HASBROUCK HEIGHTS PUBLIC SCHOOL
SCHOOL HEALTH SERVICES

DIABETIC PACK

TO BE COMPLETED BY THE DOCTOR

Diabetes Medical Management Form
Insulin Orders (doctor will have their own form)
Physician's Order for Medication - Glucagon

TO BE COMPLETED BY THE PARENT

Quick Reference Emergency Plan
Health History Form
Authorization to Exchange

Medication Policy

3/21/11

PHYSICIAN'S ORDER
FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL

STUDENT'S NAME_____ DOB_____ GRADE_____

NAME OF DRUG_____

DOSAGE_____ TIME(S) TO BE ADMINISTERED_____

DIAGNOSIS / REASON FOR MEDICATION_____

POSSIBLE SIDE EFFECTS _____

DURATION OF USE_____

PHYSICIAN'S SIGNATURE_____ DATE_____

PLEASE PRINT OR STAMP:
PHYSICIAN'S NAME
ADDRESS
PHONE NUMBER

PARENT AUTHORIZATION
FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL

I request that the above medication, in the original container, be administered to my child. I understand that a certified school nurse or her designated nurse substitute will be performing this service utilizing the order provided by my physician. I acknowledge that the school district and its employees and agents shall incur no liability as a result of administration of this medication to my child. I give the school nurse permission to contact the physician and / or pharmacist with any question concerning the medication.

PARENT / GUARDIAN'S SIGNATURE_____ DATE_____

HOME PHONE_____ WORK / CELL PHONE_____

INITIAL MEDICATION SUPPLY:

Name of medicine_____# of pills/tablets/capsules/ml._____

Nurse signature _____***Parent signature***_____

STUDENT'S NAME_____ DOB_____ GRADE_____

MEDICATION SUPPLY RECORD:

DATE	MEDICINE	#	PARENT SIGNATURE	NURSE SIGNATURE

Quick Reference Emergency Plan
for a Student with Diabetes

Hypoglycemia
(Low Blood Sugar)

Photo

Student's Name

Grade/Teacher Date of Plan

Emergency Contact Information:

Mother/Guardian			**Father/Guardian**		
Home phone	Work phone	Cell	Home phone	Work phone	Cell

School Nurse/Trained Diabetes Personnel **Contact Number(s)**

Never send a child with suspected low blood sugar anywhere alone.

Causes of Hypoglycemia
- Too much insulin
- Missed food
- Delayed food
- Too much or too intense exercise
- Unscheduled exercise

Onset
- Sudden

Symptoms

Mild
- Hunger
- Shakiness
- Weakness
- Paleness
- Anxiety
- Irritability
- Dizziness
- Sweating
- Drowsiness
- Personality change
- Inability to concentrate
- Other: _____ _____

Circle student's usual symptoms.

Moderate
- Headache
- Behavior change
- Poor coordination
- Blurry vision
- Weakness
- Slurred Speech
- Confusion
- Other _____ _____

Circle student's usual symptoms.

Severe
- Loss of consciousness
- Seizure
- Inability to swallow

Circle student's usual symptoms.

Actions Needed

Notify School Nurse or Trained Diabetes Personnel. If possible, check blood sugar, per Diabetes Medical Management Plan. When in doubt, always TREAT FOR HYPOGLYCEMIA.

Mild
- Student may/may not treat self.
- Provide quick-sugar source.
  3-4 glucose tablets
  or
  4 oz. juice
  or
  6 oz. regular soda
  or
  3 teaspoons of glucose gel
- Wait 10 to 15 minutes.
- Recheck blood glucose.
- Repeat food if symptoms persist or blood glucose is less than _____.
- Follow with a snack of carbohydrate and protein (e.g., cheese and crackers).

Moderate
- Someone assists.
- Give student quick-sugar source per MILD guidelines.
- Wait 10 to 15 minutes.
- Recheck blood glucose.
- Repeat food if symptoms persist or blood glucose is less than _____.
- Follow with a snack of carbohydrate and protein (e.g., cheese and crackers).

Severe
- Don't attempt to give anything by mouth.
- Position on side, if possible.
- Contact school nurse or trained diabetes personnel.
- Administer glucagon, as prescribed.
- Call 911.
- Contact parents/guardian.
- Stay with student.

Excerpted from: Helping the Student with Diabetes Succeed: A Guide for School Personnel. Published by National Diabetes Education Program: A Joint Program of the National Institutes of Health and the Centers for Disease Control and Prevention

Quick Reference Emergency Plan

for a Student with Diabetes

Hyperglycemia (High Blood Sugar)

Photo

Student's Name

Grade/Teacher Date of Plan

Emergency Contact Information:

Mother/Guardian			**Father/Guardian**		
Home phone	Work phone	Cell	Home phone	Work phone	Cell

School Nurse/Trained Diabetes Personnel **Contact Number(s)**

Causes of Hyperglycemia

- Too much food
- Too little insulin
- Decreased activity
- Illness
- Infection
- Stress

Onset

- Over time—several hours or days

Symptoms

Mild

- Thirst
- Frequent urination
- Fatigue/sleepiness
- Increased hunger
- Blurred vision
- Weight loss
- Stomach pains
- Flushing of skin
- Lack of concentration
- Sweet, fruity breath
- Other: _____

Circle student's usual symptoms.

Moderate

- Mild symptoms plus:
- Dry mouth
- Nausea
- Stomach cramps
- Vomiting
- Other:_____

Circle student's usual symptoms.

Severe

- Mild and moderate symptoms plus:
- Labored breathing
- Very weak
- Confused
- Unconscious

Circle student's usual symptoms.

Actions Needed

- Allow free use of the bathroom.
- Encourage student to drink water or sugar-free drinks.
- Contact the school nurse or trained diabetes personnel to check urine or administer insulin, per student's Diabetes Medical Management Plan.
- If student is nauseous, vomiting, or lethargic, ____ call the parents/guardian or ____ call for medical assistance if parent cannot be reached.

Excerpted from: Helping the Student with Diabetes Succeed: A Guide for School Personnel. Published by National Diabetes Education Program: A Joint Program of the National Institutes of Health and the Centers for Disease Control and Prevention

HASBROUCK HEIGHTS PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES

Health History Questionnaire

To the parents or guardians of _____

It is important we have this information for your child's well-being during his/her school hours. Please complete and return this form to the School Nurse as soon as possible.

1. Does he/she have a medical Problem? If yes, please state problem:

_____

_____

_____

_____

_____

2. Is he/she on medication? If yes, pleas list medication(s):

_____

_____

3. Are there any restrictions? If yes, please list restrictions:

_____

_____

4. Does your child have any allergies to food or medication? If yes, what:

_____

_____

This information will be shared with staff as necessary. If you DO NOT want this information shared, please notify me immediately. Thank you for your cooperation in this matter.

Parent Signature:_____ Date: _____

UPDATED 1/23/09

(PARENT)

Hasbrouck Heights Public School
School Health Services

AUTHORIZATION

FOR THE EXCHANGE OF CONFIDENTIAL INFORMATION

STUDENT_____ DATE OF BIRTH_____

As the parent/guardian of the above named student, I hereby authorize the release of pertinent medical information (medical conditions, allergies, medications and treatment regimes) to be exchanged among appropriate professional staff involved in the care of the above named student.

This consent is valid while your child attends school in the Hasbrouck Heights Public School and is intended to allow the staff to better serve your child. If you have any questions or concerns, please contact my office at the telephone number noted above.

_____ _____
Signature of Parent / Guardian Date

_____ _____
Print name of Parent / Guardian Telephone Number

Thank you,

The Nursing Department
Hasbrouck Heights Public School

updated 1/23/09