"We Inspire and Empower Learners"

NSG-203A
Rev. 01-2016

NORTH ROYALTON CITY SCHOOLS
6579 Royalton Road
North Royalton, Ohio 44133

DIABETES PACKET

Dear Parent/Guardian:

You have indicated that your child has Diabetes. Please complete the attached **SCHOOL DIABETIC RECORD and DIABETIC HEALTH CARE PLAN. If your doctor chooses to provide his/her own medical order form, please provide a copy, including parent signature, as well.** Return all forms as soon as possible to the school's clinic. The information will only be shared with the appropriate personnel. This information that you provide will help to ensure the health and safety of your child.

To ensure your child's well-being, please provide the school with the following supplies:

1. Blood glucose meter **(required)**
2. Blood glucose test strips **(required)**
3. Lancets/Lancet Device **(required)**
4. Insulin, Needles, Insulin Pen, Pen Needles **(if applicable)**
5. Insulin pump supplies **(if applicable)**
6. Fast-acting source of glucose (tablets or snacks) **(required)**
7. Extra Batteries for meter **(required)**
8. Urine Ketone Strips **(if applicable)**
9. Glucagon **(if applicable)**

Please inform the school's clinic of any changes in your child's health condition or medication schedule.

Thank you,

Carolyn Baetjer RN

Carolyn Baetjer, R.N., BSN, NCSN
District Health Coordinator
North Royalton City Schools
14709 Ridge Road
North Royalton, Ohio 44133
440.582.9067

"We Inspire and Empower Learners"

NSG-203B
Rev. 01-2016

SCHOOL DIABETIC RECORD

(To be Completed by Parent/Guardian)

Child's Name ____________________________________ Date ______________________________

Parent/Guardians(s) Name ____

Address ____ Home Phone _______________________

City ____ Alternate Phone ____________________

Physician Treating Child's Diabetes ____

Physician's Phone ______________________________

1. When was your child diagnosed with Diabetes? Type I or Type II? Insipidus?

2. Has your child ever been hospitalized because of Diabetes? If yes, when?

3. Can your child test his or her blood sugar level independently? When are blood sugars checked?

4. Is the Diabetes controlled solely by diet? If yes, please describe.

5. Does your child received Insulin injections? If yes, who administers them?

6. Does your child understand the possible side effects of Insulin if he or she does not eat?

7. List all medications that your child takes routinely including dosages, frequency, & side effects?

8. Does your child require a morning or afternoon snack, and if so, what?

9. Does your child experience frequent bouts of low and/or high blood sugar? Please describe.

10. Please list any additional information that will assist with your child's plan of care:

Parent/Guardian Signature _______________________________ Date ____________________

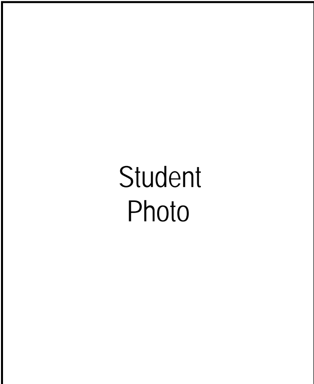
"We Inspire and Empower Learners"

NORTH ROYALTON CITY SCHOOLS
DIABETIC HEALTH CARE PLAN
* CONFIDENTIAL *

☐ Addendum Attached

__________ _____
Received by Date

This form is intended to be used as an addendum to a Section 504 plan, if necessary, or for those students who need diabetes-related support in the school environment but are not eligible under Section 504. Use of this form for 504-eligible students does not eliminate the need for a 504 plan (DSE-504D).



Student Photo

Student ____

Grade/Homeroom ______________________________________

Contact Telephone Numbers in Priority

Call	*Name*	*Tel*	*Location*
1.			
2.			
3.			

Physician ____ TEL ________________

DIAGNOSIS: ☐ DIABETES TYPE I ☐ DIABETES TYPE II ☐ INSIPIDUS

TARGET RANGE OF BLOOD GLUCOSE IS: ☐ 70-150 ☐ 70-180 ☐ Other: ________

Check Blood Glucose:

*Can student perform own blood glucose checks? ☐Yes ☐No

Name of Blood Glucose Meter:________________________________

☐ Before Lunch ☐ After Lunch: ______________________

☐ Before snacks ☐ When he/she feels low/high/or ill

-Please list usual signs for low blood sugar:______________________________

-Please list usual signs for high blood sugar:______________________________

Treatment of Low Blood Glucose:

☐ Student may treat "low" with food according to schedule:

If blood glucose is less than 70, give ____

If blood glucose is less than 50, give ____

☐ Retest blood glucose 15 minutes after treating "low."

CALL PARENT WHEN BLOOD GLUCOSE IS LESS THAN ________

Snacks are located (check all that apply):

☐ in clinic
☐ in classroom
☐ other ______________________

____

Does student require Glucagon? ☐ Yes ☐ No
Glucagon dose:____
May student self-carry Glucagon? ☐ Yes ☐ No
Circumstances under which Glucagon should be administered: ___________________________________

____

***IF GLUCAGON IS REQUIRED, ADMINISTER IT PROMPTLY; CALL 911, then PARENTS/GUARDIANS**

Name and Type of Insulin

Name of Insulin:____________________________ Type: ______________________________

Treatment of High Blood Glucose (2 options):

Option 1: Parental authorization should be obtained before administering a correction dose for high blood glucose levels: ☐

Option 2: Use Insulin Correction Doses for High Blood Sugar listed below: ☐

******Call parent and/or doctor when blood glucose is greater than __________.**

Can student draw correct dose and give own injection? ☐ Yes ☐ No
Comment(s):____

____

☐ Insulin Correction Doses for High Blood Sugar

______units if blood glucose is __________ to __________ mg/dl
______units if blood glucose is __________ to __________ mg/dl
______units if blood glucose is __________ to __________ mg/dl
______units if blood glucose is __________ to __________ mg/dl
______units if blood glucose is __________ to __________ mg/dl

☐ Retest blood glucose after treating "HIGH": (When):_______________________________________

☐ Student can retreat "HIGH" blood sugar with Insulin according to the above scale: (When): ________________

☐ Parents are authorized to adjust the Insulin Correction Doses for High Blood Sugar.

☐ Check urine ketones for blood glucose level greater than: __________mg/dl
-Treatment for ketones:____

Insulin Required Prior to LUNCH (2 options):

Option 1: No Insulin is required prior to LUNCH: ☐

Option 2: Use the Insulin Dose listed below prior to LUNCH: ☐

Can student count carbohydrates in meal(s)? ☐ Yes ☐ No

Comment(s):____

____

☐ Insulin Dose prior to Meals

Give ________units of insulin per ________grams of carbohydrates to be eaten at lunch

******If the student's blood glucose is high prior to a meal, should the student COMBINE the Insulin Correction Dose for High Blood Sugar AND the Insulin Dose prior to Meals:** ☐Yes ☐No

Comment(s):____

____

For Students with Insulin Pumps

Type of pump: ______________________ Basal rates: _____ 12 am to _____

_____ _____ to _____

_____ _____ to _____

Type of insulin in pump: ____

Type of infusion set: ____

Insulin/carbohydrate ratio: ___________________________ Correction factor: _______________

Is Student Independent with Pump? ☐ ***Yes*** ☐ ***No***

Meals and Snacks Eaten at School

Must or should the student have a snack(s) during school hours: ☐Yes ☐No

If Yes: When:____

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

☐ Parent must be called ☐ Student can/will make determination

____

Restrictions

Are there any restrictions that the student must follow: ___________________________________

____

Signatures

____ ____________________

Health Care Provider Signature Date

____ ____________________

Health Care Provider Printed Name Phone

I give permission for school personnel to follow this plan, administer medication (if any) and care for my child and contact my physician if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Diabetic Health Care Plan for my child. I also consent to the release of the information contained in this Diabetes Health Care Plan to all staff members 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.

____ ____________________

Parent/Guardian's Signature/Printed Date

____