



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

Questions? Please call your school nurse at 614-268-8671 ext.290



DIABETES MANAGEMENT AT SCHOOL

Dear Parent/Guardian of _____:

Date: _____

Bishop Watterson High School provides nursing services that promote student’s 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:

1. The school nurse at Bishop Watterson High School 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:

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

Phone number: 614-268-8671 ext.290

Days at school: Monday-Friday



AUTHORIZATION FOR RELEASE OF INFORMATION

Date:

Student Name:		Birth Date:	
School Name:		School Phone:	
Requested by: (BWHS Staff)		School Fax:	

In order to release any confidential information regarding your student, Bishop Watterson High School is required by law to have your written permission as this information is protected under the Family Educational Rights and Privacy Act (FERPA). Please sign this form to indicate the agencies or individuals that Bishop Watterson High School may receive information from or release information to regarding your student. Please keep a copy for your records. This signed authorization will be valid for one year from the date of your signature. If you wish to revoke this consent, please provide written notice to your student's school. *Please indicate the name, address and phone number of the providers that BWHS may request from or send information to. Make sure to un-check any information you do NOT wish to be shared.*

OK to Request data	Ok to Send data	Provider Name	Provider Address	Provider Phone
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			

I understand the requested information below will be used by the Bishop Watterson High School staff for educational and health care planning and service delivery: **Please un-check any information you do NOT wish to be shared.*

<input type="checkbox"/> Medical Information/Records	<input type="checkbox"/> Psychological Information/Records	<input type="checkbox"/> Immunization Records
<input type="checkbox"/> TB Test Results/Records	<input type="checkbox"/> Speech and/or Hearing Evaluation	<input type="checkbox"/> School Health Records
<input type="checkbox"/> Other information, as specified:		

I understand any release of information pertaining to substance abuse, mental health or HIV related records will be done only if needed to better meet the educational and school health needs of the student named above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above-mentioned entity. Release of alcohol and drug abuse information is protected by Federal Confidentiality Rules (42 CFR Part 2) without written consent of the person to whom it pertains or as otherwise permitted. Federal rules also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52 FR 21809, June 9, 1987; 52 FR 41997, November 2, 1987).

Authorization for Redisclosure: Under federal law, BWHS may not redisclose the information identified above to any other party without prior consent.

Parent/Guardian or Adult Student Signature

Date

Printed Name of Parent/Guardian or Adult Student

DIABETES QUESTIONNAIRE

STUDENT: _____ D.O.B _____
 SCHOOL: Bishop Watterson High School GRADE: _____ SCHOOL YEAR: _____

Complete & Return to the School Nurse as soon as possible. The information is needed to assist your student.

Person to Contact:	Relationship:	Work/Cell Phone:	Home Phone:
1. _____	_____	_____	_____
2. _____	_____	_____	_____
Preferred Communication Method <input type="checkbox"/> phone <input type="checkbox"/> written <input checked="" type="checkbox"/> in person <input type="checkbox"/> 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
<input type="checkbox"/> Pen
<input type="checkbox"/> Syringe/vial
<input type="checkbox"/> 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: _____ - _____

School: _____ Birth date: _____ Grade: _____

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 HIGH SCHOOL 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 student's Medical Management Plan.
4. I authorize Bishop Watterson High School Health Services personnel to communicate with the student's healthcare providers as necessary concerning the medical management of the student at school.
5. I release and agree to hold the Board of Education, 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.
- **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.***