

Student's Name: _____ School Year: 20____ to 20____ Grade: _____ Date: _____

TASK

ACTION(S)

Blood Glucose Testing

- _____ for signs/symptoms of low blood sugar (report to school nurse)
- _____ for signs/symptoms of high blood sugar (report to school nurse)
- _____ every day before lunch
- _____ other (specify; i.e. before or after PE, sport, etc.) _____
- _____ notify parent/guardian immediately for blood sugar < _____ mg/dl and /or > _____ mg/dl
- _____ student will notify parent/guardian of blood glucose results done at school
- _____ student may test in classroom and keep daily blood glucose log with them
- _____ **OR** student should test in health office, keep daily log in health office
- _____ student to have glucose meter at all times-one with student and one in health office
- _____ student/parent will supply health office with back-up diabetic supplies (see diabetic supply list)

Urine Ketone Testing

- _____ for blood sugar > _____ mg/dl
- _____ for acute illness, i.e. vomiting, fever, etc.
- _____ student must have unlimited access to restroom and drinking fountain/water bottle and should drink _____ oz of fluid every _____ min. if ketones are present
- _____ notify parent/guardian immediately for _____ ketones (NOTE: if parent/guardian cannot be reached and the student has _____ ketones and is vomiting, contact paramedics for transport to E.R.)
- _____ notify parent/guardian daily of any ketone results done at school
- _____ other (specify) _____
- _____ restrict gym/sports/etc. for _____ ketones

Meal Planning

- _____ mid-morning snack at _____ a.m.
- _____ mid-afternoon snack at _____ p.m.
- _____ other (specify) _____
- _____ snacks should be taken (specify): _____ Classroom _____ Nurse's Office Other _____
- _____ student to carry a snack/glucose tabs at all times
- _____ student is independent in calculating carbohydrates and insulin coverage

Activity

- _____ no restrictions unless ketones are present; see above
- _____ student to disconnect insulin pump during gym and/or sport
- _____ Medical ID must be worn at all times including during gym/sports/etc.

TASK

ACTION(S)

Activity _____ student may attend field trips with parental permission if a parent or nurse is unavailable
_____ other (specify) _____

Insulin at School _____ student is capable of the proper method of self-administration of Insulin without school nurse supervision
_____ **OR** all Insulin doses must be supervised or administered by the school nurse

Injections _____ administer _____ Insulin subcutaneously before lunch as follows:
for blood sugar > 240 give _____ units; > 300 give _____ units; >350 give _____ units
_____ if blood sugar > 300 at any other time of the day, please call the office for assistance

Pumps-Basal/Bolus _____ student has an Insulin infusion pump with _____ Insulin and shall be permitted to wear and attend
to the pump as needed during school and school sponsored activities
_____ Basal rate during school hours _____
_____ Bolus Rates: Meal Bolus (Insulin:Carb ratio): _____
Correction Bolus: _____
_____ other (specify) _____

Hypoglycemia/Glucagon _____ treat all blood sugar < _____ mg/dl with _____ grams of rapid-acting carbohydrate followed by meal/snack
_____ for severe hypoglycemia (or suspected severe hypoglycemia) when the student is unconscious or unable to
swallow, give _____ mg Glucagon I.M. or S.Q. AND _____ contact parent/guardian and paramedics
immediately
_____ other (specify) _____

Other _____ the student has been instructed in proper handwashing and preparation of injection sites
_____ the student has been instructed in proper needle disposal and preventing blood exposure to others

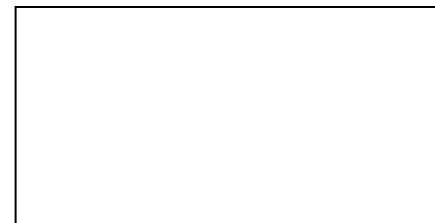
Health-care provider's Name (Please Print): _____ Doctor's Stamp:

Health-care provider's Signature: _____

Telephone Number: _____

Parent Signature: _____ Date: _____

Student Signature: _____ Date: _____



Authorization for Medication
ONLY ONE MEDICATION PER FORM

State law requires a signed prescription by a physician that includes the information below OR completion of the form below. If a prescription is faxed, the original must be forwarded to the Health Office.

Name _____ Grade _____ Date _____

Diagnosis Diabetes – Type 1 Allergies _____

Medication GLUCAGON EMERGENCY KIT

Dosage 1 mg Time(s) PRN for BS < ☐ & unable to take PO glucose Route I.M.

Possible Side Effects nausea, vomiting, hypersensitivity, bronchospasm

Termination date end of each school year (Note: State law requires that medication be renewed each school year).

Student is free of contagious disease and physically fit to attend school.
The student would not be able to attend school unless the medication is given during school hours.

Physician's Signature

Printed Name of Physician

Date

Parent/ Guardian Consent for Giving Medication During School

I request and give my consent for the School Nurse to dispense the medication prescribed by the physician on this form.

A prescription medication must be delivered to the School Nurse in the original pharmacy container labeled with the student's name, date of prescription, name of medication, dosage and the prescribing physician's name. If the medication is an over the counter medicine, it must be in the original box.

I give permission for the information on this form to be shared with the appropriate staff members, coaches, and chaperones for the safety and welfare of my child.

I give permission for the school nurse to speak with the prescribing physician regarding the medication listed above, if necessary.

Signature of Parent/ Guardian

Date

Authorization for Medication
ONLY ONE MEDICATION PER FORM

State law requires a signed prescription by a physician that includes the information below OR completion of the form below. If a prescription is faxed, the original must be forwarded to the Health Office.

Name _____ Grade _____ Date _____

Diagnosis Diabetes Type 1 – Pump Failure Allergies _____

Medication _____ Insulin _____

Dosage _____ Time(s) _____ Route _____

Possible Side Effects hypoglycemia; pruritis; rash; dry mouth; blurred vision

Termination date _____ (Note: State law requires that medication be renewed each school year).

Student is free of contagious disease and physically fit to attend school.
The student would not be able to attend school unless the medication is given during school hours.

Physician's Signature

Printed Name of Physician

Date

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Signature of Parent/ Guardian

Date

NORTH HUNTERDON HIGH SCHOOL-HEALTH OFFICE
1445 ROUTE 31, ANNANDALE, NJ 08803 Phone: 908-713-4171 Fax: 908-713-4403
Health Office (Revised 1/08)
North Hunterdon High School
1445 Route 31
Annandale, NJ 08801
Phone: 908-713-4171 Fax: 908-713-4403

DIABETES SUPPLIES

Parents are responsible for providing all diabetic supplies. The following is a list of typical supplies:

INSULIN SUPPLIES

Insulin
Insulin syringes OR
Insulin pen with cartridge loaded
Insulin pen needles OR
Insulin pump supplies
Alcohol wipes

BLOOD GLUCOSE TESTING SUPPLIES

Blood glucose meter and manufacturer's instructions
Test strips (with code information)
Lancet device
Lancets
Logbook to record blood sugar and amounts of insulin (student to carry if approved by MD)

FOOD SUPPLIES

Snack foods
Low blood sugar (hypoglycemia supplies: glucose tablets, juice and carbohydrate/protein snack)
Water

OTHER

Urine ketone strips
Glucagon kit