

DIABETES HEALTH HISTORY FORM

Name _____ Birthdate _____ Grade _____

Father/Guardian _____ Phone (home) _____ (work) _____

Mother/Guardian _____ Phone (home) _____ (work) _____

Known Allergies _____

Date diagnosed with Diabetes _____ Last hospitalization _____

Has Glucagon ever been administered? YES ____ NO ____ If yes, what was the reaction? _____

DIABETES MEDICATIONS

Type of Insulin/Oral Med	Dosage	Time to be given	Reaction Signs/Symptoms
--------------------------	--------	------------------	-------------------------

1) _____	_____	_____	_____
----------	-------	-------	-------

2) _____	_____	_____	_____
----------	-------	-------	-------

3) _____	_____	_____	_____
----------	-------	-------	-------

Will medication be taken at school? _____

Test(s) to be performed at school _____ Time(s) _____

Equipment needed (supplied by parent/guardian) _____

PHYSICAL EDUCATION (PE)/EXERCISE ACTIVITIES PE class period (circle) 1 2 3 4 5 6 7

PE Modification _____

FOOD INTAKE Times: Breakfast _____ Lunch _____ AM Snack _____ PM Snack _____

Brings own food _____ Selects from cafeteria _____

EMERGENCY INSTRUCTIONS

If parent or guardian cannot be reached, contact:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Physician/Health Care Provider _____ Phone _____

Hospital Preferred _____

Other Instructions _____

Other health concerns _____

Additional Medication(s) _____

Parent/Guardian Signature _____ Date _____

School Nurse Signature _____ Date _____

**Health Services Department
Universal Release of Information**

FROM: _____
(Name of person and agency releasing information)

(Address)

TO: Montgomery County R-II Schools

394 North Highway 19

Montgomery City MO 63361

I (we), the undersigned, do hereby authorize the above-named persons, educational institutions, firms, physicians, clinics, hospitals, or agency(ies) to release and/or receive the following confidential information (as specific as possible):

The above information is released for the following purpose and that purpose only. Any other use is forbidden.

I understand that my records are protected by state and federal law, and cannot be disclosed or re-disclosed without my written consent unless otherwise provided for by law. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance hereon, and that unless sooner revoked, this consent will expire on (date, event or condition): _____ (Consent will expire one year from date of signature if no otherwise noted.)

I want the agency listed above to accept a copy of this form as a valid consent to share information on an as needed, if needed basis to assist with service coordination and treatment planning. If I do not sign this form, information will not be shared and I will have to contact the agency personally to give them information about me that they need.

I hereby release any person, educational institution, firm, physician, clinic, hospital, or agency from any liability for information furnished pursuant to this authorization.

Print/Type Patient name: _____

Complete Address: _____

SSN: _____ Date of Birth: ____/____/____

Telephone #: _____ DCN #: _____

Maiden name or alias: _____

(Client signature) (Date) (Parent/Guardian signature) (Date)

Prohibition on re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations when applicable (42 CFR Part 2) prohibit you from making any further disclosure of this information except with specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than \$500.00 in the case of a first offense, and not more than \$5,000.00 in the case of each subsequent offense.

Source: "Diabetes Management in the School Setting", 1998, Missouri Association of School Nurses

BLOOD GLUCOSE AND INSULIN PROCEDURES

(Name of Student)

Grade/Teacher

(Name of Physician or Health Care Provider)

(Phone)

(Name of Medication)

(Dosage)

(Time)

Medication must be dispensed following the School District Medication Policy.

Responsibilities for monitoring blood glucose and administering insulin:

OBSERVED

YES NO

- ____ ____ Demonstrates correct use of blood glucose monitor
____ ____ Demonstrates knowledge of self-administration of insulin.
____ ____ Proper timing and documentation of monitoring of blood glucose.
____ ____ Proper timing for administration of insulin
____ ____ Demonstrates appropriate use of supplies
____ ____ Follows appropriate method for disposal of supplies
____ ____ Keeps treatment for low/high blood sugar with own belongings in case of emergency
____ ____ Agrees to seek assistance from school personnel as needed

The student (does/does not) demonstrate meeting the above specified responsibilities. The privilege of monitoring blood glucose and self-administration (will/will not) be allowed.

(Student's signature)

Date

(School Nurse signature)

Date

My child will be responsible for carrying this medication and will self-administer. My child agrees to follow the District's procedures concerning the handling and administration of this medication.

(Parent/Guardian signature)

Date

EXPECTATIONS OF THE STUDENT IN DIABETES CARE

"Children and youths should be able to implement their diabetes care in school with parental consent to the extent that is appropriate for the student's development and his or her experiences with diabetes" (*Diabetes Care*, 25:S 122-S125, 2002©2002 by the American Diabetes Association). The "Blood Glucose and Insulin Procedures" form outlines what a student is capable of performing and how medication will be dispensed according to School District's Medication Policy.

Below is an outline of ages at which students should be able to perform self-care tasks.

- 1) *Preschool and Daycare*. The preschool child is usually unable to perform diabetes tasks independently. By 4 years of age, children may be expected to generally cooperate in diabetes tasks.
- 2) *Elementary School*. The child should be expected to cooperate in all diabetes tasks at school. By age 8 years, with supervision most children are able to perform their own finger-stick blood glucose tests. By age 10, with supervision some students can administer insulin.
- 3) *Middle School or Junior High School*. The student should be able to administer insulin with supervision and perform self-monitoring of blood glucose when not experiencing a low blood glucose level.
- 4) *High School*. When not experiencing a low blood glucose level, the student should be able to perform self-monitoring of blood glucose. In high school, adolescents should be able to administer insulin without supervision.

Reminder – at any age, individuals with diabetes may require assistance to perform a blood glucose test when blood glucose is low.

(THIS PAGE INTENTIONALLY LEFT BLANK)



Montgomery County R-II Health Services

394 N. Hwy 19, Montgomery City, MO 63361

Carla Parker, RN-Montgomery City Elementary/Immaculate Conception

Vickie Biggs, RN- Middle School/High School/Preschool

Karen Parrish, RN- Bellflower Elementary/Jonesburg Elementary

Christy Futhey, EMT-High School

573-564-3711

573-564-2253/573-564-2213

573-929-3211/636-488-5923

573-564-2213

Date: _____

Dear _____
(Name of Physician/Health Care Provider)

The Montgomery County R-II School District has been asked to provide specialized health care for your patient _____.

If it is essential that this procedure be provided during school hours, we will need your written order on file.

Attached is a tentative health care plan for this student, including a description of a standardized procedure. Please review these materials, make written comments, and provide the requested information to guide us in providing a safe school environment. We will incorporate your comments and make adjustments in the procedure as directed. Services will begin when we have the necessary orders and adequately trained personnel in place.

Please feel free to contact _____, who is assuming the responsibility for the management of this student's health care in our school. She can be reached at (_____) _____.

Sincerely,

PRESCRIPTION MEDICATION ORDER AND PERMISSION TO ADMINISTER MEDICATION AND TO TEST BLOOD SUGAR

From time to time, it may be necessary for your child to take prescription medication for treatment of an illness. If medication must be taken at school, the school nurse or designee, as mandated by state law, may dispense medications **ONLY WITH THE FOLLOWING:**

- 1) Medication order, signed by physician
- 2) Parental authorization, signed by the parent/guardian
- 3) Original pharmacist labeled bottle

MEDICATION ORDER and PERMISSION TO TEST BLOOD SUGAR LEVEL

Student _____ Date of Birth _____

Medication _____

Directions _____

Reason for giving _____

Telephone number of physician or health care provider (_____) _____

I grant permission for the school nurse or designee to test this child's blood sugar level at school during a crisis or emergency situation or if the child is not capable of checking him/herself.

(Signature of Physician or Health Care Provider)

Date

PERMISSION TO ADMINISTER MEDICATION AND PERMISSION TO TEST BLOOD SUGAR LEVEL

I hereby give my permission for my child _____ to take the above prescription at school as directed. I also grant permission for the school nurse or designee to test my child's blood sugar level at school during a crisis or emergency situation or if the child is not capable of checking him/herself.

(Signature of Parent/Guardian)

Date

Individual Health Care Plan
(Name of School)

Name:

Condition: **Diabetes**

Class:

What	When	Why	By Whom
Blood Sugar monitoring In nurse's office	Before lunch Any time feels "low"	Glucose or insulin per order (see MD Order) May need juice, snack, glucose or recheck by nurse Student will recognize signs of low blood sugar	Self/All staff
Allow to use bathroom and get drinks as often as needed	As requested. Need is higher in students with diabetes	Condition requires good hydration and more frequent urination	All staff
Snacks/juice/glucose tabs <i>In nurse's office</i>	As needed, including in class	Low/high blood sugar can be life-threatening	Self/All staff
Allow snack and send to nurse accompanied by another student	Anytime student states "feeling low"	Low/ high blood sugar affects mental and physical functioning	All staff
Staff aware of s/s of low blood sugar (see below)	At all times, especially when active or ill	Activity will lower BS, illness may change food intake	All staff
Glucometer, supplies from home, and testing on field trips	Before lunch or whenever student feels low	May need glucose, snack, food or insulin	Self/All staff

Signs of low blood sugar	Signs of high blood sugar	Emergency Symptoms
<ul style="list-style-type: none"> • Headache • Sweating • Pale, moist skin • Cold and clammy • Extreme/sudden hunger • Weakness/Dizziness • Shakiness • Fatigue/tiredness • Rapid pulse rate • Blurred/double vision • Shallow breathing • Confusion/inattention • Loss of coordination 	<ul style="list-style-type: none"> • Extreme thirst • Frequent urination • Drowsiness, lethargy • Dry, hot skin • Lack of appetite • Fruity, sweet, or wine-like odor on breath • Heavy, labored breathing • Stupor, unconsciousness 	<ul style="list-style-type: none"> • Seizure • Loss of consciousness <p>Emergency Phone Numbers:</p> <p>EMS: 911</p> <p>Health Services: (School phone number or ext)</p> <p>Parent: (NAME - PHONE NUMBER) (NAME - PHONE NUMBER) (DR - NAME PHONE NUMBER)</p>

By signing below you acknowledge and authorize that this information will be shared with school staff on a "need to know" basis.

Parent Signature: _____ Date: _____

Signature of School Nurse or Designee: _____ Date: _____

Health Services Department

Emergency Plan

DIABETES

Student name:

In an emergency:

- 1) Stay with child.
- 2) Call/ask someone to call school nurse or health aid who will assess child and summon EMS if needed.

<u>IF YOU SEE THIS:</u>	<u>DO THIS:</u>
IF student is unconscious or not responsive (Unable to treat self or is lethargic or stuporous)	<ul style="list-style-type: none"> • CALL 911...Call Parents • DO NOT GIVE FLUIDS OR FOOD • Turn student to side
IF STUDENT IS NON-RESPONSIVE	<ul style="list-style-type: none"> • Squirt Glucose Gel or honey inside cheek closest to ground or administer Glucagon (Glucagon to be administered by trained nurse, aid, or designee) • Gel or honey is kept in Health Services room and High School Office. Glucagon is kept in student's low box in the Health Services Room. • Measure Blood Sugar with monitor (to be done by nurse, aid, or designee)
IF STUDENT IS RESPONSIVE	<ul style="list-style-type: none"> • Hypoglycemic Reaction: IF Blood Sugar reading is 80 or below, then give ½ cup juice and peanut butter crackers • Hyperglycemic Reaction: Keep student walking or sitting and drinking water. • If Blood Sugar is >300 mg/dl, student, school nurse, or designee should check urine for ketones.

IMPORTANT EMERGENCY NUMBERS:

(Doctor Name – phone number)

(mother name – phone numbers)

(father name – phone numbers)

504 DIETARY PLAN

Section 504 of the Rehabilitation Act of 1973 assures handicapped students access to school meal service, even if special meals are needed because of their handicap. "Handicapped student" means any student who has a physical or mental impairment, which substantially limits one or more life activities, has a record of such impairment, or is regarded as having such an impairment. If special meals are needed and requested, certification from a medical doctor or health care provider must (1) verify that special meals are needed because of the handicap, and (2) prescribe the alternate foods and forms needed. Completion of the following by a student's physician or health care provider will provide the necessary certification:

Name of Student:	School District:
Birth date:	School Attended:
Parent Name:	
Telephone:	

FOR PHYSICIAN'S USE

Identify and describe disability, or medical condition, including allergies that require the student to have a special diet. Describe the major life activities affected by the student's disability.

DIET PRESCRIPTION (Check all that apply):

- Diabetic (include calorie level or attach meal plan) Modify Texture and/or Liquids
- Reduced Calorie Food Allergy (describe) _____
- Increased Calorie Other (describe) _____

FOOD OMITTED AND SUBSTITUTIONS:

Use space to list specific food(s) to be omitted and food(s) that may be substituted. You may attach an additional sheet if necessary.

OMITTED FOODS	SUBSTITUTIONS
_____	_____
_____	_____
_____	_____

INDICATE TEXTURE:

- Regular Chopped Ground Pureed

INDICATE THICKNESS OF LIQUIDS:

- Regular Nectar Honey Pudding

SPECIAL FEEDING EQUIPMENT: _____

ADDITIONAL COMMENTS: _____

I CERTIFY THAT THE ABOVE NAMED SUDENT NEEDS SPECIAL SCHOOL MEALS AS DESCRIBED ABOVE, DUE TO THE STUDENT'S DISABILITY OR CHRONIC MEDICAL CONDITION.

_____ Physician's Signature	_____ Telephone Number	_____ Date
_____ Signature of Preparer or Other Contact	_____ Telephone Number	_____ Date

I HEREBY GIVE MY PERMISSION FOR THE SCHOOL STAFF TO FOLLOW THE ABOVE STATED NUTRITION PLAN.

_____ Parent/Guardian Signature	_____ Date
------------------------------------	---------------

MEAL PLAN

Student Name _____ Date _____

Meal Plan (Calories) _____

Time	Number of Exchanges/Choices	Total Carbohydrate Grams
	_____ Carbohydrate group _____ Starch _____ Fruit _____ Milk _____ _____ Meat group _____ _____ Fat group _____	
	_____ _____ _____	
	_____ Carbohydrate group _____ Starch _____ Fruit _____ Milk _____ _____ Meat group _____ _____ Fat group _____	
	_____ _____ _____	
	_____ Carbohydrate group _____ Starch _____ Fruit _____ Milk _____ _____ Meat group _____ _____ Fat group _____	
	_____ _____ _____	