Diabetes Health Care Plan

Student's Name:______________________________ **Date of Birth:**__________ **Grade:**______

Effective Dates:__________________

To be completed by parents and the student's health care team. This document should be reviewed with necessary school staff and kept with the student's school records and where easily accessible by staff in emergencies.

1. CONTACT INFORMATION:

a. Parent/Guardian #1: Name: ______________________________
Address: ______________________________
Telephone: Home: ______________ Work: ______________ Cell: ______________

b. Parent/Guardian #2: Name: ______________________________
Address: ______________________________
Telephone: Home: ______________ Work: ______________ Cell: ______________

c. Student's Health Care Providers: Doctor: ______________________________
Address: ______________________________
Telephone number: ______________________________

d. Other Emergency Contact:
Name: ______________________________ Relationship: ______________
Telephone: Home: ______________ Work: ______________ Cell: ______________

e. Notify parent/guardian or emergency contact in the following situations: ______________________________
____
____

2. BLOOD GLUCOSE MONITORING

a. Target range for blood glucose is __________ mg/dl to __________ mg/dl.
b. Usual times to test blood glucose: __________ __________ __________

c. **Times to do extra blood glucose test (check all that apply)**
_____Before Exercise
_____After Exercise
_____When student exhibits symptoms of hyperglycemia
_____When student exhibits symptoms of hypoglycemia
_____Other (explain): ______________________________

d. Can student perform own blood glucose test? _______ Yes _______No
Exceptions: ______________________________
e. Type of blood glucose meter student uses: ______________________________

3. INSULIN

a. Can student give own injections? _________Yes _________No
b. Can student determine correct amount of insulin? _________Yes _________No
c. Can student draw correct dose of insulin? _________Yes _________No
d. Types, times and dosages of insulin injections to be given during school:

Time	Type(s)	Dosage

4. FOR STUDENTS WITH INSULIN PUMPS

a. Type of pump: ______________________ Basal rates: ______________
b. Insulin/carbohydrate ratio: ______________________ Correction factor: ______________
c. Is student competent regarding pump? ________Yes ________No
d. Can student effectively troubleshoot problems (e.g., ketosis, pump malfunction)? ________Yes ________No
e. Comments: ______________________

5. MEALS AND SNACKS EATEN AT SCHOOL

a. Insulin to Carbohydrate Ratio ______________________

b. Meal/snack	Time	Food content/ amount
Breakfast		
Mid-morning snack		
Lunch		
Mid-afternoon snack		
Dinner		

c. Snack before exercise? ____Yes ____No ______________
d. Snack after exercise? ____Yes ____No ______________
e. Other times to give snacks and content/amount: ______________
f. A source of glucose such as ______________ should be readily available at all times.
g. Preferred snack foods: ______________
h. Foods to avoid, if any: ______________
i. Instructions for when food is provided to the class, e.g., as part of a class party or food sampling: ______________

j. Instructions for what snacks/food to be eaten and when, during shortened school days: ______________

6. EXERCISE AND SPORTS

a. A snack such as ______________ should be available at the site of exercise or sports.
b. Restrictions on activity, if any: ______________

c. Student should not exercise if their blood glucose level is below mg/dl ________ or above ________ mg/dl.

7. HYPOGLYCEMIA (Low Blood Sugar)

a. Usual symptoms of hypoglycemia: ______________

b. Treatment of hypoglycemia: ______________

****Glucagon** should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow. If glucagon is required, it should be administered promptly. Then, 911 (or other emergency assistance) and the parents should be called*

8. HYPERGLYCEMIA (High Blood Sugar)

a. Usual symptoms of hyperglycemia: ______________

b. Treatment of hyperglycemia: ______________

c. Circumstances when urine ketones should be tested ______________
d. Treatment for ketones: ______________

9. SUPPLIES AND PERSONNEL

a. Where are supplies for testing blood glucose levels kept?____________________
b. Where are supplies for administering insulin kept?____________________
c. Where are supplies for testing ketones kept?____________________
d. Where is glucagon kept?____________________
e. Where are supplies of snack foods kept?____________________
f. School personnel trained in the symptoms and treatment of high and low blood sugar…

	dates of training
1. ____________________	__________
2. ____________________	__________
3. ____________________	__________
4. ____________________	__________
5. ____________________	__________
6. ____________________	__________

:

SIGNATURES

This Health Plan has been reviewed by:

______________________________ ____________
Student's Health Care Provider Date

Acknowledged and received by:

______________________________ ____________
Student's Parent(s) or Guardian(s) Date

Acknowledged and received by:

______________________________ ____________
School Representative Date

Diabetes Supply Sheet

Month:_________

Dear Parents/Guardian:

Your child needs the following supplies. Please send in the marked supplies on the first day of school. Please remember to check the expiration dates on all supplies.

SNACKS:

Fast Acting

- ☐ Juices
- ☐ Glucose Tablets
- ☐ Glucose Gel/Icing
- ☐ Other_________________

Complex Snacks

- ☐ Cheese Cracker
- ☐ Other_________________

INSULIN SUPPLIES:

- ☐ Pen Needles
- ☐ Syringes
- ☐ Insulin Bottle
- ☐ Insulin Pen
- ☐ Ketone Strips
- ☐ Alcohol Wipes

GLUCOMETER SUPPLIES:

- ☐ Glucometer
- ☐ Glucose Test Strips
- ☐ Lancets
- ☐ Batteries

GLUCAGON:

Expires on:____________________

Please bring all supplies to the Health Office

PERMISSION TO SHARE INFORMATION
2023-2024

As you are aware, everyday each of our students has contact with a variety of staff members; teachers, bus drivers, therapists, assistants, cafeteria workers, and student interns. While your child is in the care of these people, it is important that they are aware of any information that would require special considerations for his or her health and safety.

To comply with privacy laws, I am requesting your permission to share personal information about your child. This would consist of only that information deemed necessary to protect the well-being of your child. Examples of information that could be shared about your child may include; known allergies, special diets or food restriction, and a history of seizures. This may be done in the form of a printed list or verbal contact with those people who will be working closely with your child. If you have specific questions regarding your child, please call me at school. As always, please feel comfortable knowing that any information you do not want shared with anyone will be kept confidential. Thank you.

PLEASE COMPLETE, SIGN BELOW AND RETURN THIS FORM TO YOUR CHILD'S SCHOOL

Child's Name: ______________________________

_____ **Yes,** I give permission for personal information about my child to be shared with other staff members if it will protect his/her health and safety.

_____ **No,** I do not give permission for personal information about my child to be shared with other staff members if it will protect his/ her health and safety.

______________________________ ______________

Parent/Guardian Signature Date

Health Office
90 Whippany Rd, Whippany, NJ, 07981
(973) 888-2083

MEDICATION PROTOCOL

Medication will be given in school only when a pupil's health and continuing attendance in school requires it and it is administered in accordance with the medication policy. **No student is to carry medication** to and from school. If it is necessary that medication be taken during school hours, the following is required:

1. All medication, prescription and over the counter, must be accompanied by a written request from a physician. These orders must include the diagnosis or type of illness, name of drug, dosage, time of administration, length of time for which it is required, and side effects of medication. Written orders must be renewed on an annual basis at the beginning of each school year.
2. A Mandatory Medication Form, Asthma Action Plan and/or Allergy Emergency Treatment form must be completed by the primary care provider and signed by parent/guardian.
3. Medication is to be in the correct prescription bottle, labeled with the name of the child, current dosage, date of prescription, and name of prescribing primary care provider
4. Parents must bring all medications to the Health Office. Students should never carry medication to school unless the doctor specifically orders that the student may carry and self-administer emergency epinephrine or inhaler.
5. Self-administration of medication for asthma or other potentially life-threatening illnesses require additional doctor and parent signatures on the form.
6. Non Prescription medications (i.e. Ibuprofen, Tylenol) may only be administered when a Mandatory Medication Form is completed by the primary care provider and signed by a parent. These medications must come in the original container.
7. According to NJ Law, school nurses cannot administer alternative remedies such as herbal medications and essential oils.
8. No parent's or primary care provider's phone instructions can be accepted.
9. Parents must pick up the medication from the Nurse in June on the last day of school. No medications will be sent home with a student. Medications will be properly disposed of if parents do not pick up the medication on the last day of school.

2023-2024 MANDATORY MEDICATION FORM

ALL MEDICATION (prescription and OTC, including Tylenol and Advil) must be accompanied by written permission from BOTH the PARENT and PHYSICIAN.

- **Prescription medication** must be delivered to the nurse by the parent in the original container, labeled with the student's name, medication, dosage and physician's name.
- **OTC medication** must be delivered to school by the parent in the original sealed container and labeled with the student's name.
- **Written permission** of the student's physician and parent/guardian are required, including the student's name, purpose of the medication, the time (or circumstance) at which the medication should be administered, and the length of time for which the medication is prescribed.

Only those medications which are medically necessary during school hours for a student's wellbeing should be sent to school.

NOTE: THE FIRST DOSE OF ANY MEDICATION MAY *NOT* BE GIVEN AT SCHOOL.

NAME OF STUDENT______________________________ DOB_______________

NAME OF MEDICATION____

DOSAGE____

TIME TO BE GIVEN____

REASON FOR MEDICATION____

MEDICATION TO BE GIVEN FROM__________________ TO________________
DATE DATE

HOW IT IS TAKEN____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS____

____________________________ ____________________________
PARENT SIGNATURE/DATE PHYSICIAN SIGNATURE/DATE

____________________________ ____________________________
TELEPHONE NUMBER TELEPHONE NUMBER

ADDITIONAL MEDICATIONS

NAME OF STUDENT____ DOB_______________

NAME OF MEDICATION____

DOSAGE____

TIME TO BE GIVEN____

REASON FOR MEDICATION____

MEDICATION TO BE GIVEN FROM_______________________ TO______________________
DATE DATE

HOW IT IS TAKEN____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS____

NAME OF STUDENT____ DOB_______________

NAME OF MEDICATION____

DOSAGE____

TIME TO BE GIVEN____

REASON FOR MEDICATION____

MEDICATION TO BE GIVEN FROM_______________________ TO______________________
DATE DATE

HOW IT IS TAKEN____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS____

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_____________________________________ _____________________________________
PARENT SIGNATURE/DATE PHYSICIAN SIGNATURE/DATE

_____________________________________ _____________________________________
TELEPHONE NUMBER TELEPHONE NUMBER

2023-2024 PHYSICIAN/PARENT CERTIFICATION FOR STUDENT'S SELF-ADMINISTRATION OF MEDICATION

CERTIFICATION TO BE COMPLETED BY PHYSICIAN

STUDENT NAME: ______________________________

DIAGNOSIS: ______________________________

NAME OF MEDICATION: ______________________________

DOSAGE: ______________________________

TIME AND CIRCUMSTANCES OF ADMINISTRATION: ______________________________

POSSIBLE SIDE EFFECTS: ______________________________

I certify that ______________________________ (Student) has a potentially life threatening illness which requires the use of ______________________________ (Medication). I further certify that ______________________________ (Student) is capable and has been instructed in the proper method of self-administration of ______________________________ (Medication)

______________________________ Signature of Physician

______________________________ Date

PHYSICIAN NAME: ______________________________ TELEPHONE #: ______________

****

CERTIFICATION TO BE COMPLETED BY PARENT

I hereby authorize my son/daughter ______________________________ to self-administer (Name of Medication)______________________________ in accordance with special guidelines.

I acknowledge that the school shall incur no liability as a result of any injury arising from the self-administration of medication by (student name) ______________________________.

I shall indemnify and hold harmless the school, its employees and agents against any and all claims arising out of the self-administration of (medication) ______________________________ by (student name) ______________________________.

______________________________ Parent/Guardian Signature

______________________________ Date

SELF-ADMINISTRATION OF MEDICATION IN SCHOOL

Under N.J.S.A. 18A:40-12.3, self-administration of medication by a pupil for asthma or other potentially life threatening illness is allowed under guidelines established by the school and provided that the statutory requirements set forth in this form are complied with.

Any permission for the self-administration of medication is effective for this school year only.

N.J.S.A. 18A:40-12.3 PROVIDES THAT THE SCHOOL SHALL INCUR NO LIABILITY AS A RESULT OF ANY INJURY ARISING FROM THE SELF-ADMINISTRATION OF MEDICATION BY A STUDENT.