Physician ☐
Parent ☐

Bullitt County Public Schools

1040 Highway 44 East
Shepherdsville, Kentucky 40165

502-869-8000
Fax 502-543-3608
www.bullittschools.org

Moving Forward

DIABETES PARENT PACKET

Dear Parent and/or Guardian;

I am sending home forms that will be used by school personnel in caring for your child's medical needs during the 2018-2019 school year. Attached is a diabetes school action plan and medication permission form that will need to be completed **in full** with physician signature prior to bringing the medication to school.

Students are allowed to carry their diabetes supplies if the following conditions are met:

- **Physician/Parent Authorization Form is complete and on file at school each school year;**
- **Medication Permission Form is complete and on file at school;**
- **Primary Care Provider has instructed student in self-administration of the student's prescribed medication to treat the diabetes and is confirmed with physician signature that student is to keep supplies on person.**

When Students self-administer medication the school staff will NOT be responsible for monitoring frequency of use, expiration date, or amount of medication available for use.

As our policy 09.2241 states, " All prescription medication, original or refill, shall be brought to school in the most current pharmacy labeled container which includes the student's name, date, medication, dosage, strength, and directions for use including frequency, duration, and mode of administration, prescriber's name, pharmacy name, address and phone number. Labels that have been altered in any way shall not be accepted."

GLUCAGON: If provided, the medication form must be completed for both Insulin and glucagon. If not provided, please just mark through that portion of the medication form and write "NA". It is preferred that Glucagon be kept in school office at all times. *Please contact me if other arrangements are needed*.

SNACKS: Emergency snacks must be readily available to the student at all times which shall be provided by the parent/guardian. Scheduled snacks will need to be ordered by the physician.

PUMPS: On the advice and direction given by the local endocrinology physician group, all blood sugar checks will be entered into the pump and advance settings will require additional orders. Please clarify with your physician what your child will need and outline that on the forms provided.

Please remember that the schools are not to administer any medication and your child is not to carry any medication without proper paperwork and signatures on file. We appreciate your understanding and cooperation with this policy.

Sincerely,

Lesa A. Howell, RN

Lesa A. Howell, R.N. B.S.N.
District Health Coordinator
Bullitt County Public Schools

Wendy Novak Diabetes Center

ATTN: SCHOOL NURSE **Fax #** _____

MDI Diabetes Management Plan – School year 2018-2019

Student's Name:	DOB:	Diabetes Type:	Date Diagnosed:
School:		Grade:	Home Room:
Please fax BG levels to office!	**Every ☐ weeks(s)**	**Phone: 502-588-3400**	**Fax: 502-588-3401**

Student's Self-Management Skills	**Needs Assistance**	**Needs Supervision**	**Independent**
Performs and Interprets Blood Glucose Tests	☐	☐	☐
Calculates Carbohydrate Grams	☐	☐	☐
Determines Correction Dose of Insulin for High Blood Glucose	☐	☐	☐
Determines Insulin Dose for Carbohydrate Intake	☐	☐	☐
Administers Insulin by injection	☐	☐	☐
Must have NURSE for calculation of dosages and administers insulin: ☐ Yes ☐ No			

Insulin Administration

Type of Insulin at school	☐ Fast-acting	Humalog	Novolog	Apidra	☐ Long-acting	Lantus/Basaglar	Levemir	Other_____
Insulin Delivery:	☐ Syringe	☐ Pen	**Other** _____					
Uses CGM (brand _____): ☐ Yes ☐ No	**** May use phone/receiver and CGM instead of finger sticks ****							

LOW Blood Sugar (HYPO-glycemia) – Test Blood Sugar to Confirm

Signs and Symptoms (may include any of the following**:**
Does the student recognize signs of **LOW** blood sugar? ☐ Yes ☐ No

Low Blood Sugar:	Hungry	Weak/shaky/Pale		Headache	Inattention/confusion	Dizziness
Very Low Blood Sugar:	Nausea or loss of appetite	Slurred speech	Seizures	Clamminess or sweating	Loss of consciousness/ unresponsive	Blurred vision

Management of Low Blood Glucose (below 70 / 80 mg/dl)

If student is awake and able to swallow:

1. Give 15 grams of simple carbohydrate.
   a. i.e. 4 ounces of juice, 4 sugar packets, 4 ounces of a regular soft drink (not diet), 15 skittles, OR 4 glucose tablets
2. If a meal or snack is already scheduled within 30 minutes, give that scheduled meal/snack (administering the insulin after the food is consumed).
3. Re-test blood glucose in 15 minutes, if remains less than 70 mg/dL, repeat the 15-gram simple carbohydrate.
4. Continue the 15 grams of simple carbohydrate snack every 15 minutes until blood glucose level rises above 70 mg/dL.
5. Once blood glucose rises above 70 mg/dL, give a 15-gram complex carbohydrate and protein snack*
   a. i.e. 3 graham cracker squares, 6 saltine crackers, or a half of a sandwich. Peanut butter or cheese should be added to the crackers if available.
6. Notify Parent when blood glucose is below 70 mg/dl after 2 treatments.
7. Delay exercise and academic testing if blood glucose remains below 90 mg/dl.

If student is unconscious or having a seizure, call 911 immediately and notify parents. Position student on side if possible.

If student is transferred via EMS, an adult must accompany the student.
Glucagon: Give 1 mg administered into the muscular area of the upper arm or leg by trained personnel**.**

Updated 7/26/18

HIGH Blood Sugar (HYPER-glycemia) – Test Blood Sugar to Confirm

Signs and Symptoms (may include any of the following):
Does the student recognize signs of **HIGH** blood sugar? ☐ Yes ☐ No

High Blood Sugar:	Increased thirst and/or urination	Tired/drowsy	Blurred vision	Warm, dry or flushed skin	Weakness/muscle aches
Very High Blood Sugar:	Nausea/ vomiting	Abdominal pain	Extreme thirst	Fruity breath odor	Other _____

Management of High Blood Glucose (over 300 mg/dl)

1. Encourage extra liquids without sugar. Do NOT give milk or juice.
2. Allow frequent trips to the restroom.
3. Check ketones if blood glucose over 200 mg/dl x 2 episodes.
4. Notify parent if ketones positive.
5. Do NOT participate in PE or sports if ketones are present.
6. Refer to the Correction Dose section below.
7. Student does NOT need to be sent home unless vomiting or other acute illness.
8. Prior to academic testing, if blood glucose is > 300 mg/dL, do not participate in testing. If blood glucose is > 200 mg/dL, but insulin has been given within the past 2 hours, ok to proceed with testing
9. Retest blood glucose in 1 hour.

High Blood Sugar Correction Dose

The student's target Blood Glucose range is _____ to _____.

☐ **Use Insulin Correction Dose Formula**

Determine insulin **correction dose** per c**orrection formula** below:

If BG > _____ mg/dL, give _____ unit per _____ mg/dL > _____ mg/dL

(i.e. BG - _____ /_____ = correction dose)

☐ **Use Ketone Supplementation Formula**

Check urine for ketones when blood glucose is ≥ 200 mg/dl x 2 episodes or when student is ill.

Give additional insulin as follows: Small = _____ units; Moderate = _____ units; Large = _____ units

**NOTE: Do NOT correct for ketones more often than every 4 hours. **

Blood Glucose Testing (Check what applies)	Insulin Dosage based on Carb Count	
Test Blood	**Insulin Dose or Carb Formula**	
☐ Before Breakfast	1 unit per grams of carbs	**Boluses:** Before ☐ After ☐
☐ Before Morning Snack	1 unit per grams of carbs	**Round Dose:** No ☐ Half ☐ Whole ☐
☐ Before Lunch	1 unit per grams of carbs	
☐ Before Afternoon Snack	1 unit per grams of carbs	**Correct for high BG if > 3 hours since last bolus**
☐ Before PE/Activity	1 unit per grams of carbs	
☐ After PE/Activity	1 unit per grams of carbs	
☐ Dismissal	1 unit per grams of carbs	
☐ As needed for signs/symptoms.		

Fruit juice or any sugar sweetened drink should NOT be offered at meal/snack times. Only use for treatment of low BG!

I understand that all treatments and procedures may be performed by the student and/or authorized trained school personnel. I also understand that the school is not responsible for damage/loss of equipment. **Snacks and supplies are to be furnished/restocked by parent.**

Signature allows school personnel to communicate with Wendy Novak Diabetes Center:

Parent's Signature_____ Printed Name_____Date_____

Physician's Signature_____ Printed Name_____Date_____

School Nurse's Signature_____ Printed Name_____Date_____

Updated 7/26/18

Permission Forms for Medication

PHYSICIAN AUTHORIZATION FOR MEDICATION FORM

Student's Name: _____ Grade: _____ Age:_____ Date of Birth: _____/_____/_____

School: _____

COMPLETED BY THE PARENT/GUARDIAN AND HEALTH CARE PROVIDER

Procedure 09.2241 AP.1 – Medication shall be in the original container, dated upon receipt. Prescribed medication/self-administration/over-the-counter medication needed for longer than three (3) days requires a parent/guardian and Health Care Provider to complete the required form.

Name of medication:_____	**Name of medication:**_____
Reason for medication:_____	**Reason for medication:**_____
Instructions: Time:_____ **Dose:**_____	**Instructions: Time:**_____ **Dose:**_____
Start Date:_____/_____/_____ **Stop Date:**_____/_____/_____	**Start Date:**_____/_____/_____**Stop Date:**_____/_____/_____
Signs & symptoms of emergency administration: _____	Signs & symptoms of emergency administration: _____
Restriction and/or important side effects: ☐ No restrictions ☐ Yes. Please describe:_____ ☐ Other *Student must carry this medication on his/her person and self-administer during school hours: ☐ *Yes **(If yes, please initial below)** ☐ No **SPECIFIC TO FIELD TRIPS:** ☐ Trained personnel to assist student to self-medicate (School personnel will hold medication until dosing time) ☐ *Student to self-administer **(*MD to initial below)** (Student will hold medication on their person) ☐ Student requires medication to be administered (School personnel will hold medication and administer)	Restriction and/or important side effects: ☐ No restrictions ☐ Yes. Please describe:_____ ☐ Other *Student must carry this medication on his/her person and self- administer during school hours: ☐ *Yes **(If yes, please initial below)** ☐ No **SPECIFIC TO FIELD TRIPS:** ☐ Trained personnel to assist student to self-medicate (School personnel will hold medication until dosing time) ☐ *Student to self-administer **(*MD to initial below)** (Student will hold medication on their person) ☐ Student requires medication to be administered (School personnel will hold medication and administer)

_____***(MD INITIALS)** The above named student has been instructed on the care, storage, dosage, and use of the above medication(s) and has sufficient knowledge and ability to self-administer the medication(s) in the school setting and while on field trips.

_____
*Physician/Health Care Provider Signature/Date

Physician Practice name:_____

Address:_____

Phone: (___)_____ Fax: (___)_____

PARENT AUTHORIZATION FOR ABOVE LISTED MEDICATIONS.

I give permission for _____ to receive the above medication(s) at school according to
Student's Name
standard school policy and expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration or lack of administration of the above medication. For on-going medications, I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable orders from a physician or health care provider to be followed.

Date: _____ *Signature:* _____ *Relationship:* _____

Home Phone: _____ *Work Phone* _____ *Emergency Phone* _____

I/we reviewed the statement and authorization for completion.

Administrator/designee _____ Date _____

Review/Revised: 6/19/2017

Consent Form for Mutual Exchange of Information

Student's Name: _____ Date: _____

Date of Birth: _____ Parent/Guardian: _____

Address: _____

I the parent/guardian of the above named student hereby authorize the mutual exchange of information including use and/or disclosure of protected health information and educational records between the Bullitt County Public School's District Health Coordinator and the physician, individual or organization listed below.

Name: _____ Phone #: _____
(physician)

Address: _____

The information will be used or disclosed upon request for the following purposes:

- ☐ Developing a medical plan for the student at school
- ☐ Assessing the need for a medical transfer
- ☐ Assessing the need for the student to access the Home Hospital Program
- ☐ Addressing medical needs related to treatment for the following condition or injury _____ on or about _____
- ☐ Reviewing medical records covering the period of time _____ to _____
- ☐ Addressing issues related to the student missing school/excessive absences
- ☐ Other: _____

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the named physician/practice/organization and the Bullitt County Public Schools. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires on the following date or event: _____

I certify that I have received a copy of this authorization. I further certify that I am the parent or legal guardian of the above-named student or that I am the student of majority age and have the authority to sign this release.

_____ _____
Signature Date

Public Law 93-380 (Federal Family Educational Rights and Privacy Act of 1974) specifically states that school records may be released to third parties provided:

1. Written consent is obtained from the parent, guardian, or student of legal age.
2. The reason for the release is stated.
3. The identity of the third party is specified.
4. The parents receive a copy of the record, if desired.
5. The records to be released are specified.

Review/Revised: 7/19/11