Physician ☐
Parent ☐

Bullitt County Public Schools

1040 Highway 44 East
Shepherdsville, Kentucky 40165

502-869-8000
Fax 502-921-9467
www.bullittschools.org

DIABETES PARENT PACKET

Dear Parent and/or Guardian;

I am sending home forms that will be used by school personnel in caring for your child's medical needs during the 2020-2021 school year. Attached is a diabetes school action plan and medication permission form that will need to be completed **in full** with physician signature prior to bringing the medication to school.

Students are allowed to carry their diabetes supplies if the following conditions are met:

- **Physician/Parent Authorization Form is complete and on file at school each school year;**
- **Medication Permission Form is complete and on file at school;**
- **Primary Care Provider has instructed student in self-administration of the student's prescribed medication to treat the diabetes and is confirmed with physician signature that student is to keep supplies on person.**

When students self-administer medication, the school staff will NOT be responsible for monitoring frequency of use, expiration date, or amount of medication available for use.

As our policy 09.2241 states, " All prescription medication, original or refill, shall be brought to school in the most current pharmacy labeled container which includes the student's name, date, medication, dosage, strength, and directions for use including frequency, duration, and mode of administration, prescriber's name, pharmacy name, address and phone number. Labels that have been altered in any way shall not be accepted."

GLUCAGON: If provided, the medication form must be completed for both Insulin and glucagon. If not provided, please just mark through that portion of the medication form and write "NA". It is preferred that Glucagon be kept in school office at all times. *Please contact me if other arrangements are needed*.

SNACKS: Emergency snacks must be readily available to the student at all times which shall be provided by the parent/guardian. Scheduled snacks will need to be ordered by the physician.

PUMPS: On the advice and direction given by the local endocrinology physician group, all blood sugar checks will be entered into the pump and advance settings will require additional orders. Please clarify with your physician what your child will need and outline that on the forms provided.

Please remember that the schools are not to administer any medication and your child is not to carry any medication without proper paperwork and signatures on file. We appreciate your understanding and cooperation with this policy.

Sincerely,

Lesa A. Howell, RN

Lesa A. Howell, R.N. B.S.N.
District Health Coordinator
Bullitt County Public Schools

Bullitt County Public Schools Health Service
Primary Care Provider Authorization: Diabetes

Name: _____ Date of Birth: _____ School: _____ School Year: _____

DIAGNOSIS: □ Type I Diabetic □ Type II Diabetic **Management:** □ GOOD □ FAIR
□ Pre-Diabetes □ Other Condition requiring Glucose Monitoring
DIET: □ No Concentrated Sweets □ Carbohydrate Counting; _____ Carbs/Meal □ Other _____
SCHEDULED SNACKS: □ NO □ YES, □ Mid-Morning □ Mid-Afternoon If yes, is insulin required? □ YES □ NO
SPECIAL EVENT/PARTY FOODS: □ Parent/Guardian Discretion □ Student Discretion
****PARENTS MUST PROVIDE SNACKS AND EMERGENCY SUPPLIES*
EXERCISE: □ Unrestricted □ Restricted (Specify): _____

Blood Sugar (glucose) monitoring/testing:

1. Does this student need assistance/supervision to perform the blood glucose test? □ YES □ NO
2. Should blood glucose monitor and equipment be: □ kept with child □ kept in front office □ kept in classroom by teacher
3. When should monitoring be done?
   □ Before lunch □ Before Snacks □ Before Exercise □ After Exercise □ Before Dismissal
   □ As needed to determine hypoglycemia or hyperglycemia □ Other (Specify):_____
   *** Please note, if a student has a pump, blood sugar must be entered into the pump every time it is checked. ***

Child's target blood sugar?
□ 100-180 (0-5 years) □ 90-180 (6-12years) □ 90-130 (13+ years) □ Other _____

Insulin Requirements:

1. Student requires insulin during school: □ **YES** □ **NO**
2. Student requires assistance/supervision with insulin administration: □ **YES**, (medication will be kept in office) □ **NO**
3. Student calculates carbohydrates without supervision**:** □ **YES** □ **NO**
4. Student calculates insulin dose without supervision: □ **YES** □ **NO**
5. Student to receive insulin: □ **Before Lunch** □ **After Lunch**
6. Student has insulin pump: □ **YES**, parent to supply insulin pen for emergency □ **NO**
7. Student manages pump without supervision: □ **YES** □ **NO**

If no, please provide any special precautions/instructions/advance settings for school setting and specifically if/when pump may be disconnected: _____
_____
Should insulin dose calculations be rounded? □ **YES** □ **NO** □ Half Unit □ Whole Unit
If blood glucose meter reads "High" dose insulin on a blood sugar of 600 □ **YES** □ **NO**, use _____ reading.

Insulin Type: _____ (must complete medication form 09.2241 AP.21) □ Syringe □ Insulin pen □ Pump

Dose: ____ unit per ____ grams of carbohydrate
____ unit per ____ grams of carbohydrate at snack ≥ _____ carbohydrate

Low Blood Glucose Correction: If BG < ____ mg/dl, give insulin after the meal or snack
High Blood Glucose Correction: IF BG > ____ mg/dl, give ___ unit per ____ mg/dl > ____ mg/dl
** NOTE: Correct for high blood glucose every _____ hours.
Correct for high blood glucose when pump recommends ____ *(MD initials)*

Student to check urine ketones (at school) □ **NO** □ **YES,** for blood sugar greater than_____ (Parents provide Ketone Strips)
If positive: Give additional insulin as follows: SM __ unit/ MOD __ unit/ LG __ unit (Parents must be notified)
NOTE: Do not correct for ketones more often than every 4 hours

School use only:

GLUCAGON LOCATION: □ not provided □ office □ to and from home in student's kit
□ _____

HYPOGLYCEMIA (low blood sugar)

Please circle usual symptoms

SIGNS & SYMPTOMS: •hunger •staring •becoming very quiet •pale •headache •unable to think clearly •weak •combative •unusually sleepy •shaky •clammy sweat •confused or disoriented •dizzy •pounding heart •stumbling around •nervous •blurry vision •change in personality •restless •crying

LOW BLOOD SUGAR FOR THIS CHILD REQUIRING INTERVENTIONS IS ≤ _____

1. Give 15 grams of simple sugar if able to swallow (**one** of the following):
   - •1/2 cup (4 oz) regular soft drink • 15 skittles • 1 small tube of Cake mate icing gel
   - •1/2 cup (4 oz) juice • 12 Sweet Tarts • 3-5 small sugar cubes
   - •3-4 glucose tablets • 2-3 rolls of smarties • 2-3 packs of table sugar
2. Re-test blood glucose in 15 minutes, if remains < 70 mg/dl repeat the 15 gram simple carbohydrate.
3. Continue the 15 grams of simple carbohydrate snack every 15 minutes until blood glucose level rises above 70mg/dl
4. Once blood glucose rises above 70mg/dl, follow immediately with a 15 gram carbohydrate snack:
   - • 4 peanut butter or cheese crackers • ½ sandwich • 1 small bag of pretzels **OR** LUNCH
5. Recheck blood sugar 30 minutes after initial treatment
6. Call parent/guardian if blood sugar does not rise above 60 after two treatments
7. Delay exercise and exams if blood glucose is below 90mg/dl – Allow for complete recovery.
8. OTHER (SPECIFY): _____
9. Does this student have **Glucagon** ordered? ☐ YES ☐ NO

NEVER SEND A CHILD TO THE OFFICE ALONE IF HAVING SYMPTOMS OF LOW BLOOD SUGAR

EMERGENCY PLAN OF ACTION

Emergency Glucagon: Given only if ordered for a student when that student is having a **seizure, unconscious or severely neurologically impaired** related to severe hypoglycemia or low blood sugar. Glucagon kits are to be provided by the parent/guardian.

1. Call EMS 911. (Administer glucagon if provided – lay child on side)
2. Notify school personnel trained in CPR/first aid to respond and initiate CPR if needed prior to EMS arrival.
3. Contact parent/guardian or emergency contact immediately.
4. If EMS is called the student must be transported via EMS to emergency facility, or parent/guardian must sign release with EMS and then parent/guardian assumes responsibility for student. The student may not return to school that day.
5. When student is transported via EMS, BCPS staff must ride with student unless parent and/or emergency contact accompanies them.
6. If student requires medical treatment while on the bus, the driver will contact EMS.
7. If student has insulin pump, position child on side, place pump in suspend/stop mode or disconnect/cut tubing.

HYPERGLYCEMIA (high blood sugar)

Please circle usual symptoms

SIGNS & SYMPTOMS: • dry mouth • increased urination •sores or infections that will not heal • thirsty • loss of appetite • poor attention span • sleepy/tired • dry, itchy skin • headache

*** If symptoms persist – can lead to nausea, vomiting, stomach pain, fruity smelling breath

HIGH BLOOD SUGAR FOR THIS CHILD REQUIRING THE FOLLOWING INTERVENTIONS IS ≥ _____

1. Encourage extra water: ___ounces per hour and recheck blood sugar every hour until < ____mg/dl
2. Allow frequent trips to the restroom.
3. Do not participate in PE or sports for the following: _____
4. Ketone Monitoring: _____
5. Call parent/legal guardian for blood sugar > ____ for further instructions
6. OTHER (SPECIFY): _____

_____ **(*MD INITIALS*) PHYSICIAN ORDER FOR INDEPENDENT MANAGEMENT AT SCHOOL**: I, this student's physician, give authorization for this student to check his/her own blood sugar, calculate his/her own carb intake, then determine and administer the appropriate amount of insulin INDEPENDENTLY. He/she must carry his/her diabetic supplies with them at all times, including on field trips, during before and after school events and while participating in school sponsored athletic events. I understand that if a student is deemed independent on the aforementioned procedures, the school nurse or trained personnel is not required to oversee the student's actions, but will be available for emergencies.

_____ **(*PARENT INITIALS*)** Being the parent/guardian of the above named student, I give consent for the information on this form to be shared with school personnel having direct contact with my child for the current school year. I understand that a trained staff member may administer prescribed medication and/or assist my child to comply with his/her physician's prescribed medications or treatments if needed. If my child's physician gives authorization for my child to carry and self-administer his/her medication, I consent and understand that medication independently self-administered is not monitored by school staff. I agree to provide the necessary prescribed medication or treatment supplies and agree to notify the school nurse immediately of any changes. If medication is to be on student's person, the parent/guardian agrees the medication will be carried in a secure, protective container and that the medication will be labeled with the student's name.

The school nurse shall contact the student's Parent/Guardian to discuss any concerns regarding the student's care which might require medical follow-up and/or shall contact the health care provider to obtain current information verbally when necessary to manage the student's condition at school. I hereby agree to release and hold BCPS free and harmless for any claims, demands, or suits for damages from any injury /complication that may result from such treatment described by me or prescribed by my child's physician.

✕**Parent/Guardian Signature** _____ **Date** _____

✕**Physician Signature** _____ **Date** _____

Permission Forms for Medication

PHYSICIAN AUTHORIZATION FOR MEDICATION FORM

Student's Name: _____ Grade: _____ Age: _____ Date of Birth: _____/_____/_____

School: _____

COMPLETED BY THE PARENT/GUARDIAN AND HEALTH CARE PROVIDER

Procedure 09.2241 AP.1 – Medication shall be in the original container, dated upon receipt. Prescribed medication/self-administration/over-the-counter medication needed for longer than three (3) days requires a parent/guardian and Health Care Provider to complete the required form.

Name of Medication: _____	**Name of Medication: _____**
Reason: _____ Stop date: ___/___/___ or End of School Year	**Reason: _____ Stop date**: ___/___/___ or End of School Year
Time to be given: _____ Dose _____MG/ML/PUFFS/UNITS (please circle one)	**Time to be given: _____ Dose _____MG/ML/PUFFS/UNITS (please circle one)**
Signs and symptoms of emergency administration: _____	Signs and symptoms of emergency administration: _____
Restriction and/or important side effects: _____	Restriction and/or important side effects: _____
* Student must self-carry medication on his/her person and may self-administer. (Student will hold medication on their person for self-administration or for immediate access of school trained personnel.) ☐ Yes **(*MD to initial below)** ☐ No	* Student must self-carry medication on his/her person and may self-administer. (Student will hold medication on their person for self-administration or for immediate access of school trained personnel.) ☐ Yes **(*MD to initial below)** ☐ No
SPECIFIC TO FIELD TRIPS ONLY: *(*Please check 1 box*)* ☐ Trained personnel to assist student to self-medicate. (School personnel will hold medication until dosing time)	***SPECIFIC TO FIELD TRIPS ONLY:*** *(*Please check 1 box*)* ☐ Trained personnel to assist student to self-medicate. (School personnel will hold medication until dosing time)
☐ * Student to self -carry and may self-administer. (Student will hold medication on their person for self-administration or for immediate access of school trained personnel) **(*MD to initial below)**	☐ * Student to self -carry and may self-administer. (Student will hold medication on their person for self-administration or for immediate access of school trained personnel) **(*MD to initial below)**
☐ Student requires medication to be administered (School personnel will hold medication and administer)	☐ Student requires medication to be administered (School personnel will hold medication and administer)

PROVIDER SIGNATURE FOR ALL MEDICATIONS

_____ ___/___/___ Physician Practice name: _____

Physician/Health Care Provider Signature Date

Address: _____

Phone: (___) _____ Fax: (___) _____

***FOR SELF CARRYING/ SELF ADMINISTRATION ONLY**

_____***(MD INITIALS)** The above-named student has been instructed on the care, storage, dosage, and use (up to/and including getting help of trained personnel if student feels they are unable to administer the medication safely/effectively in an emergency situation) of the above medication(s) and has sufficient knowledge and ability to self-carry / self-administer the medication(s) in the school setting and while on field trips.

PARENT AUTHORIZATION FOR ABOVE LISTED MEDICATIONS

I give permission for _____ to receive the above medication(s) at school according to
Student's Name
standard school policy and expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration or lack of administration of the above medication. For on-going medications, I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable orders from a physician or health care provider to be followed.

Date: _____ *Signature:*_____*Relationship:* _____

Home Phone: _____ *Work Phone* _____ *Emergency Phone* _____

I/we reviewed the statement and authorization for completion. ***Administrator/designee*** _____ Date ___/___/___

Consent Form for Mutual Exchange of Information

Student's Name: _____Date: _____

Date of Birth: _____ Social Security Number: XXX-XX-_____

Parent/Guardian: _____

Address: _____

I, the parent/guardian of the above-named student, hereby authorizes the mutual exchange of information including use and/or disclosure of protected health information and educational records between the Bullitt County Public School's District Health Coordinator and the physician, individual or organization listed below.

Physician, Individual, or Organization Name: _____

Address: _____Phone #: _____

The information will be used or disclosed upon request for the following purposes:

□ Developing a medical plan for the student at school.
□ Assessing the need for a medical transfer.
□ Assessing the need for the student to access the Home Hospital Program.
□ Addressing issues related to the student missing school/excessive absences.

Please allow consultation and/or forward documents to Bullitt County Public Schools:

□ Addressing medical needs related to treatment for the following condition or injury _____ on or about _____.
□ Including medical records covering the period of time _____ to _____.
□ Reviewing or requesting any and all progress notes, care plan notes, and/or discharge notes to assess student needs, covering the period of time _____ to _____.
□ Other: _____

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the named physician/practice/organization and the Bullitt County Public Schools. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that if my healthcare provider is asking to use/disclose my information, I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, enrollment in any health plan, or payment/benefit eligibility. I may inspect or copy any information used/disclosed under this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires on the following date or event: June 30, 2021

I certify that I have received a copy of this authorization. I further certify that I am the parent or legal guardian of the above-named student or that I am the student of majority age and have the authority to sign this release.

_____ _____ _____

Signature Relationship Date

34 CFR SEC 99.30 (Federal Family Educational Rights and Privacy Act of 1974) allows the release of certain records to third parties when:

1. Written consent is obtained from the parent, guardian, or student of legal age.
2. Written consent must: a. Specify the records to disclose. b. Purpose of disclosure. c. Identify whom disclosure made.
3. When disclosure is made: a. Parent or eligible student to receive a copy of records, if desired. b. Student to be provided a copy of the records disclosed, if parent requests.
4. Signed and dated written consent may include signature in electronic form if person is identified, authenticated and person's approval indicated.