Alamogordo Public Schools
Health Services
Parent Check-Off Sheet

The following checklist is to assist you with completing the necessary information from your physician. The information provided is necessary to minimize emergency situations and to prepare in the even one should arise. Please bring the following to school when your child returns.

☐ Returned Contact Information

☐ Provided Insulin

☐ Provided Glucagon

☐ Provided Snacks

☐ Provided Ketone Strips

☐ Provided Syringes

☐ Provided Glucometer

☐ Assisted with Glucagon Training

☐ Signed Care Plan

☐ Signed Medical Release of Information

Provided the following from the Doctor:

☐ Blood Sugar/Snacks/ Competency form -

☐ Carbohydrate Counting and Correction Sheet

☐ Student Nutrition Information

☐ Medication Consent form

Alamogordo Public Schools
Health Services

Diabetes Medical Management Plan

School: _____ **School Year:** _____ **Grade:** _____

Student Name: _____ **DOB:** _____

Provider Name: _____ **Phone #:** _____ **Fax #:** _____

Blood Glucose Monitoring at School

Blood Glucose Target Range: _____ - _____ **mg/dl**

Monitoring Schedule:
❒ Before breakfast ❒ Before lunch ❒ 10-20 min. before boarding bus ❒ Suspected hyper/hypoglycemia
❒ Is ill or requests testing ❒ Other: _____

Student Self Monitoring (Check all that apply.):
❒ Can test independently ❒ Needs supervision ❒ Needs assistance with testing and blood glucose management
❒ Other:_____

Diabetes Medication

Oral medications: Home: _____ School: _____

Insulin: (***Opened insulin must be discarded after 28 days.***)
❒ **No insulin at School** **Insulin at Home:** ❒ Humalog ❒ Novolog ❒ Lantus Other: _____
Insulin at School: ❒ Humalog ❒ Novolog ❒ Lantus Other: _____
Insulin delivery devise at school:
❒ Syringe & vial ❒ Insulin Pen ❒ Insulin Pump (See Pump Section.)

Insulin management at school:
Student is able to:

Give own injections.	❒ Y	❒ N	❒ With supervision
Draw up correct dose of	❒ Y	❒ N	❒ With supervision
Determine correct amount of insulin.	❒ Y	❒ N	❒ With supervision
Independently self manage pump or insulin injection.	❒ Y	❒ N	❒ With supervision

Meals & Snacks at School

Independent in Carbohydrate calculations and management: ❒ Yes ❒ No ❒ Needs Supervision

Meal/Snack	Carbohydrate Count	Not on Fixed Carb Count	Meal/Snack	Carbohydrate Count	Not on Fixed Carb Count
Breakfast			Lunch		
Mid-morning Snack			Mid-morning Snack		

Snack before exercise: ❒ Yes ❒ No ❒ As Needed **Snack after exercise:** ❒ Yes ❒ No ❒ As Needed

Snack/content/amount at other times: ❒ As Needed **OR** _____

Food to avoid: Liquid sugars such as fruit juice, regular soda and Gatorade. Use only for low blood sugars.
Other: _____

Instructions when food provided in classroom (e.g. class party, food sampling): _____

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Alamogordo Public Schools Diabetes Medical Management Plan con't

Carbohydrate Counting and Correction Sheet

Humalog/Novolog Insulin

Food: _____ units of insulin for every _____ grams of carbohydrate for meals and snacks.
Blood Sugar: _____ units of insulin for every _____ mg/dl over _____ mg.dl. Correction can be made every 3 hours as needed.

Daily Lantus/Levemir Insulin: _____ units a.m. _____ at bedtime

Insulin Pump: Use pump dosing. Dose listed above to be used in event of pump failure. See insulin pump care.

Parent authorized to adjust insulin dosage under the following circumstances: _____

Precautions

Unless otherwise stated, cover all carbohydrates/snacks with insulin except those used to treat low blood sugar.
Parents need to communicate modifications of carbohydrate counting/insulin coverage to school nurse in writing.

Pre-Meal Humalog/Novolog Doses

Blood Sugar Correction			+	Food Carbohydrates		
Under	=	Units		Grams	=	Units
to	=	Units		Grams	=	Units
to	=	Units		Grams	=	Units
to	=	Units		Grams	=	Units
to	=	Units		Grams	=	Units
to	=	Units		Grams	=	Units
to	=	Units		Grams	=	Units
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to	=	Units		Grams	=	Units
to	=	Units		Grams	=	Units
to	=	Units		Grams	=	Units
to	=	Units		Grams	=	Units
to	=	Units		Grams	=	Units
to	=	Units		Grams	=	Units

Exercise and Sports

A fast-acting carbohydrate such as juice, regular soda, Gatorade, or glucose tablets need to always be available at the site of exercise or sports.

Individual Activity Restrictions for Student: ❒ Y ❒ N
If yes, list restrictions:_____

General Restrictions from Exercising:

If blood sugar is below **80 mg/dl**, treat for hypoglycemia with above fast acting carbohydrates.
Snack listed above should be given: ❒ Y ❒ N

If glucose is above **300 mg/dl** **OR** moderate to large urine ketones are present **OR** blood ketones are **≥0.6 mmol/l**,
Notify physician or parent/guardian.

If student is symptomatic.

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Hypoglycemia (Low Blood Sugar) = _____mg/dl and/or Physical Symptoms

Symptoms of Hypoglycemia:

Shaky Headache Confused Clumsy Sweaty Drowsy Hungry Pale
Uncooperative Irritable Weak Behavior Changes Other:_____

Precautions

- **Never leave this student unattended! If treatment is to be provided in the Health Office, a responsible adult needs to accompany the student to the Health Office.**
- **Check blood sugar if student has not done so and is symptomatic.**
- **Notify School Nurse and Parent when any of the following treatments are performed.**

Low Blood Sugar Treatment:

• Give ½ cup (4 oz.) of juice or regular soda or 3-4 glucose tablets (or 15 grams of fast acting carbohydrate). Do not cover with insulin. The carbohydrate is given to treat the low blood sugar.
• Recheck blood glucose in 15 minutes. If blood sugar is still **below_____** give another 15 grams of carbohydrate.
• If the student's blood sugar is **above_____**, give a 15-30 gram carbohydrate snack or lunch.
• Make sure the student feels well before sending to lunch.
• Comments_____

Treatment if disoriented, combative, and incoherent but is <u>conscious</u>:

• Give ½ to 1 tube of glucose gel or cake decorating gel. Place gel between cheek and gum.
• Massage the outside of cheek to facilitate absorption through the membrane of the cheek.
• Encourage student to swallow.
• Recheck blood sugar in 10 minutes.
• If still **below ____,** repeat treatment as above.
• Give sugar containing liquid and snack when student is alert and able to swallow safely.
• Comments_____

Treatment for seizures, loss of consciousness, inability/unwillingness to take gel or juice:

• Stay with student
• Position student on side
• Give glucagon immediately by injection. Dose: ❒ **0.3cc** ❒ **0.5cc** ❒ **1.0cc**
• Call 911
• **Notify parents**
• Comments_____

Hyperglycemia (High Blood Sugar) = <u>❒ 250 or ❒300 mg/dl</u>

Symptoms of Hyperglycemia:

Extreme Thirst Frequent Urination Abdominal Pain Headache Nausea
Other:_____

Check Ketones:

• Urine should be checked for ketones when blood glucose levels are above 300 mg/dl.
• If urine ketones are moderate to large, CALL PARENT IMMEDIATELY!
• If student is on pump, and urine ketones are moderate to large OR blood ketones are 0.6mmol/l or more, call parents.

Treatment for ketones and/or high blood sugar:

• Increase sugar free liquid intake
• Allow student to use restroom as often as necessary
• Call parent immediately if student is vomiting

Treatment for high glucose with ketones, moderate, large or ≥ 0.6 or greater: (check all that apply)

❒ Call parent immediately for action plan
❒ Parent will determine the insulin coverage needed
❒ Follow blood sugar correction guidelines – see dosing sheeta

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Supplies Kept at School

Blood glucose meter, test strips, meter batteries
Meter location:_____
Insulin, pen, pen needles, insulin cartridges
❒ Lancet device, lancets, gloves, etc.

❒ Glucagon Emergency Kit
❒ Urine ketone strips
❒ Insulin vials and syringes
❒ Carbohydrate containing snack

❒ Fast-acting source of glucose
❒ Blood ketone meter and strips
❒ Insulin pump and supplies

Insulin Pump

☐ N/A

❒ Insulin Pump Care Information Attach

Student able to operate insulin pump: ❒ Y ❒ N ❒ With Supervision

Student can troubleshoot problems: ❒ Y ❒ N ❒ With Supervision
(e.g. Urine Ketones, pump malfunction)

Comments: _____

_____

Insulin Adjustments by Healthcare Provider or Parent (for use by School Nurse)

Date New Orders Obtained	Order * Note Change in Care Sheet	Nurse Signature
	❒ Verbal ❒ Written	
	❒ Verbal ❒ Written	
	❒ Verbal ❒ Written	
	❒ Verbal ❒ Written	

SIGNATURES:

This Diabetes Medical Management Plan has been approved by:

_____	_____	_____	_____
Student Healthcare Provider	**Phone**	**Date**	**E-mail**
_____	_____	_____	_____
Diabetes Educator	**Phone**	**Date**	**E-mail**

I give my permission to the school, school nurse, licensed/unlicensed assistive personnel, and other designated staff member(s) to perform and carry out the diabetes care tasks as outlined by this Diabetes Medical Management Plan for my child, _____ _____, and I acknowledge that I have received a copy of the signed plan.

I also consent to the release of the information contained in this plan to all staff and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I will notify extra-curricular staff about health plan and care to be

given during after school activities. I give my permission for the school nurse to contact my child's healthcare provider(s) regarding the above condition.

_____	_____	_____	_____
Parent/Guardian	**Phone**	**Date**	**E-mail**

Acknowledged and received by:

_____	_____	_____	_____
School Nurse	**Phone**	**Date**	**E-mail**

SPECIAL DIETARY PRESCRIPTION

(Breakfast, Lunch, Snacks)

Student's Name (Last, First, Middle Initial) _____ Age _____ School _____

Grade Level _____ Teacher _____ Parent's Phone Number _____

This student has a ☐ **DISABILITY** or a ☐ **MEDICAL CONDITION** that requires the student to have a special diet. The major life activity affected by the student's disability is:

_____

_____

Foods to be omitted	Foods to be substituted
_____	_____
_____	_____
_____	_____
_____	_____

Food texture adjustment: _____

_____

Special eating equipment needed: _____

Name of Dietitian/Licensed Nutritionist _____ Dietitian/Licensed Nutritionist's Phone number _____

Printed Name of Physician _____ Signature of Physician _____

Physician's Phone Number _____ Physician's License Number _____

Date Form Completed _____ Date Completed Form Received and Initials of APS Person Receiving the Form _____

Alamogordo Public Schools
Health Services

Diabetes Care Packet
MEDICATION CONSENT FORM

Name of Student _____

I give my permission for the school nurse to supervise the administration of the medication(s) prescribed by my doctor and listed below. I give consent for the registered nurse to consult the physician regarding these orders, if necessary, and I will be notified.

I understand that it is essential that the school nurse (registered nurse) be notified of all students taking medications at school. Because the school nurse is not always available to give the medications required by all the children, the principal will authorize another school employee to supervise the actual administration of the medication in the absence of the registered nurse.

I understand that it is my responsibility to provide this medication in a container that is properly labeled. Prescription drugs will require the original bottle/box with pharmacy label. Over the counter medications will require the original bottle with the label. I understand that it is my responsibility to bring the medication to the health office and to pick up medications as needed/required.

_____
Parent/Guardian Signature

Date: _____

TO BE COMPLETED BY THE PHYSICIAN:

It is necessary that _____ receive the below listed medication(s) during school hours:

MEDICATION	DOSAGE	TIME	REACTIONS
INSULIN			
GLUCAGON			

SPECIAL INSTRUCTIONS:

If the AM dose is missed, it may be given as needed, with parent/guardian consent

- ☐ **Student has been instructed on the proper use of Glucometer**
- ☐ **Additional comments: _____**

_____
Physician's Signature

Date: _____

Telephone Number: _____

Order and computer / medication sheets reviewed by school nurse:

_____ _____

Signature **Date**

CONSENT TO EXCHANGE/RELEASE CONFIDENTIAL INFORMATION

Student Name:_____ DOB_____ Date Sent/Mailed_____

This consent for exchange/release of confidential information is for the exchange/release between the school district and the third party of the above-named student's record(s)/confidential information including health information, as follows:

_____	_____
NAME OF SCHOOL PERSONNEL	**THIRD PARTY**
ALAMOGORDO PUBLIC SCHOOLS	
ADDRESS: 1211 Hawaii Avenue	**ADDRESS:**_____
Alamogordo, NM 88310	_____
Phone: 575-812-6095 FAX: 575-812-6099	**FAX:** _____

PURPOSE OF EXCHANGE/RELEASE:

☐ **Special Education Department** ☐ **504 Section Accommodation** ☐ **Other**
☐ **Student Assistant Team** ☐ **Health Care Plan** ☐ **Behavioral Plan**

Records/Information to be Exchanged/Released These records/information to be exchanged/released are protected by the Family Educational Rights and Privacy Act (FERPA)	Records/Information to be Exchanged/Released These records/information to be exchanged/released may include health information protected by the Health Insurance Portability and Accountability Act (HIPAA)
By the School District:	**By the Third Party:**
___Cumulative records ___Student Assistance Team Records ___Observations ___Grade Reports ___Behavior reports ___Attendance Records ___School health records ___ Two-way verbal communication ___Specialty education records (if evaluated/served in special education) ___Other_____	___Medical Records ___Physical Therapy records ___Occupational Therapy records ___Speech Therapy records ___Evaluations ___All counseling records ___All psychological/psychiatric records ___Two-way Communication ___Other_____

If permission is granted, the third party to whom information is disclosed may not disclose the information to any other party without the prior consent of the parent or eligible student.

Please respond to each statement with a **Yes** or **No** and sign at the bottom.

☐ ☐ I have been fully informed of the record(s) and information to be disclosed, the purpose of the disclosure, and the parties who will be exchanging.
Yes **No**

☐ ☐ I give my consent for the exchange/release of confidential information.
Yes **No**

☐ ☐ I understand that my consent for the exchange/release of confidential information is voluntary and may be revoked at any time. However, that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked).
Yes **No**

☐ ☐ The information provided to me has been provided in my native language or other mode of communication. If other than English, specify_____.
Yes **No**

_____ _____ _____ _____
Signature of Parent/Guardian **Date** **Signature of Interpreter, if used** **Date**

Alamogordo Public Schools
Health Services

DIABETES CARE PACKET

Student Name _____ Month of _____

Date	Time	Results (BS)	Action (ie. snack, insulin)	Disposition

MEDICAL WAIVER AND RELEASE FOR GLUCAGON

We, _____and _____
Are the parents/legal guardians of _____ who is a student enrolled in the Alamogordo Public School System. Our child is a diabetic who may become hypoglycemic while he/she is at school. We understand that she/he may require the administration of glucagons intramuscularly quickly when he/she becomes hypoglycemic and that he/she may suffer adverse consequences if he/she does not receive glucagons immediately upon becoming hypoglycemic.

We request that school personnel volunteers be trained in accordance with the established protocols to administer glucagons to our child when necessary. We further agree that we will not hold liable either the trained volunteers or Alamogordo Public Schools or its agents or employees for administering glucagons or taking any other emergency action to assist our child in the event that he/she becomes hypoglycemic and requires emergency assistance.

_____ Date _____
Parent

_____ Date _____
Parent

_____ Date _____
Alamogordo Public Schools

_____ Date _____
Trained Volunteer