# REQUEST FOR DIABETES CARE/INSULIN ADMINISTRATION IN SCHOOL

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

| **Name:** | **DOB:** |
|---|---|
| **Medical Insurance** | **(Check one)** ☐ QUEST ☐ Medicaid ☐ Tricare ☐ HMSA-Private ☐ Kaiser-Private<br>Other (specify): _____ ☐ None |

## I. PARENT'S REQUEST AND AUTHORIZATION (Public Health Nursing Services):

I, the undersigned, request and authorize the Department of Education to provide health services to my child with diabetes. I request and authorize release of health information between the school, Public Health Nurse (PHN), prescribing provider, and pharmacist pertinent to my child's condition. **I will provide necessary supplies and equipment**, and notify School Health Aide, School Administrator and consulting PHN if there is a change in my child's health status, or attending provider. (**I have read the instructions on page 2**.)

Parent(s)/Legal Guardian Signature:_____ Date:_____

## II. PARENT'S REQUEST AND AUTHORIZATION (Skilled Nursing Services):

I, the undersigned, request and authorize the Department of Education and nursing personnel to provide health services to my child with diabetes. I request and authorize release of health information between the school, Registered Nurse (i.e. DOH PHN, agency RN), prescribing provider, and pharmacist pertinent to my child's condition. **I will provide necessary supplies and equipment**, and notify DOE and nursing personnel if there is a change in my child's health status, attending provider, or health services in school. (**I have read the instructions on page 2**.)

Parent(s)/Legal Guardian Signature:_____ Date:_____

## III. PROVIDER'S REQUEST

**1. Blood Glucose Testing**
- ☐ Before lunch / meals
- ☐ For suspected hypoglycemia
- ☐ At student's discretion
- ☐ No blood glucose testing at school

Expected blood glucose range while at school:
_____

**2. Hypoglycemia - Refer to EAP**
- ☐ Assistance for all lows
- ☐ OK to use glucose gel inside cheek; if conscious
- ☐ Glucagon * IM ☐ 0.5 mg wt ≤ 44 pounds
  ☐ 1.0 mg wt ≥ 45 pounds

***Must complete Act 207 Glucagon Consent Form**

**3. Hyperglycemia - Refer to EAP**

**If blood glucose is >** _____ **mg/dl:**
- ☐ Check ketones if BS high > 2 hours post carbohydrate consumption
  ☐ Urine ☐ Blood

**If Ketones are** _____ **or greater, then:** _____
- ☐ Other: _____

**4. Meal/Snacks**
- ☐ Adult supervision to assure student eating
- ☐ AM snack time: _____ ☐ PM snack time: _____
- ☐ Other: _____
- ☐ Extra food allowed:
  - ☐ Vigorous exercise
  - ☐ Bus rides over 30 minutes

**5.** ☐ **NO INSULIN ORDER: STUDENT/ PARENT CAN SELF- MANAGE**

**6.** ☐ **Insulin Orders: Provider to complete if student is not able to self-manage.**

**Administration Time:** _____**(to be determined by school)**
- ☐ Before breakfast ☐ Before AM snack
- ☐ Before lunch ☐ PM snack
- ☐ Other: _____

**Insulin administration via:**

Insulin type: _____
- ☐ Syringe and vial ☐ Insulin pen
- ☐ Insulin pump ☐ Other: _____

** **Dosage:**
- ☐ Standard lunchtime dose: _____ units
- ☐ Correction factor based on Blood Glucose:
  - from _____ to _____ = _____ units
  - from _____ to _____ = _____ units
  - from _____ to _____ = _____ units
  - from _____ to _____ = _____ units
  - from _____ to _____ = _____ units
  - from _____ to _____ = _____ units
- ☐ As per pump
- ☐ **1 unit for** _____**carbs**
  Insulin dosage is based on carbohydrate count.
  *Carbohydrate count + insulin calculation shall be the responsibility of parents/legal custodian /student.*

**If insulin dosage adjustment is needed, parent(s)/legal guardian(s) will Instruct the student of change.

**Provider Signature:** _____ **Date:** _____

**Provider Name (type/print):** _____ **Phone:** _____ **FAX:** _____

**Address:** _____ **City:** _____ **Zip:** _____

**The Administrator's initial confirms that the Department of Health PHN's Recommendation form is attached.**

_____ _____
Administrator's Initials Date

☐ **Approved by Agency RN:**

_____ _____
RN's Signature Date

# INSTRUCTIONS
# FOR
# "REQUEST FOR DIABETES CARE AND INSULIN ADMINISTRATION AT SCHOOL"

## GENERAL INSTRUCTIONS (SH 36 DM), SECTIONS I, II:

1. **These instructions pertain to *both* skilled nursing services (SNS) and non-skilled nursing services.**
2. No medication will be stored in the Health Room and no supportive services will be provided without the completion of this form, SH 36 DM (Rev. 4/16). It must be reviewed/approved by registered nurses (RNs) for SNS.
3. Medication must be dispensed by a pharmacist in accordance with HAR § 328-16 (10), in a container labeled "**FOR SCHOOL USE**" with name of student, medication dosage, strength, time of administration, and prescribing provider's name.
4. *Parent(s)/Legal Guardian(s)* is responsible for sending properly labeled medication to school. If there are concerns with getting medication to the school safely, parent(s)/legal guardian(s) should call a school administrator.
   - Send refills in properly labeled container/vial before medication runs out.
   - Provide a picture of your child for the school.
   - Remind child to report to Health Room or nurse (for SNS) at the designated time(s).
5. For any *changes in medication orders(s)* by the prescribing provider, a *new* "Request for Diabetes Care in School" (SH 36 DM) must be processed.
6. This form is good for the current school year and needs to be renewed at the start of each school year.
7. Parent(s)/legal guardian(s) is responsible for obtaining a *new* form *each school year.*

## PROVIDER'S REQUEST INSTRUCTIONS, SECTION III:

1. Complete **ALL** areas of Section III.
2. *All* identified students with diabetes should have Emergency Action Plans (EAPs) for hypoglycemia and hyperglycemia whether able to self-manage or not.
3. Check boxes as applicable:

   Box 1: Note blood glucose testing times.
   Box 2-3: For all students with diabetes whether able to self-manage or not.
   Box 4: Indicate Meal/Snack as needed.
   Box 5: "No Insulin Order" – Student assessed by prescribing provider and deemed capable of self-administration and dosage calculation/adjustment without supervision or with parental supervision. *Skip* box 6 (leave blank).
   Box 6: "Insulin Order" – Complete if student will need glucose monitoring and insulin administration at school at a scheduled time.
   - Carbohydrate counting and insulin calculation is the responsibility of parent(s)/legal custodian/student. Please complete *units per carb*.

4. Sign, date and include contact information.