STUDENT HEALTH HISTORY - DIABETES

Student Name: ________________________________ Student Number: ____________________

Date of Birth: ___________ School: _______ Teacher/Grade: _____________________

Doctor: ________________ Doctor's Number: ______________ Ride Bus: Yes__ No__

Allergies: ____

Parent/Guardian: _______________________ Home Phone: __________ Other Phone: _____________

Parent/Guardian: _______________________ Home Phone: __________ Other Phone: _____________

Emergency Contact: _____________________ Home Phone: ___________ Other Phone: _____________

Relationship: ___________________________

Emergency Contact: _____________________ Home Phone: ___________ Other Phone: _____________

Relationship: __________________________

Year diagnosed with diabetes: _______________

Does your child take insulin at home? ☐ Yes ☐No If yes, type: ____________ Time(s): __________

Will insulin administration be required at school? ☐ Yes ☐ No

If prescribed, have you ever had to give Glucagon to your child? ☐ Yes ☐ No

Child's healthcare provider must complete a Diabetes Medical Management Plan

INSULIN PUMP MANAGEMENT

Name of pump: ________________________________ Manufacturer Number: ____________________

My child is able to change the insulin infusion set using standard precautions. ☐ Yes ☐ No

If student is unable to change site independently, parent will be notified

My child is able to administer insulin via a syringe or pen if the pump malfunctions. ☐ Yes ☐ No

Parent must provide extra supplies to include, but not limited to: infusion sets, reservoirs, batteries, insulin, syringes, and any other associated equipment.

Parent will be contacted should any of the following occur at school:

- Soreness or redness at pump insertion site
- Detached dressing
- Site change needed
- Corrective measures do not return blood glucose to target range
- Infusion set displaced.

*Please complete and sign reverse

STUDENT HEALTH HISTORY - DIABETES

SNACKS

Will your child require a snack at school? ☐ Yes ☐ No Indicate time(s) ____________________________

Snacks are to be provided, monitored and replaced by the parent as needed.

EMERGENCY PLANS:

- In the event of a lockdown, medication kept in the clinic will not be available to your child. We encourage you to discuss a plan with your child's physician and the school nurse. Please note any special instructions to be included as part of your child's Emergency Action Plan below.

  ____

- In the event of an evacuation, emergency medications will be taken to the evacuation site, whenever possible.

I understand that my child's healthcare provider must complete a **Diabetes Medical Management Plan,** directing the specific care to be provided at school and indicating what procedures the student may or may not perform independently.

I understand that my child's Emergency Action Plan will be shared with appropriate school staff that have a need to know about the health condition. I further understand that the school is not responsible for damage or loss of equipment utilized in providing medically prescribed treatments or procedures.

I give permission for my child's health care provider to be contacted for information regarding my child's medical condition. I have reviewed and agree with the information provided on this Health History form.

Parent/Guardian: ____ ____________________
Signature Date

Reviewed by: ____ ____________________
School Nurse Date

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FOR SCHOOL NURSE USE ONLY

Notes: ____

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Rev 4/18

Student Name ______________________ # _______________

The District School Board of Collier County
Diabetes Medical Management Plan

This form provides professional and parental authorization for medical treatment to be provided. Both the prescribing health care provider and the parent/legal guardian are required to complete the respective sections of this document entirely before the services can be provided.

Student's Name ______________________ Sex ________ Date of Birth ____________ Student # ____________

School ______________________ Fax Number ____________

Note: Please have your child's physician complete this portion of the form and return it or fax it to the school nurse.
It is the parent's/guardian's responsibility to notify the school if and when these orders change.

The following section is to be completed by the prescribing health care provider:

DIAGNOSIS: ☐ **DIABETES TYPE 1** ☐ **DIABETES TYPE 2** ☐ **OTHER** ___________

BLOOD GLUCOSE MONITORING

To be performed by student? ☐**Yes** ☐**No**

Location for testing: ☐ Clinic/Health Room
☐ Classroom ☐ Other_______________

Time, frequency of testing during school hours:
☐ Lunch ☐ PRN symptoms of hypoglycemia/hyperglycemia
☐ Before P.E. ☐ Before Dismissal
☐ Dexcom Instructions: ______________________________

INSULIN ADMINISTRATION

Student requires the ROUTINE administration of ____________ type of insulin.

Route: ☐Pen ☐Pump ☐Injection
☐ If pump failure, use sliding scale.

Frequency:
☐ Lunch
☐ PRN per physician verbal order
☐ Other ____________________

Target Range: _______________

Insulin/Carbohydrate Ratio: ______

Correction Factor: ___________

Please indicate which activities the student may perform without supervision:

Activity	Yes	No
Can student perform blood glucose monitoring?	☐ Yes	☐ No
Can student perform urine ketone testing when indicated?	☐ Yes	☐ No
Can student administer own insulin via prescribed route?	☐ Yes	☐ No
Can student determine correct amount of insulin?	☐ Yes	☐ No
Can student draw-up correct amount of insulin?	☐ Yes	☐ No
Student is authorized to self-carry glucometer/supplies	☐ Yes	☐ No
Student is authorized to self-carry and administer insulin	☐ Yes	☐ No
Student may self-carry fast-acting glucose snacks	☐ Yes	☐ No
Student may self-carry glucagon	☐ Yes	☐ No

PRE-MEAL SLIDING SCALE INSULIN

High BG Levels

For BG levels:	Sliding Scale Insulin
Between _____ – _____	# Units_______Type_______
Between _____ – _____	# Units_______Type_______
Between _____ – _____	# Units_______Type_______
Between _____ – _____	# Units_______Type_______
Between _____ – _____	# Units_______Type_______

High BG Levels:
≥ ________
☐ Check ketones
☐ Call physician & parent if mod.– large ketones
☐ Other ______________________________

ICD 10 Code _______

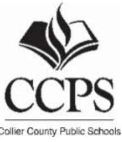
Low BG levels: If BG is below __________, take the following actions:

☐ Give 15 gm. of fast-acting glucose/gel/tabs. Recheck in 15 minutes. If <80, give additional 15 grams of fast-acting glucose and recheck in 15 minutes. If >80, and not lunchtime, give 15 grams of complex carbs (crackers, granola bar)
☐ If >80 at lunchtime, send to lunch

GLUCAGON ADMINISTRATION

☐ I have prescribed injectable Glucagon for this student	Dosage:	Frequency:

Please see other side-



The District School Board of Collier County
Diabetes Medical Management Plan

Student Name: ____ **Student ID#** ___________________

The student named in this document is under my medical supervision. I have prescribed the care/treatment that is necessary to be given during school hours for the child's health or safety. I am also aware that prescribed care or treatments may be administered by trained diabetes personnel.

Physician's Name (Print): ____ Phone Number: __________

Physician's Signature: ______________________________ Date: _______ Fax Number: ____________

Physician's Address: ____

Parent/Legal Guardian Permission

The following section is to be completed by the parent/legal guardian:

I hereby grant permission to the Principal or his/her designee of ________________________________ school to assist in the administration of the care/treatment prescribed in this order for my child while in school, while participating in official school activities such as field trips, and during after-school programs operated by Collier County Public Schools. (F.S. 1006.062). **It is my responsibility to notify the school if and when these orders change. A new written Authorization for Diabetes Care/Treatment will be needed.** I understand that the law provides there shall be no liability for civil damages as a result of the administration of such care/treatment where the person administering such care/treatment acts as an ordinarily prudent person would under the same or similar circumstances. If my child is authorized to carry diabetic supplies or equipment, I indemnify the school district, county health department and any public-private partner, and the employees and volunteers of those organizations, from any and all liability with respect to my child's use of such supplies and equipment.

1. I hereby give permission for my child's doctor or other authorized health care practitioner to be contacted for information regarding my child's illness, health or medical condition that may require nursing care or treatment.
2. I hereby authorize the school nurse or trained diabetes personnel to perform nursing care or treatments that may be prescribed by my child's authorized health care provider for the school day or while my child is participating in school related activities, including administration of glucagon.
3. I understand and I agree that I am responsible for providing the equipment, supplies, snacks, and/or prescribed medications to the school that are required to perform these services.
4. I understand that all medications, materials and supplies not picked up at the end of the school year, or when medication or materials have an expired "discard after date" or a manufacturer's expiration date that has passed will be disposed of per current District protocol, following verbal and/or written notification to the parent/guardian.
5. This Authorization is effective as of the date it is received at the child's school and it supersedes all previous authorizations or orders. This Authorization shall remain in effect until changed by the physician.
6. This Authorization must be renewed annually.

My child has:	☐ No allergies, ☐ The following allergies:______________________________		
Parent/Guardian Name:		Relationship:	
Home Phone:		Cell Phone:	
Parent/Guardian Signature:		Date:	

Reviewed by: ____ Date: ________
School Nurse

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