following purpose(s): (check all that apply)

X To develop care or therapy plans for routing and emergent school management
X To design appropriate educational programs
X To assess the impact of the medical condition(s) on school programming and/or attendance
__To share school observations/concerns surrounding behavior
__To assess a medical basis for modification of transportation and/or home tutoring
X Medication delivery and/or therapy prescriptions for PT, OT, ST
__At patients request with no specified purpose
X Other Diabetes Management_____

Please select one:

X This authorization is valid for the entire academic school year (August-May)
__This authorization shall expire on ____/____/____ (MO/DD/YR)

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the School Nurse.

I understand that the revocation of this authorization is not effective if the Healthcare Provider or District has used the authorization for disclosure of the Protected Health Information before receiving my written revocation notice.

I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws may be subject to re-disclosure and may no longer be protected by federal or state law.

I understand that my child's treatment is not dependent on my agreement to release or withhold information.

_____

Date Parent Guardian (or Student if over 18) Signature Relationship

SAHUARITA UNIFIED SCHOOL DISTRICT #30

SCHOOL HEALTH SERVICES

Diabetic Student Supply List

Child's Name:_____ Date of Birth:_____
School: _____ Grade:_____

The following is a checklist of supplies that may be needed during the school day and will be provided by the student's parent/guardian. Please provide a full set of supplies to be stored in the health office for emergencies. Students who are determined by their Physician and School Nurse to be capable of managing their diabetes may also carry a set of supplies with them.

Supplies	**Health Office Held**	**Student Held**
☐ Insulin		
☐ Insulin syringes		
☐ Alcohol wipes/antiseptic wipes		
☐ Insulin pen		
☐ Cartridges		
☐ Pen needles		
☐ Pump supplies		
☐ Manufactures operating instructions		
☐ Log book		
Blood Sugar Testing Supplies	**Health Office Held**	**Student Held**
☐ Glucose meter/instruction manual		
☐ Test strips with code information		
☐ Finger lancing device		
☐ Lancets		
Ketone Testing Supplies	**Health Office Held**	**Student Held**
☐ Urine Ketone test strips		
Food Supplies	**Health Office Held**	**Student Held**
☐ Snack foods		
☐ Low blood sugar (hypoglycemia) supplies		
☐ Glucose tablets		
☐ Juice		
☐ Carbohydrate/protein snack		
☐ Lock down low bag(s)		
Other	**Health Office Held**	**Student Held**
☐ Glucagon kit		
☐ Water bottle		
☐ Fanny pack to carry supplies		

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Health Staff Member Date

Keeping Well WITH DIABETES

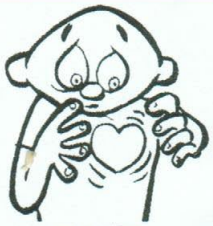
HYPOGLYCEMIA
(Low Blood Glucose)

Causes: Too little food or skip a meal; too much insulin or diabetes pills; more active than usual.

Onset: Often sudden; may pass out if untreated.

SYMPTOMS:


SHAKY


FAST HEARTBEAT


SWEATING


DIZZY


ANXIOUS


HUNGRY


BLURRY VISION

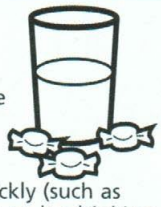

WEAKNESS OR FATIGUE

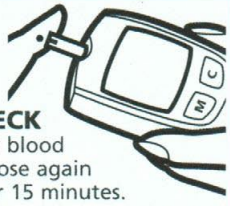

HEADACHE


IRRITABLE

WHAT CAN YOU DO?


CHECK your blood glucose, right away. If you can't check, treat anyway.


TREAT by eating 3 to 4 glucose tablets or 3 to 5 hard candies you can chew quickly (such as peppermints), or by drinking 4-ounces of fruit juice, or 1/2 can of regular soda pop.


CHECK your blood glucose again after 15 minutes. If it is still low, treat again. If symptoms don't stop, call your healthcare provider.

Concept developed by Rhoda Rogers, RN, BSN, CDE.

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Keeping Well WITH DIABETES

HYPERGLYCEMIA
(High Blood Glucose)

Causes: Too much food, too little insulin or diabetes pills, illness, or stress.

Onset: Often starts slowly. May lead to a medical emergency if not treated.

SYMPTOMS:

EXTREME THIRST

NEED TO URINATE OFTEN

DRY SKIN

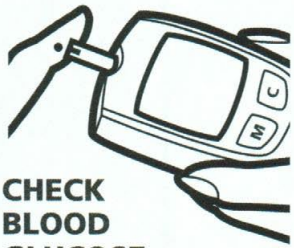
HUNGRY

BLURRY VISION

DROWSY

SLOW-HEALING WOUNDS

WHAT CAN YOU DO?



CHECK BLOOD GLUCOSE

If your blood glucose levels are higher than your goal for 3 days and you don't know why,

CALL YOUR HEALTHCARE PROVIDER

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