Harrison County Board of Education
Health Services Department

Diabetic Questionnaire for the School Year:_____

Student Name:_____ Grade:_____ Teacher:_____

On the first day of school there *must be:*

1. Physician orders for medication or treatment. They can be hand carried into the school or faxed to 304_____.

2. Insulin Supplies includes insulin pen or insulin vial and syringes or extra pump supplies.

3 Blood glucose meter kit (includes meter, alcohol pads, gauze, extra meter battery, test strips, & lancing device with lancets).

4. Low blood glucose supplies including Glucagon kit and a fast acting carbohydrate (glucose tabs/gel or other fast acting carbohydrate labeled with student name).

5. High blood glucose supplies including water bottle and ketone test strips.

What was your student's last Hemoglobin A1C reading?_____ on _____. A1C is the lab value for blood glucose control during the previous 3 months.

What concerns or questions do you have about your child's diabetes management while at school?_____
_____.

Any emergency contact numbers in addition to guardian: _____

Will you be accompanying your student on field trips? _____

Please understand that because your student has a potentially life threatening medical condition they must submit these forms **prior** to starting school every year. This allows us to assure your child is safe at school. Please feel free to call the school nurse with any concerns or questions. I'm looking forward to a great year with your student!

Sincerely,

Certified School Nurse
Harrison County Schools

Return To School Nurse

HARRISON COUNTY SCHOOL HEALTH SERVICES

EMERGENCY ACTION PLAN

Hyperglycemia (High Blood Sugar)

Student Name: _____ DOB: _____ Grade/Teacher: _____

EMERGENCY CONTACT INFORMATION

Parents/Guardians:	Phone #1:	Phone #2:	Phone #3:
Parents/Guardians:	Phone #1	Phone #2:	Phone #3:
Alternate Contact:	Phone #1	Phone #2:	Phone #3:

If the School Nurse is in the building please notify nurse immediately!

IF YOU SEE THIS:	DO THIS:
Mild Symptoms: **(thirst, fatigue/sleepiness, blurred vision, stomach pain, lack of concentration, frequent urination, increased hunger, flushing of skin)** ***Student may remain in school with a high blood glucose unless symptoms become intolerable for the student****	*** Notify school nurse immediately if in the building** ***Assist student in checking blood glucose.** ***Check urine for ketones if blood glucose if >300 and strips are available. (Typically Negative to Trace/Small)** ***Encourage student to drink 8 oz. of water.** ***Have student &/or nurse administer insulin per physician orders.** ***Recheck blood glucose and ketones again in 2 hours.** ***Communicate with parents as needed.**
Moderate Symptoms: **(Sweet, fruity breath, dry mouth, stomach cramps, nausea, vomiting)**	*** Notify school nurse immediately if in the building** *** Notify parent/guardian immediately** ***Assist student in checking blood glucose.** ***Check urine for ketones if blood glucose if >300 and strips are available. (Typically Small to Moderate)** ***Encourage student to drink 16 oz. of water.** ***Restrict physical activity/recess** ***Have student &/or nurse administer insulin per physician orders.** ***Recheck blood glucose and ketones again in 2 hours.**
Severe Symptoms: ***Mild and moderate symptoms plus*** **Labored breathing, confused, very weak or Unconcious**	***Activate Code Blue and call parent immediately** ***Notify school nurse immediately if in the building** ***Assist student in checking blood glucose (in conscious)** ***Call Code Blue**

I understand and agree that information in this Emergency Action Plan will be shared with appropriate school staff.

_____ _____

Parent/Guardian Signature Date

School Nurse Received and Reviewed: _____ _____

School Nurse Signature Date

Feb 2016- Dark Pink

Return To School Nurse

HARRISON COUNTY SCHOOL HEALTH SERVICES

EMERGENCY ACTION PLAN

Hypoglycemia (Low Blood Sugar)

Never send a student with suspected low blood sugar anywhere alone!

Student Name: _____ DOB: _____ Grade/Teacher: _____

EMERGENCY CONTACT INFORMATION

Parents/Guardians:	Phone #1:	Phone #2:	Phone #3:
Alternate Contact:	Phone #1	Phone #2:	Phone #3:

If the School Nurse is in the building please notify nurse immediately!

IF YOU SEE THIS:	DO THIS:
Mild/Moderate Symptoms: **(hunger, shakiness, weakness, paleness, anxiety, dizziness, irritability, sweating, drowsiness, poor concentration, headache, confusion, blurred vision, slurred speech, poor coordination)**	*** Notify school nurse immediately if in the building** ***If nurse is not in the building (if ordered) have student check blood glucose** ***Provide quick acting sugar source of 15 grams carbohydrate: 3-4 glucose tabs or 4 ounces of juice** ***Wait 15 minutes & recheck blood glucose (if ordered)** ***Staff to remain with student if no nurse available** ***Repeat quick acting sugar source if symptoms persist or blood glucose is less than _____.** ***If next meal or snack is longer than 30 minutes away, follow with a snack of carbohydrate and protein (e.g., cheese and crackers or peanut butter and crackers)** ***Communicate with parents**
Severe Symptoms: **(Loss of consciousness, seizure, or inability to swallow)**	***Activate Code Blue and Call 911** ***Contact parents/guardians immediately** ***Do not attempt to give anything by mouth** ***Position on side, if possible** ***Administer glucagon per physicians order (if ordered).** ***Do NOT leave student unattended**

I understand and agree that information in this Emergency Action Plan will be shared with appropriate school staff.

_____ _____

Parent/Guardian Signature Date

School Nurse Received and Reviewed: _____ _____

School Nurse Signature Date

To Be Completed By School Nurse

Location of medicine_____ ***Authorized person to give medicine***_____

Feb 2016- Pale Pink

School_____

Harrison County Schools Medication Form

Student Information

Student Name _____
Last First Middle

Birth Date _____ Homeroom Teacher _____ Grade _____

Medication Allergies_____

Physician

This section of the Medication Form is to be filled out by a licensed prescriber. Medication orders are valid for the current school year including any summer school programs or extended school year programs. A medication order is required for any prescription and non-prescription (over the counter) medication. If there is any change in medication, dosage, time, or route, a new medication order must be received before the medication can be administered by school personnel. By signing this form, the licensed prescriber is authorizing that this medication may be given at school.

(Use one form for each medication)

Medication _____ Diagnosis _____

Dose _____ Time _____ Route _____

Intended Effect of Medication _____

Potential Side Effects for this Medication _____

Other Medication(s) taken by student _____

If rectal Diastat/Diazepam or Klonopin is prescribed, may this be administered by unlicensed trained personnel? ___Yes ___No

Please note that Nasal Versed cannot be delegated to unlicensed personnel

May the student self-administer their emergency medication per county policy? ___Yes ___No

May the student carry their emergency medications on them per county policy? ___Yes ___No

Name and Title of Licensed Prescriber (**PRINT**) _____

Address _____

Phone _____ Fax_____

Signature of License Prescriber _____ Date _____

Parent/Guardian

Parent/Guardian Authorization

I understand the following:

- *Medication must be brought by an adult to the school in the original container and properly labeled with the child's name.
- *The licensed prescriber may be contacted concerning the medication order for reasons including, but not limited to clarification, effectiveness, administration time, dosage, discontinuation, or new medication order.
- *Medication administration and procedures may be delegated to school personnel who have been trained by and remain under direct or indirect supervision of the school nurse.
- *A photograph of my child may be taken to assist in the correct administration of my child's medication.
- *Information may be shared with appropriate school personnel to insure the safety of my student.
- *it is the parent/guardian responsibility to replenish long-term and emergency medications as needed and retrieve unused or expired medication from the school.
- *At no time will non-emergency medication be sent home with the student. It will be the responsibility of a parent/guardian to pick up all remaining medications from the school.

I hereby give permission for my child to receive medication at school per the Harrison County Schools Medication Policy and as ordered by my child's licensed prescriber. I have read and understand that Harrison County Board of Education and its employees are exempt from any liability, except for willful and wanton conduct.

Parent/Guardian Signature_____ Date_____

Form Received and Reviewed by School Nurse _____ Date _____
Signature