MOUNT LAUREL SHOOL DISTRICT

PARENT PACKET
For Diabetes

PARENT/GUARDIAN PERMISSION TO RELEASE AND EXCHANGE CONFIDENTIAL INFORMATION

I hereby authorize an exchange of information to occur between the School Health Services Nursing Staff and:

NAME: ____ PHONE: ________________________

ADDRESS:

____

Regarding: _____ any or all information
_____ specific information regarding ______________________________________

Contained in the record of:

____ ________________________________
Name Date of Birth

____
School

This authorization is in effect for one calendar year from today: ______________________
Date

Signature of Parent/Guardian:

____

Medication Permission for Administration of Glucagon by a Delegate

****Please note that a delegate may *ONLY* give glucagon, therefore the physician's order must note the specific symptoms as to when the delegate should administer the glucagon****

School Year ________________ Class _____________

Name of Student: ___________________________________ D.O.B. __________________

***Check off* the appropriate times the delegate should administer glucagon indicated below.** (This must be completed for delegate order to be in effect.)

____ Severe confusion/ incoherent
____ Seizure
____ Inability to shallow
____ Loss of consciousness
____ Other S&S_______________________

Glucagon and dosage that will be given: ____________________________

Possible side- effects: ____

After administration of glucagon the delegate will: call 911 and monitor patient until EMS arrives. Parents will also be called and notified.

If student awakens prior to the arrival of EMS

Treat: with quick-sugar source _____ yes _____ no
Followed with snack of carbohydrate and protein (e.g. cheese and crackers) _____ yes _____ no

______________________________________ ______________________________________
NAME OF PHYSICIAN (PRINTED) **SIGNATURE OF PHYSICIAN**

______________________________________ ______________________________________
TELEPHONE NUMBER OF PHYSICIAN **DATE**

I hereby give permission for my child's delegate(s) to administer the above medication to my child named above. I shall provide this medication in its original container, properly labeled from the pharmacy/store. I release the Mt. Laurel Township Board of Education and its employees from any liability concerning the administration of such medication to my child.

______________________________________ ______________________________________
PARENT/GUARDIAN SIGNATURE DATE

Please have your child's
endocrinologist fill out
the following plan in the event
that they do not
provide their own office form

DIABETES MEDICAL MANAGEMENT PLAN

School Year: ____________

Grade ______

Student Name: ______________________________________

School Name: ____________________________ Date of Birth: ____________ Diabetes: ☐ Type 1, ☐ Type 2 ☐ Date of Diagnosis: ______

Homeroom: ____________________ Plan effective Date(s):

Contact Information

Parent/Guardian #1: ______________________

Parent/Guardian #2: ______________________

Diabetes Healthcare Provider: ______________________

Other Emergency Contact: ______________________

Telephone Numbers:		
Home:	Work:	Cell/Pager:
XXXXXXXXXXXXXXXX		
Relationship: __________	Home #	Work/ Cell #

EMERGENCY NOTIFICATION: Notify parents or guardians of the following conditions (If unable to reach parents, call Diabetes Healthcare Provider listed above)

a. Loss of consciousness or seizure (convulsion) immediately after Glucagon given and 911 called.
b. Blood sugars in excess of ________ mg/dl
c. Positive urine ketones
d. Abdominal pain, nausea/vomiting, diarrhea, fever, altered breathing, or altered level of consciousness.

MEALS/SNACKS: Student can: ☐ Determine correct portions and number of carbohydrate serving ☐ Calculate carbohydrate grams accurately.

Meal Type:	Time/Location	Food Content and Amount	Meal Type:	Time/Location	Food Content and Amount
☐ Breakfast			☐ Mid-afternoon		
☐ Midmorning			☐ Before PE/Activity		
☐ Lunch			☐ After PE/Activity		

If outside food for party or food sampling provided to class:

BLOOD GLUCOSE MONITORING AT SCHOOL: ☐ Yes ☐ No Type of Meter: ____________________

If yes, can student ordinarily perform own blood glucose checks ☐ Yes ☐ No Interpret results: ☐ Yes ☐ No Needs supervision? ☐ Yes ☐ No

Time to be performed: ☐ Before breakfast ☐ Mid-morning before snack ☐ Before Lunch ☐ Dismissal ☐ Before PE/Activity Time ☐ After PE/Activity Time ☐ Mid-afternoon ☐ As needed for signs/symptoms of low/high blood glucose

Place to be performed: ☐ Classroom ☐ Clinic/Health room ☐ Other: ____________________

OPTIONAL: Target range for blood glucose: ______ mg/dl to ______ mg/dl (Completed by Diabetes Healthcare Provider

INSULIN INJECTIONS DURING SCHOOL: ☐ Yes ☐ No ☐ Parent /Guardian elects to give insulin needed at school

If yes, can student: Determine correct dose ☐ Yes ☐ No Draw up correct dose? ☐ Yes ☐ No

Give own injection? ☐ Yes ☐ No Needs supervision? ☐ Yes ☐ No

Insulin delivery: ☐ Syringe/Vial ☐ Pen ☐ Pump (If pump worn, use "Supplemental Information Sheet for Student wearing an Insulin Pump")

Standard Daily Insulin at School: ☐ Yes ☐ No

Type:	Dose:	Time to be Given:
__________	__________	__________
__________	__________	__________

Calculate insulin dose for carbohydrate intake: ☐ Yes ☐ No

If Yes, use , ☐ Regular ☐ Humalog ☐ Novolog

____# unit(s) per ______ grams Carbohydrate

☐ Add carbohydrate dose to correction dose

Correction Dose of Insulin for High Blood Glucose: ☐ Yes ☐ No

If yes, ☐ Regular ☐ Humalog ☐ Novolog Time to be given: __________

☐ Determine dose per sliding scale below (in units)

Blood sugar: __________ Insulin Dose: __________
Blood sugar: __________ Insulin Dose: __________
Blood sugar: __________ Insulin Dose: __________
Blood sugar: __________ Insulin Dose: __________
Blood sugar: __________ Insulin Dose: __________
Blood sugar: __________ Insulin Dose: __________

☐ Use formula
(Blood glucose- ________) + ________ = ______ Units of insulin

OTHER ROUTINE DIABETES MEDICATIONS AT SCHOOL: ☐ Yes ☐ No

Name of Medication	Dose	Time	Route	Possible Side Effects

EXERCISE, SPORTS, FIELD TRIPS AND CLASS PARTIES

Blood glucose monitoring and snacks as above. Quick access to sugar-free liquids, fast-acting carbohydrates, snacks and monitoring equipment.
A fast-acting carbohydrate such as ________________ should be available at the site.
Child should not exercise if blood glucose level is below _____mg/dl OR if ____________________.
Carb Ratio:_______# of carbs:____________ Insulin coverage____________

SUPPLIES TO BE FURNISHED/RESTOCKED BY PARENT/GUARDIAN: (Agreed-upon locations noted on emergency card/nursing care plan)

☐ Blood glucose meter/strips/lancets/lacing device
☐ Ketone testing strips
☐ Sharps container for classroom
☐ Fast-acting carbohydrate: ________________
☐ Carbohydrate-containing snacks
☐ Carbohydrate free beverage/snack
☐ Insulin vials/ syringe
☐ Insulin pen/pen needles/cartridges
☐ Glucagon Emergency Kit