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 health record, your child has a diagnosis of **Diabetes**. Enclosed is a packet of required paperwork to be completed for the start of the school year. **All documents in this packet, along with physician orders, must be returned on or before the first day of school.** A checklist is enclosed for your convenience. ***Please ensure the required paperwork is completed on or after July 1st of the new school year.***

If your child plans to participate in a fall sport, all paperwork must be submitted to the Nurses' Office **prior to the start of the fall season,** including tryouts. Students will not be permitted to participate in activities outside of the school building without the required paperwork and necessary diabetic supplies.

Please review all required paperwork and the attached checklist carefully. All medications and supplies must be brought to the Nurses' Office on or before the first day of school.

If you have any questions regarding this packet, please contact the Nurses' Office at 508-998-3321 ext. 204/205/661/791. The direct confidential fax number is 508-998-4647.

Thank you,
GNBVT School Nurses

Proudly Serving the Towns of Dartmouth and Fairhaven and the City of New Bedford

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Diabetes Checklist:

Required for students with DIABETES

☐ **Physician/Medical Providers Orders**

- ☐ Completed and signed orders for:
  - Insulin
  - Blood Glucose/Ketone monitoring
  - Insulin delivery method (pump/pen/syringe)
  - CGM orders (if applicable)
  - Glucagon
  - Hyperglycemia treatment plan
  - Hypoglycemia treatment plan

☐ **Parent/Guardian Forms**

- ☐ Parent/Guardian Authorization for Diabetes Management
- ☐ Diabetes Emergency Plan (Hyper/Hypoglycemia)
- ☐ Diabetic Supplemental Health History Form

☐ **Diabetic Supplies**

- ☐ Monitoring supplies (glucometer, test strips for glucose and ketones, lancets, skin prep wipes, extra batteries)
- ☐ Treatment supplies (glucose tabs, snacks, water)
- ☐ Medication Supplies (Insulin, pump supplies, emergency glucagon)

Revised June 2026

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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:

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 a medical provider and the school nurse determines that it is safe and appropriate.

YES ☐ NO ☐

I give permission for the school nurse to remotely monitor my child's blood glucose through the iPad located in the Health Office. Remote monitoring will be used as a supplementary tool only, and continuous monitoring cannot be guaranteed.

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:

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**
  - o If ketones are present, allow student to administer insulin as ordered
  - o 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:

Revised June 2026

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:

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

I give permission for emergency glucagon to be delegated to trained unlicensed personnel during field trips, placements, and extracurricular activities when a nurse is not present.	Initial: ☐
I give permission for my student to attend field trips, placement, and extracurricular activities without a nurse present, provided the student's healthcare provider determines they are independent in managing their diabetes and the school nurse determines it is safe and appropriate.	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:**

Revised June 2026