SAHUARITA UNIFIED SCHOOL DISTRICT #30

SAHUARITA HIGH SCHOOL
SAHUARITA MIDDLE SCHOOL
SAHUARITA PRIMARY SCHOOL
ANZA TRAIL SCHOOL
WALDEN GROVE HIGH SCHOOL
SAHUARITA INTERMEDIATE SCHOOL
SOPORI ELEMENTARY SCHOOL
COPPER VIEW ELEMENTARY SCHOOL
EARLY CHILDHOOD CENTER

SCHOOL HEALTH SERVICES

Parent Diabetes Information Letter

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.

- ☐ 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 signed by a Licensed HealthCare Provider and parent/guardian**:**
    - ☑ **Please see school health staff if your child requires diabetes medications/supplies at school.**

_____ _____ _____
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

Diabetes Injection Therapy Medical Management Plan for School

Valid for 1 school year. To be completed and signed ANNUALLY by licensed Primary Care Provider/Physician

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 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 to 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).

Physician's Name _____ **Phone Number:** _____

Physician's Signature_____ **Date:** _____

(Required)

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

Parent/Guardian's Signature_____ **Date:** _____

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SCHOOL HEALTH SERVICES

Diabetes Pump Therapy Medical Management Plan for School

Valid for 1 school year. To be completed and signed ANNUALLY by licensed Primary Care Provider/Physician

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 most 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
  - Carbohydrates
  - Protein
- ☐ Notify parent.

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

- ☐ Disconnect insulin pump (Do not remove insertion set, just disconnect cathete tubing)
- ☐ Glucose gel, 1mg of glucagon IM or Sub-Q and call 9-1-1 (Glucagon to 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. 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:

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- ☐ 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).

Physician's Name _____ **Phone Number:** _____

Physician's Signature_____ **Date:** _____

(Required)

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

Parent/Guardian's Signature_____ **Date:** _____