

NORTH HUNTERDON-VOORHEES REGIONAL HIGH SCHOOL DISTRICT

DIABETES SUPPLIES & PAPERWORK

Parents are responsible for providing all diabetic supplies and orders at the start of each school year. The following is a list of typical supplies:

DIABETIC ORDERS/PLANS FROM ENDOCRINOLOGIST

NORTH HUNTERDON-VOORHEES DESIGNEE AUTHORIZATION & RELEASE FORM

NORTH HUNTERDON-VOORHEES INSULIN ORDER FORM (PUMP FAILURE)

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

NORTH HUNTERDON-VOORHEES REGIONAL HIGH SCHOOL DISTRICT

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

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 Dat

Part D. Authorization for Services and Release of Information

Permission for Care

I give permission to the school nurse to perform and carry out the diabetes care tasks outlined in the Diabetes Medical Management Plan (DMMP), Individualized Health Care Plan (IHP), and Individualized Emergency Health Care Plan (IEHP) designed for my child _____.

I understand that no school employee, including a school nurse, a school bus driver, a school bus aide, or any other officer or agent of a board of education, shall be held liable for any good faith act or omission consistent with the provisions of *N.J.S.A. 18A:40-12-11-21*.

Student's Parent/Guardian

Date

Permission for Glucagon Delegate

I give permission to _____ to serve as the trained glucagon delegate(s) for my child, _____, in the event that the school nurse is not physically present at the scene. I understand that no school employee, including a school nurse, a school bus driver, a school bus aide, or any other officer or agent of a board of education, shall be held liable for any good faith act or omission consistent with the provisions of *N.J.S.A. 18A:40-12-11-21*.

Student's Parent/Guardian

Date

Note: A student may have more than one delegate in which case, this needs to be signed for each delegate.

Release of Information

I authorize the sharing of medical information about my child, _____, between my child's physician or advanced practice nurse and other health care providers in the school.

I also consent to the release of information contained in this plan to school personnel who have responsibility for or contact with my child, _____, and who may need to know this information to maintain my child's health and safety.

Student's Parent/Guardian

Date