Tempe Union High School District
Request for Medical Documentation – Diabetes

Student:
Student ID:

Date:

Dear Parent/Guardian,

Attached are forms for your student for the upcoming school year. New forms are required each school year. The forms attached are:

1. Diabetes History form, to be filled out by the parent
2. Diabetic Release, to be filled out by your licensed health care provider
3. Consent for Medication Administration Form, to be filled out by the parent and your licensed health care provider
4. List of supplies needed to appropriately care for your student.

Other Forms:

1. Diabetes Medical Management Plan, to be provided by and filled out by your licensed health care provider

Please complete the Consent for Medication Administration Form. Students are allowed to carry emergency diabetes medications in school, if the licensed health care provider and parent deems them capable of doing so. These medications can also be kept in the health office.

A meeting can be set up for the start of the school year for training regarding your student's health care needs. All required paperwork and supplies needed for the care of your student must be brought to school at that time.

Feel free to contact your school health office with any questions.

Thank you,

Tempe Union High School District
DIABETES HISTORY FORM

Instructions: Complete and return form to the school health office

Student Name ____ DOB ____________________

Student ID ____ Date ____________________

1. What type of diabetes has your student been diagnosed with? When was your student diagnosed?

____

2. How is your student's insulin delivered (i.e. syringe, pen, pump)?

____

3. Will your student be eating school lunch, or will you provide lunches from home?

____

4. Will your student be riding the bus? ☐ No ☐ Yes If yes, the health assistant will share a copy of the standard bus care plan.

____

5. Will your student be taking a culinary class? ☐ No ☐ Yes

____

6. Is your student currently taking any medication needed during the school day? ☐ No ☐ Yes If yes, list name, dosage, and how often your student takes this medication. **A Consent for Medication Administration form must be on file.**

____

Parent/Guardian Signature: ____ Date: ____________________

TEMPE UNION HIGH SCHOOL DISTRICT
DIABETIC RELEASE

Student Name ____ DOB__________________

Student ID ____ Date __________________

The above named student may treat his or her own low or high blood sugar, calculate and administer his or her own insulin on school campus, field trips, and school activities off school campus with no supervision of school personnel, and is demonstrated as competent to do so.

Per ARS 15-344.01, if the student is deemed unable to practice proper safety precautions for the handling and disposal of the equipment and medications, the school district reserves the right to withdraw the student's authorization to monitor blood glucose and self-administer diabetes medication.

When diabetes care is done outside of the health office, diabetes care supplies (i.e. syringes, lancets, any item containing blood) must be properly disposed of.

Diabetes Supply Disposal Plan (i.e. store in container and brought home, brought to health office for disposal, placed in parent provided sharps container)

____

Healthcare Provider's Signature ________________________________Date____________

Parent/Guardian Signature ____________________________________Date____________

Student's Signature ____Date______

School Nurse Signature ____Date_____

Is there Glucagon in the health office for emergencies? (If yes, please complete Consent for Medication Administration Form)

Yes ______ No ______

Is your student carrying Glucagon on their person for emergencies? (If yes, please complete Consent for Medication Administration Form)

Yes ______ No _____

TEMPE UNION HIGH SCHOOL DISTRICT
Consent for Giving Prescription and Non-Prescription Medications at School
School Year ________ to ________

Student Name ____

School ______________________________ **Student ID** ______________________

Medication must be delivered to school in the original container with the label intact.

The medication is to be given in the following manner:

Name of Medication: ____

Strength of Medication: ____

Amount to be Given: ____

Time of Administration at School: ____

Route of Administration (by mouth, etc.):____

Comments and/or Instructions: ____

Reason for Medication: ____

Date Medication is to be discontinued: ____

☐ Student may self-carry and self-administer their medication (**Valid only for diabetes, asthma, and anaphylactic reactions. Students may not carry any other medications.**)

Healthcare Provider Name: ______________________ **Phone No.** ________________
(Please print)

____
Healthcare Provider Signature **Date**

I hereby request and my consent for the School Nurse or person designated by the School Administration to give my child medication prescribed by the below listed licensed health care provider. **I acknowledge that it may be necessary for the assistance in administration of medication to my child to be performed by an individual other than a nurse, and specifically consent to such practice.**

I understand the law provides that there shall be no liability for civil damages as a result of the assistance in administration of such medication and/or treatment where the person assisting in the administration of such medication and/or treatment acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I understand my child's medication is to be presented to a school representative by an adult. I will assume full responsibility for the supply, appropriate transportation and maintenance of above medication. If any changes in medication or dosage occur, the school must be notified immediately, and a new form must be completed. I give permission for the exchange of information directly with the healthcare provider regarding my child's medication. **Any medications not picked up by the last day of school by the student's parent/guardian, or other designated adult, will be destroyed.**

____
Parent/Guardian Home Phone # **Parent/Guardian Work Phone #**

____
Parent/Guardian Signature **Date**

Tempe Union High School District

Diabetes Supply List

1. Insulin
2. Pump supplies (if applicable)
3. Glucometer
4. Glucometer test strips
5. Lancet and Lancet supplies
6. Ketone Strips
7. Glucagon
8. Fast Acting Carbohydrate Snacks, including Glucose Tabs
9. “Free Carb” snacks – snacks students can eat without insulin administration
10. Lock Down Safety kit for multiple classrooms
11. Bottled water

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Diabetes Medical Management Plan (DMMP)

This plan should be completed by the student's personal diabetes health care team, including the parents/guardians. It should be reviewed with relevant school staff and copies should be kept in a place that can be accessed easily by the school nurse, trained diabetes personnel and other authorized personnel.

Date of plan: ____________________ This plan is valid for the current school year: __________-__________

Student information

Student's name: ____ Date of birth: _________________________

Date of diabetes diagnosis: ________________________ ☐ Type 1 ☐ Type 2 ☐ Other: ________________________

School: ____ School phone number: _________________________

Grade: __________________________ Homeroom teacher: ____

School nurse ____ Phone: ____________________________

Contact information

Parent/guardian 1: ____

Address: ____

Telephone: Home: ___________________________ Work: ________________________ Cell: ____________________

Email address: ____

Parent/guardian 2: ____

Address: ____

Telephone: Home: ___________________________ Work: ________________________ Cell: ____________________

Email address: ____

Student's physician/health care provider: ____

Address: ____

Telephone: ______________________________________ Emergency number: __________________________________

Email address: ____

Other emergency contacts:

Name: ____ Relationship: ______________________________________

Telephone: Home: ___________________________ Work: ________________________ Cell: ____________________

Checking blood glucose

Brand/model of blood glucose meter: ____

Target range of blood glucose:

Before meals: ☐ 90–130 mg/dL ☐ Other: ____________________

Check blood glucose level:

☐ Before breakfast ☐ After breakfast ☐ _____ Hours after breakfast ☐ 2 hours after a correction dose

☐ Before lunch ☐ After lunch ☐ _____ Hours after lunch ☐ Before dismissal

☐ Mid-morning ☐ Before PE ☐ After PE ☐ Other: __________________

☐ As needed for signs/symptoms of low or high blood glucose ☐ As needed for signs/symptoms of illness

Preferred site of testing: ☐ Side of fingertip ☐ Other: _______________________

Note: The side of the fingertip should always be used to check blood glucose level if hypoglycemia is suspected.

Student's self-care blood glucose checking skills:

☐ Independently checks own blood glucose

☐ May check blood glucose with supervision

☐ Requires a school nurse or trained diabetes personnel to check blood glucose

☐ Uses a smartphone or other monitoring technology to track blood glucose value

Continuous glucose monitor (CGM): ☐ Yes ☐ No Brand/model: ______________________________________

Alarms set for: Severe Low: _____________ Low: ________________ High: _______________

Predictive alarm: Low: ____________ High: ___________ Rate of change: Low: ____________ High: _____________

Threshold suspend setting: ____

CGM may be used for insulin calculation if glucose is between ___-___ mg/dL ___Yes ___No

CGM may be used for hypoglycemia management ___ Yes ___ No

CGM may be used for hyperglycemia management ___ Yes ___ No

Additional information for student with CGM

- Insulin injections should be given at least three inches away from the CGM insertion site.
- Do not disconnect from the CGM for sports activities.
- If the adhesive is peeling, reinforce it with approved medical tape.
- If the CGM becomes dislodged, return everything to the parents/guardians. Do not throw any part away.
- Refer to the manufacturer's instructions on how to use the student's device.

Student's self-care CGM skills	Independent?	
The student troubleshoots alarms and malfunctions.	☐ Yes	☐ No
The student knows what to do and is able to deal with a HIGH alarm.	☐ Yes	☐ No
The student knows what to do and is able to deal with a LOW alarm.	☐ Yes	☐ No
The student can calibrate the CGM.	☐ Yes	☐ No
The student knows what to do when the CGM indicates a rapid trending rise or fall in the blood glucose level.	☐ Yes	☐ No

The student should be escorted to the nurse if the CGM alarm goes off: ☐ Yes ☐ No

Other instructions for the school health team:

____

____

Hypoglycemia treatment

Student's usual symptoms of hypoglycemia (list below):

____

____

____

If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than ______ mg/dL, give a quick-acting glucose product equal to ______ grams of carbohydrate.
Recheck blood glucose in 15 minutes and repeat treatment if blood glucose level is less than _______ mg/dL.

Additional treatment:

____

____

If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movement):

- Position the student on his or her side to prevent choking.
- Administer glucagon Name of glucagon used: ___________________________

Injection:

☐ 1 mg ☐ ½ mg ☐ Other (dose) __________________________

- Route: ☐ Subcutaneous (SC) ☐ Intramuscular (IM)
- Site for glucagon injection: ☐ Buttocks ☐ Arm ☐ Thigh ☐ Other: _____________

Nasal route:

☐ 3 mg

- Route: ☐ Intranasal (IN)
- Site: ☐ Nose

- Call 911 (Emergency Medical Services) and the student's parents/guardians.
- Contact the student's health care provider.
- If on insulin pump, stop by placing mode in suspend or disconnect. Always send pump with EMS to hospital.

Hyperglycemia treatment

Student's usual symptoms of hyperglycemia (list below):

____

____

____

- Check ☐ Urine ☐ Blood for ketones every _____ hours when blood glucose levels are above _____ mg/dL.
- For blood glucose greater than _______ mg/dL AND at least _____ hours since last insulin dose, give correction dose of insulin (see correction dose orders).
- Notify parents/guardians if blood glucose is over _________ mg/dL.
- For insulin pump users: see **Additional Information for Student with Insulin Pump.**
- Allow unrestricted access to the bathroom.
- Give extra water and/or non-sugar-containing drinks (not fruit juices): _____ ounces per hour.

Additional treatment for ketones: ____

- Follow physical activity and sports orders. (See **Physical Activity and Sports**)

If the student has symptoms of a hyperglycemia emergency, call 911 (Emergency Medical Services) and contact the student's parents/guardians and health care provider. Symptoms of a hyperglycemia emergency include: dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy or depressed level of consciousness.

Insulin therapy

Insulin delivery device:

☐ Syringe ☐ Insulin pen ☐ Insulin pump

Type of insulin therapy at school:

☐ Adjustable (basal-bolus) insulin ☐ Fixed insulin therapy ☐ No insulin

Adjustable (Basal-bolus) Insulin Therapy

- **Carbohydrate Coverage/Correction Dose:** Name of insulin: ____________________________________
- **Carbohydrate Coverage:**

  Insulin-to-carbohydrate ratio:

  Breakfast: 1 unit of insulin per _____ grams of carbohydrate

  Lunch: 1 unit of insulin per _____ grams of carbohydrate

  Snack: 1 unit of insulin per _____ grams of carbohydrate

Carbohydrate Dose Calculation Example		
Total Grams of Carbohydrate to Be Eaten / ***Insulin-to-Carbohydrate Ratio***	**=**	______ ***Units of Insulin***

Correction Dose: Blood glucose correction factor (insulin sensitivity factor) = ______
Target blood glucose = ______mg/dL

Correction Dose Calculation Example		
Current Blood Glucose – Target Blood Glucose / ***Correction Factor***	**=**	______ ***Units of Insulin***

Correction dose scale (use instead of calculation above to determine insulin correction dose):

Blood glucose ______ to _____ mg/dL, give ______ units Blood glucose ______ to _____ mg/dL, give ______ units
Blood glucose ______ to _____ mg/dL, give ______ units Blood glucose ______ to _____ mg/dL, give ______ units

See the worksheet examples in **Advanced Insulin Management: Using Insulin-to-Carb Ratios and Correction Factors** for instructions on how to compute the insulin dose using a student's insulin-to-carb ratio and insulin correction factor.

Insulin therapy (continued)

When to give insulin:

Breakfast

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and ______ hours since last insulin dose.

☐ Other: _____________

Lunch

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _______ mg/dL and _____ hours since last insulin dose.

☐ Other: _____________

Snack

☐ No coverage for snack

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _______ mg/dL and _____ hours since last insulin dose.

☐ Correction dose only: For blood glucose greater than _______ mg/dL AND at least ______ hours since last insulin dose.

☐ Other: _____________

Fixed Insulin Therapy Name of insulin: ____

☐ _____ Units of insulin given pre-breakfast daily

☐ _____ Units of insulin given pre-lunch daily

☐ _____ Units of insulin given pre-snack daily

☐ Other: _____________

Basal Insulin Therapy Name of insulin: ____

To be given during school hours:

___ Pre-breakfast dose: ____ units

___ Pre-lunch dose: ____ units

___ Pre-dinner dose: ____ units

Other diabetes medications:

Name: _____________________ Dose: __________ Route: ______________ Times given: __________________

Name: _____________________ Dose: __________ Route: ______________ Times given: __________________

Parents/Guardians authorization to adjust insulin dose:

☐ Yes ☐ No Parents/guardians authorization should be obtained before administering a correction dose.

☐ Yes ☐ No Parents/guardians are authorized to increase or decrease correction dose scale within the following range: +/- ______ units of insulin.

☐ Yes ☐ No Parents/guardians are authorized to increase or decrease insulin-to-carbohydrate ratio within the following range: _____ units per prescribed grams of carbohydrate, +/- ______ grams of carbohydrate.

☐ Yes ☐ No Parents/guardians are authorized to increase or decrease fixed insulin dose within the following range: +/- ______ units of insulin.

Student's self-care insulin administration skills:

☐ Independently calculates and gives own injections.

☐ May calculate/give own injections with supervision.

☐ Requires school nurse or trained diabetes personnel to calculate dose and student can give own injection with supervision.

☐ Requires school nurse or trained diabetes personnel to calculate dose and give the injection.

Additional information for student with insulin pump

Brand/model of pump: ________________________________ Type of insulin in pump: _________________________

Basal rates during school: Time: _________ Basal rate: __________ Time: _________ Basal rate: __________

Time: _________ Basal rate: __________ Time: _________ Basal rate: __________

Time: _________ Basal rate: __________

Other pump instructions:

____

____

Type of infusion set: ____

Appropriate infusion site(s): ____

☐ For blood glucose greater than ______ mg/dL that has not decreased within _____ hours after correction, consider pump failure or infusion site failure. Notify parents/guardians.

☐ For infusion site failure: Insert new infusion set and/or replace reservoir, or give insulin by syringe or pen.

☐ For suspected pump failure: Suspend or remove pump and give insulin by syringe or pen.

Physical Activity

May disconnect from pump for sports activities: ☐ Yes, for ______ hours ☐ No

Set a temporary basal rate: ☐ Yes, ______% temporary basal for _____ hours ☐ No

Suspend pump use: ☐ Yes, for _____ hours ☐ No

Additional information for student with insulin pump (continued)

Student's self-care pump skills	Independent?	
Counts carbohydrates	☐ Yes	☐ No
Calculates correct amount of insulin for carbohydrates consumed	☐ Yes	☐ No
Administers correction bolus	☐ Yes	☐ No
Calculates and sets basal profiles	☐ Yes	☐ No
Calculates and sets temporary basal rate	☐ Yes	☐ No
Changes batteries	☐ Yes	☐ No
Disconnects pump	☐ Yes	☐ No
Reconnects pump to infusion set	☐ Yes	☐ No
Prepares reservoir, pod and/or tubing	☐ Yes	☐ No
Inserts infusion set	☐ Yes	☐ No
Troubleshoots alarms and malfunctions	☐ Yes	☐ No

Meal/Snack	Time	Carbohydrate Content (grams)
Breakfast		_______ to _______
Mid-morning snack		_______ to _______
Lunch		_______ to _______
Mid-afternoon snack		_______ to _______

Other times to give snacks and content/amount: ____

____

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event):

____

Parent/guardian substitution of food for meals, snacks and special events/parties permitted.

Special event/party food permitted: ☐ Parents'/Guardians' discretion ☐ Student discretion

Student's self-care nutrition skills:

☐ Independently counts carbohydrates

☐ May count carbohydrates with supervision

☐ Requires school nurse/trained diabetes personnel to count carbohydrates

Physical activity and sports

A quick-acting source of glucose such as ☐ glucose tabs and/or ☐ sugar-containing juice must be available at the site of physical education activities and sports.

Student should eat ☐ 15 grams ☐ 30 grams of carbohydrate ☐ other: __________

☐ before ☐ every 30 minutes during. ☐ every 60 minutes during ☐ after vigorous physical activity

☐ other: ________

If most recent blood glucose is less than _________ mg/dL, student can participate in physical activity when blood glucose is corrected and above __________ mg/dL.

Avoid physical activity when blood glucose is greater than _________ mg/dL or if urine/blood ketones are moderate to large.

(See **Administer Insulin** for additional information for students on insulin pumps.)

Disaster/Emergency and Drill Plan

To prepare for an unplanned disaster, emergency (72 hours) or drill, obtain emergency supply kit from parents/guardians. School nurse or other designated personnel should take student's diabetes supplies and medications to student's destination to make available to student for the duration of the unplanned disaster, emergency or drill.

☐ Continue to follow orders contained in this DMMP.

☐ Additional insulin orders as follows (e.g., dinner and nighttime):

____

____

____

☐ Other: ____

Signatures

This Diabetes Medical Management Plan has been approved by:

____

Student's Physician/Health Care Provider Date

I, (parent/guardian) ____________________________________ give permission to the school nurse or another qualified health care professional or trained diabetes personnel of (school) ___________________ to perform and carry out the diabetes care tasks as outlined in (student ________________________ Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified health care professional to contact my child's physician/health care provider.

Acknowledged and received by:

____

Student's Parent/Guardian Date

____

Student's Parent/Guardian Date

____

School Nurse/Other Qualified Health Care Personnel Date

This form was developed by the American Diabetes Association.

October 2019