BISHOP WATTERSON HIGH SCHOOL

Health forms for students with

Diabetes who receive care from NCH

Please complete packet and return to nurse at child's school

What's in this packet?

1) **Parent Letter**

2) **Release of Information** - allows the doctor to talk to the school nurse if there are any questions

3) **Diabetes Questionnaire** – parent completes, explains how your child is affected by and manages their diabetes

4) **Diabetes Management Agreement** – parent signs giving consent for care at school and introduces how care will be provided at school

5) **Guidelines for Medicines at School** – parent reference

6) If your child receives diabetes care from Nationwide Children's Endocrinology – they generate and complete the **Diabetes Medication Order form;** parent brings to the school nurse

7) If your child receives diabetes care from COPEDS; they generate and complete the **Diabetes Medical Management Plan;** parent brings to the school nurse

Questions? Please call your school nurse.

BISHOP WATTERSON HIGH SCHOOL

Diabetes Management At School

Dear Parent/Guardian of _____: Date:_____
Bishop Watterson provides nursing services that promote students' ability to learn. Our goals are to:

- Assist students in learning how to take care of their health.
- Ensure a safe school environment.
- Promote good control of a student's health condition so they are ready to learn.

To help us meet the above goals:

The school nurse at Bishop Watterson

1. Is a registered nurse.
2. The school nurse works closely with the student's parents/guardians and their Healthcare Providers to assure access to necessary resources.

To assist your student at school and promote diabetes management, the forms below *are required each school year*. Please give the completed and signed forms below to the school nurse prior to starting school:

- ***Diabetes Management - Parent Agreement*** – Parent permission for the school to provide diabetes care
- ***Diabetes Questionnaire*** - Parent/Guardian completes
- ***Release of Information –*** Parent/Guardian completes

Your student's healthcare provider needs to provide you or the school with the **Insulin/Diabetes Medication Orders/Diabetes Medical Orders for School**–which are needed prior to attending school.

To follow medical orders and in the best interest of your student's health, your student can NOT be in school unless we have ALL diabetes related paperwork, medical orders AND ALL necessary supplies checked below:

8- Fast acting sugar sources (15 gm glucose tablets, juice, etc) to treat low blood sugar
8 - Carbohydrate/protein snacks
Insulin vial or insulin pen cartridge in Pharmacy box
Insulin syringes or pen needles Blood glucose meter
Blood glucose test strips Lancet device and Lancets
Urine Ketone testing strips
Insulin Pump Supplies for back-up (if pump is ordered for student)
Glucagon Kit
Other:_____

Please contact the school nurse with any questions or concerns. Thank you for your help in obtaining the necessary orders.

Your student's School Nurse is: **Tonya Friend, RN, BSN**
Phone number: **614-268-8671 ext. 290** Days at school: **Monday- Friday**

BISHOP WATTERSON
HIGH SCHOOL

AUTHORIZATION FOR RELEASE OF INFORMATION

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

I hereby give consent for the exchange of the information as checked below concerning the above-named child between the party indicated and Bishop Watterson.

_____ Obtain Information From: _____
_____
_____

_____ Release Information To: _____
_____
_____

_____ Medical Information/Records

_____ TB Test Results/Records

_____ Immunization Records

_____ Achievement and Aptitude Test Scores

_____ Psychological Information/Records

_____ Grades and Attendance

_____ Speech and/or Hearing Evaluation

_____ Individual Education Plan (IEP), if in Special Education

_____ Health Screening Reports

_____ Other Information, as specified: _____
_____

This information to be used for:
_____

Parent/Guardian Signature _____ Date _____

DIABETES QUESTIONNAIRE **Bishop Watterson**

Student: _____ School year: _____
DOB: _____ Grade/teacher: _____

Parent – please return to the school nurse as soon as possible!!!

Person to Contact:	Relationship:	Work/Cell Phone:	Home Phone:
1.			
2.			
Preferred Communication Method ☐ phone ☐ written ☒ in person ☐ email:			
Health Provider Name		Phone:	Fax:

Student is diagnosed with: ☐ Type 1 ☐ Type 2 Other: _____ Age at Diagnosis: _____

Does the student take insulin: ☐ at home ☐ at school ☐ none

Does the student wear a medical alert bracelet/necklace: ☐ Yes ☐ No

What is the student's blood glucose (BG) target range? _____ mg/dl to _____

Does the student check their BG? ☐ at home ☐ at school ☐ none

(Completed Medical Management Plan with medication orders is required from healthcare provider)

When does student check BG at home: ☐ before each meal ☐ before physical activity
☐ with symptoms of high BG ☐ after physical activity
☐ with symptoms of low BG ☐ other:

Does the student test urine for ketones? ☐ at home ☐ at school ☐ none

If yes, when does student check for urine ketones? When BG is greater than

What BG level is considered low for the student? below What has been their lowest BG? _____

How often does the student typically experience low BG? ☐ daily ☐ weekly
☐ monthly ☐ other

When does student typically have low BG: ☐ mid AM ☐ before lunch ☐ afternoon
☐ not often ☐ after exercise ☐ Other

If student takes the bus, how long is bus ride? _____

Please check the student's usual signs/symptoms of low blood glucose:

☐ hunger or "butterfly feeling"	☐ irritable	☐ difficulty with speech
☐ shaky/trembling	☐ weak/drowsy	☐ anxious
☐ dizzy	☐ pale	☐ confused/disoriented
☐ sweaty	☐ severe headache	☐ loss of consciousness
☐ rapid heartbeat	☐ impaired vision	☐ seizure activity
☐ inappropriate crying/laughing	☐ difficulty with coordination	☐ Other _____

Does the student recognize these signs/symptoms? ☐ Yes ☐ No

How are low BG levels treated at home? Be specific. State amount of food, beverage, Glucagon, etc.:

Does the student need daily snacks at school? ☐ Yes ☐ No **If yes, what and when:** ALL _____

SNACKS AND SUPPLIES used at school MUST be provided by the family.

What would you like done about birthday treats and/or party snacks? _____

In the past year, how often has the student been treated for **severe low** BG? _____ times

In the past year, how often has the student been treated for **severe high** BG? _____ times

In the past year, has the student been seen for diabetes care:

☐ In the emergency room ☐ overnight in the hospital NOTES/COMMENTS:

Please indicate the student's skill level for the following:

Skill	**Does alone**	**Adult Help**	**Adult Performs**	**Comments**
Checks blood glucose				
Reads meter and records				
Counts carbs for meals/snack				
Calculate carb & correction dose				
Determines total insulin dose				
Interpret sliding scale - if has one				
Draw up/dial insulin dose				
Selects insulin injection site				
Gives insulin injection				
Checks urine ketones				
Pump Skills				

Does the student use an insulin to carbohydrate ratio with meals at home? ☐ Yes ☐ No Ratio:

Does the student use an insulin adjustment for high or low BG at home? ☐ Yes ☐ No

Insulin routine at home, if applicable.

Name of Insulin:	Units or Ratio:	Time:

Typical carbs at: Breakfast -
Lunch -
Dinner -
Other -
Other -

Check Method

☐ Pen
☐ Syringe/vial
☐ Pump

Other medication taken on a regular basis:

Name	By (mouth, injection, etc.)	Dose	Time of day

As needed medication:

Name	By (mouth, injection, etc.)	Dose	Time of day

Please list side effects of the student's medications that may affect their learning and/or behavior:

A Diabetes Medical Management Plan and medication orders from the student's healthcare provider must be completed yearly. ALL insulin, medication and diabetes related supplies MUST be brought to the school by the family; for health and safety reasons, a student cannot attend school without them. All medication must be in the original labeled container.

What action do you want school staff to take if the student does not respond to treatment/medication?

Is the student compliant with their diabetes medical management at home? ☐ Yes ☐ No ☐ Sometimes

Comments: _____

Has the student received diabetes education? ☐ Yes ☐ No If yes, where: (check **all** that apply)

☐ by healthcare provider ☐ at support group ☐ community agency

☐ at camp ☐ other

Please add anything else you would like school personnel to know about the student's diabetes (or any health condition)._____

_____

_____

_____

Information provided by:

Name _____Relationship to Student_____ Date_____

I authorize reciprocal release of information related to the student's diabetes between the school nurse and the healthcare provider.

Parent/Guardian Signature _____ Date_____

BISHOP WATTERSON
HIGH SCHOOL

Diabetes Management at School – Agreement

Student Name: _____ School Year: _____-_____

Birth date: _____ Grade/Teacher: _____

PARENT/GUARDIAN TO COMPLETE:

I _____, request that the specialized health care service prescribed by the student's healthcare provider be provided for the student. I authorize the school to appoint qualified designated trained staff to ensure the prescribed treatment is provided in the absence of the school nurse. I agree to immediately notify school personnel of any change in either the student's treatment regimen or the authorizing healthcare provider.

THE FOLLOWING INFORMATION IS NECESSARY FOR Bishop Watterson STUDENTS REQUIRING PRESCRIBED MEDICATION IN SCHOOL; **PARENT must sign this form and ensure the school has the Medical Management orders from the Healthcare Provider.**

1. I request permission for the above student to use medication according to the healthcare provider's medication order as part of the Diabetes Medical Management Plan for school.
2. I assume responsibility for the safe delivery of the medication **AND SUPPLIES** to school, either by myself or by the student.
3. I will notify the school immediately if there is any change in the students' Medical Management Plan. I authorize Bishop Watterson Health Services personnel to communicate with the student's healthcare providers as necessary concerning the medical management of the student at school.
4. I release and agree to hold YOUR Board of Education or The Diocese of Columbus its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

In addition:

1. I am responsible to assure the student regularly monitors blood glucose and is compliant with medication regimen as prescribed.
2. I am to maintain regular appointments with the prescribing healthcare provider and the student.
3. This agreement will last for only one academic school year.

Signature of Parent or Guardian _____ Date_____

Home Telephone _____ Cell Phone_____ Work Telephone_____

BISHOP WATTERSON
HIGH SCHOOL

Guidelines for Medications at School

Students needing to take medication during school hours must follow these guidelines:

- **Provide the school nurse with a completed Medication Authorization Form signed by both the parent/guardian and the healthcare provider.**

- **A new Medication Authorization Form must be completed each school year AND when the medication or dose has changed.**

- **All medication must be in the original container in which it was dispensed by the healthcare provider or pharmacy** and be labeled with the correct dose and instructions.
  - The label must match what is on the Medication Authorization Form.
  - Students taking a medication at both school and home can request 2 separate labeled bottles from the pharmacy to divide the pills to have some at home and school.
  - Students using an inhaler, epinephrine pen or other emergency medications at school can request 2 prescriptions from the healthcare provider in order to have a supply at home and school.

- **School personnel cannot give over-the-counter medications unless prescribed by a healthcare provider. A Medication Authorization Form must be completed.**

  Prescribed over the counter medications follow the same guidelines as stated above for prescribed medications. (Over the counter medications include pain medication such as Tylenol, cough medicine, ointments.)

- **Medications ordered three times a day or less, unless time is specified, may not need to be taken at school.** The medication should be given before school, after school and at bedtime.

- ***All unused medication must be picked up by the parent/guardian on the last day of school or it will be discarded.*** – *OR: Expired medication will be discarded at the end of the year. Smaller, private schools frequently have students who return to that school until they age out.*