GREATER NEW BEDFORD REGIONAL VOCATIONAL TECHNICAL HIGH SCHOOL

1121 Ashley Boulevard, New Bedford, MA 02745-2496
Tel. 508-998-3321 Fax 508-995-7268 www.gnbvt.edu

Preparation • Passion • Perseverance

Dear Parent/Guardian,

According to your child's school health record, your child has a diagnosis of Diabetes. Enclosed is a packet of **required** paperwork for you to complete for the start of school. **All documents in this packet must be returned along with PHYSICIAN orders on or before the first day of school.** A ***checklist*** is enclosed for your convenience.

If your child is planning to participate in a Fall sport, all paperwork must be submitted to the school nurse's office ***before the start of the Fall season*** (including tryouts). No student will be allowed to participate in activities outside of the school building without the required paperwork as well as his/her diabetic supplies.

Please take the time to review this required paperwork for your child as well as the attached checklist in detail. **All medications, as well as supplies must be brought to the nursing office the first day of school, at the start of school.**

If you have any questions regarding this packet, please call the nurse's office at 508 998-3321, extension 204/205. Please note the direct fax number into the nurse's office is 508-998-4647.

Thank You,

School Nurses

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Diabetes Checklist:

Required for students with DIABETES

- ☐ **Physician/medical provider's name and contact information**
- ☐ **Physician/medical provider's documentation of**
  - ☐ **Diabetes diagnosis**
  - ☐ **Completed and signed orders for:**
    - ☐ **Insulin**
    - ☐ **Glucose/ketone monitoring**
    - ☐ **Insulin delivery system (i.e. insulin pen/pump or syringe)**
    - ☐ **Continuous glucose monitoring (if applicable)**
    - ☐ **Glucagon**
    - ☐ **Treatment for hyperglycemia**
    - ☐ **Treatment for hypoglycemia**
- ☐ **Parent/Guardian Authorization for Diabetes Management form:**
  - ☐ Completed and signed by parent/guardian
- ☐ **Diabetes Emergency Action Plans for Field Trip/Placement/Extracurricular Activities form (hyperglycemia & hypoglycemia):**
  - ☐ Parent/Guardian signature and initials as appropriate
- ☐ **Diabetic Supplemental Health History form:**
  - ☐ Completed and signed by parent/guardian
- ☐ **All Diabetic Supplies needed including:**
  - ☐ **Monitoring supplies**
    - ☐ Glucometer, test strips for glucose and ketones, lancets, skin prep wipes, EXTRA batteries
  - ☐ **Treatment Supplies**
    - ☐ Glucose tabs, snacks, water
  - ☐ **Medication Supplies**
    - ☐ Insulin, syringes, pump supplies, EXTRA batteries, EMERGENCY Glucagon

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Parent/Guardian Authorization for Diabetes Management

(To Be Completed By Parent/Guardian)

Student's Name:	DOB:	ID#	YOG:

Address:	City:	State:	Zip:

Parent/Guardian Name(s):	Home Phone:	Cell Phone:	Work Phone:

EMERGENCY CONTACT INFORMATION	TELEPHONE NUMBERS
Primary Contact:	Home/Cell:
Secondary Contact:	Home/Cell:
Contact:	Home/Cell:

I give permission for the school nurse to administer the following to the above named student:

Insulin ☐ Glucagon ☐ Blood Glucose Testing ☐ Ketone Testing ☐

As prescribed by:

I give permission for my child to self-administer glucose & ketone testing along with insulin if documented by medical provider and the school nurse determines that it is safe and appropriate.

YES ☐ NO ☐

I give permission to the school nurse to share health information with my child's medical providers:

YES ☐ NO ☐

I give permission to the school nurse to share essential health information to other school personnel on a "Need to Know Basis":

YES ☐ NO ☐

I understand that I may retrieve the medication(s) from the school at any time if discontinued. **All medication must be picked up on or before the last day of the school year. If medications are not picked up, they will be destroyed after that timeframe.**

Signature of Parent/Guardian:	Date:

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Diabetes Emergency Plan – Hyperglycemia (High Blood Glucose)

Field Trip/Placement/Extracurricular Activity

Student's Name:	DOB:	ID#:	YOG:

EMERGENCY CONTACT INFORMATION	TELEPHONE NUMBERS
Primary Contact:	Home/Cell:
Secondary Contact:	Home/Cell:
Contact:	Home/Cell:

School Nurse Contact Information: Phone: 508-998-3321 ext. 204 or 205

SYMPTOMS (MILD TO MODERATE)

- ☐ **Increased thirst**
- ☐ **Dry mouth**
- ☐ **Frequent or increased urination**
- ☐ **Change in appetite**
- ☐ **Nausea**
- ☐ **Blurred vision**
- ☐ **Fatigue**

ACTION:

- ☐ **Allow student to check blood glucose**
- ☐ **If Blood Glucose is over _____ mg/dl, student should check for ketones**
  - If ketones are present, allow student to administer insulin as ordered
  - If student uses insulin pump, have student check pump for proper operation
- ☐ **Notify School nurse at above number**
- ☐ **Encourage student to drink water and keep active** (lowers blood glucose)
- ☐ **Check or allow student to check blood glucose as appropriate until within normal range**
- ☐ **Remain with student at all times**
- ☐ **Other:** _____

SYMPTOMS (SEVERE)

- ☐ **Dry mouth, extreme thirst, dehydration**
- ☐ **Nausea/vomiting/abdominal pain**
- ☐ **Fruity breath**
- ☐ **Heavy breathing, shortness of breath**
- ☐ **Chest pain**
- ☐ **Sleepiness/lethargy**
- ☐ **Altered state of consciousness**

ACTION:

- ☐ **ACTIVATE 911*****
- ☐ **Contact parent/guardian**
- ☐ **Contact school nurse to report incident and provide status update**
- ☐ **Remain with student until EMS arrives**

Signature of Parent/Guardian:	Date:

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Diabetes Emergency Plan – Hypoglycemia (Low Blood Glucose)

Field Trip/Placement/Extracurricular Activity

Student's Name:	DOB:	ID#	YOG:

EMERGENCY CONTACT INFORMATION	TELEPHONE NUMBERS
Primary Contact:	Home/Cell:
Secondary Contact:	Home/Cell:
Contact:	Home/Cell:

School Nurse Contact Information: Phone: 508-998-3321 ext. 204 or 205

SYMPTOMS (MILD TO MODERATE)

- ☐ Change in behavior/personality
- ☐ Pale
- ☐ Sweaty
- ☐ Confused
- ☐ Weak
- ☐ Shaky/uncoordinated
- ☐ Hunger
- ☐ Complaint of change in vision

ACTION:

- ☐ Allow Student to Check Blood Glucose
- ☐ If Blood Glucose is less than _____ mg/dl, student should have 4 glucose tablets or other fruit juice.
- ☐ Student should consume other additional carbohydrate snack (i.e. crackers, granola bar, etc.)
- ☐ Student should recheck Blood Glucose in 15 minutes and repeat if Blood Glucose is less than _____ mg/dl.
- ☐ Notify school nurse at above number for further instructions
- ☐ Remain with student at all times
- ☐ Other: _____

SYMPTOMS (SEVERE)

- ☐ Inability to eat/drink
- ☐ Unresponsive
- ☐ Unconscious
- ☐ Seizure

ACTION:

- ☐ ACTIVATE 911***
- ☐ Place student on side
- ☐ Contact parent/guardian
- ☐ Contact school nurse to report incident and provide status update
- ☐ Remain with student until EMS arrives

Glucagon cannot be administered by an unlicensed person. I understand licensed personnel are not routinely available on field trips/placement/extracurricular activities. Initial: ☐

Signature of Parent/Guardian:	Date:

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Diabetic Supplemental Health History

Student's Name:	DOB:	ID#:	YOG:

Dear Parent/Guardian,

According to your child's school health record, your child has a diagnosis of Diabetes.

PLEASE COMPLETE, SIGN AND RETURN THIS FORM TO THE SCHOOL NURSE.

Does your child have:	Type I ☐ Type II ☐		
Does your child take:	Oral Medication ☐ Insulin ☐		
Primary Care Physician:	Name:	Phone:	
Diabetes Physician:	Name:	Phone:	
Onset of Diabetes:			
Insulin Delivery System	Insulin Syringe ☐	Insulin Pen ☐	Insulin Pump ☐
Continuous Glucose Monitor (CGM)	**Yes** ☐ **No** ☐		
Present Treatment Regime:			
Symptoms of Hypoglycemia:			
Symptoms of Hyperglycemia:			
Most Recent A1C Value:		Date:	

Please Comment on your child ability to manage their diabetes independently during the school day:

Please share any information that you feel will assist us in meeting your child needs:

Signature of Parent/Guardian:	**Date:**