Dear Parent, June 2020

Attached is the 2020-2021 diabetes packet for you to complete and return to me for the upcoming school year. It is important that I have the paper work on file by August 16, 2020. Please bring medications and blood sugar testing supplies to open house. Medications (insulin, glucagon, and glucose tablets) need to be in their original containers, labeled with the child's name, and not to expire until the end of the school year. All medications need a signed physician's order. Medication orders may be faxed to +1-636-532-6502.

Should you have any questions please feel free to call the school office.

Thank you,

Gretchen Kirsch, RN, BSN
Ascension School Nurse

Diabetes Health History Form

Date Initiated _____

Name_____Birthdate_____Grade_____

Father/Guardian_____Phone (home)_____(work)_____

Mother/Guardian_____Phone (home)_____(work)_____

Assessment/Daily Management

Baseline Information: Temp_____Pulse_____Resp_____B/P_____

Height _____ Weight _____ Glasses/Contacts_____ Hearing_____

Known Allergies _____

Date Diagnosed with Diabetes _____ Last Hospitalization _____

Has Glucagon ever been administered? Yes____ No ____ If yes, what was the reaction:

_____

Diabetes Medication

Type of Insulin/ Oral Med	Dosage	Time To Be Given	Reaction Signs/Symptoms
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Transported Daily _____Stored at School_____

Test(s) performed at school: _____Time(s)_____

Equipment needed: _____

Physical Education (PE) / Exercise Activities Scheduled: AM_____PM _____

PE Modification _____

– continued on back -

Diabetes Health History Form - Continued

Food Intake: Times: Breakfast _____ Lunch _____ AM Snack _____ PM _____

Brings own food _____ Storage _____ Selects in Cafeteria _____

Needs Assistance _____ Type of Assistance Needed _____

EMERGENCY INSTRUCTIONS:

If parent or guardian cannot be reached, contact:

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Physician/Health Care Provider_____ Phone_____

Hospital Preferred_____

Transportation Requested: Parent_____ Ambulance_____ Other_____

Other Instructions: _____

_____

Other Health Concerns:

_____

_____

Additional Medication(s):

_____

_____

_____

_____ _____

Parents/Guardian Signature Date

Source: "Diabetes Management in the School Setting", 1998, Missouri Association of School Nurses.

(Sample #1)

Emergency Action Plan
Diabetes Healthcare

Student's Name _____ _____ Grade _____

Address _____ Home Phone _____

Father/Guardian _____

Phone: Home_____ Work_____ Cell_____

Mother/Guardian _____

Phone: Home_____ Work_____ Cell_____

Other person to contact in an Emergency:
Name _____

Address _____

Phone: Home_____ Work_____ Cell_____

Hospital Preferred _____

Physician(s) or Health Care Provider's Name _____

Phone _____

Emergency items to be left at school:

Glucose tablets _____	Glucagon _____
Snacks _____	Blood glucose meter _____
Glucose Gel _____	Insulin _____
_____	Syringes _____
_____	Other _____

In the event of a low blood sugar response, the procedure routinely followed at school is: to give some form of sugar or carbohydrate, such as ½ carton of milk, ½ cup fruit juice, or ½ cup non diet soda, followed by crackers with cheese. If the student is unconscious, call 911. Call parents/guardians.

I approve the above emergency healthcare action plan as written Yes ____ No____

Please make the following changes to the emergency healthcare action plan:

_____

_____

_____

_____

- (continued on back) -

(Sample #1 Continued)

Emergency Action Plan Diabetes Healthcare

List other additional information or significant special health concerns of this student.

_____

_____

_____

_____

_____

_____

I give permission for emergency blood glucose testing by the school nurse or designee using equipment I have provided. I understand that when the school nurse or designee is not available for emergency blood glucose testing, the parent/guardian will be notified or "911" will be called. Yes _____ No _____

_____

Additional directions regarding blood glucose testing: _____

_____

_____

_____

Written and submitted by: _____ _____
Nurse or Designee Date

Reviewed and signed: _____ _____
Parent/guardian Date

_____ _____
Student Date

_____ _____
Physican or Health Care Provider Date

To be reviewed _____
Date

The emergency healthcare action plan should be revised according to the child's specific needs, at least annually.

Source: "Diabetes Management in the School Setting", 1998, Missouri Association of School Nurses. Sample of Springfield School District Emergency Action Plan – Diabetes Healthcare.

DIABETES: LOW BLOOD SUGAR EMERGENCIES

MY NAME IS _____

I HAVE DIABETES AND MUST TAKE INSULIN DAILY.

IF YOU SEE ME:

HUNGRY, WEAK

CRYING, CONFUSED IRRITABLE

PALE PERSPIRING SHAKY

DROWSY INATTENTIVE

HEADACHE NAUSEA

OR BEHAVING STRANGELY IN ANY WAY...

I may be having a LOW BLOOD SUGAR EMERGENCY (insulin reaction).
My most common symptoms are _____

_____

A LOW BLOOD SUGAR EMERGENCY (insulin reaction) would most likely occur before lunch or after strenuous exercise or _____

_____

IF THIS HAPPENS PLEASE GIVE ME SOME FORM OF SUGAR, SUCH AS:

- SOFT DRINK (non-diet)
- CANDY OR HONEY
- SUGAR (at least 2 packets)
- FRUIT JUICE

Repeat if I do not improve in 5–10 minutes!

Don't leave me alone, please.

Follow up with additional food—such as milk, cookies, crackers.

I may need coaxing to eat.

But if I'm unconscious or unable to swallow, don't force drinking or eating—GET EMERGENCY HELP!

For additional help call:

PARENT _____ PHONE _____

PARENT _____ PHONE _____

DOCTOR _____ PHONE _____

Please don't send me home alone when I've had a reaction.

(See reverse side)

BY UNDERSTANDING THE FOLLOWING INFORMATION YOU CAN GREATLY HELP YOUNGSTERS DEAL WITH THEIR DIABETES AND YOU WILL FEEL MORE CONFIDENT WITH THEM.

Facts About Diabetes

1. A person who has Type 1 diabetes has to take insulin by injection at least once a day because he or she does not make enough of the hormone insulin to meet the body's needs. Without insulin, one's food cannot be properly metabolized.

2. Sometimes the balance between sugar and insulin in the body is upset. Then the person can have a LOW BLOOD SUGAR EMERGENCY (insulin reaction). This can occur at any time, but most frequently happens after:

   - Excessive physical activity, without extra food ahead of time
   - Failure to eat the proper amount at the proper time

   Too much administered insulin

3. The symptoms of LOW BLOOD SUGAR EMERGENCY (insulin reaction) vary. Most young people with diabetes are aware when they need extra food. But there may be times when they may not be aware that a low blood sugar emergency is occurring. At that point you must be able to recognize the symptoms and offer the foods mentioned on the reverse side of this card.

4. On occasion, the youngster with diabetes may need to drink more water than usual and have to go to the bathroom more often than normally allowed. This is the result of high blood sugar, and you may want to alert the parents.

For additional copies and information:

Saint Louis Chapter
225 S. Meramec, Suite 400
Saint Louis, MO 63105

Juvenile Diabetes Research Foundation International

dedicated to finding a cure

The Juvenile Diabetes Foundation International was founded in 1970 by parents of children with diabetes who were convinced that diabetes could be cured through research. They were and still are determined to make that cure happen in their children's lifetime.

JDF is the world's leading nonprofit, nongovernmental funder of diabetes research. JDF's mission is to find a cure for diabetes and its complications through the support of research. For more information, visit our website: www.idf.org.

(See reverse side)

Prescription Medication Order and Permission to Administer Medication and to Test Blood Sugar Form

(To be returned to the school nurse or designee)

From time to time, it may be necessary for your child to take prescription medicine for treatment of an illness. Medicines that are ordered to be taken less than 4 times a day can and should be taken at home. However, if medicine must be taken 4 or more times a day, or at a specific time scheduled during school hours, the school nurse or designee, as mandated by state law, may dispense medications **ONLY WITH THE FOLLOWING:**

1. Medication order, signed by the physicians
2. Parental authorization, signed by the parent or guardian
3. Original pharmacist labeled bottle.

MEDICATION ORDER

Student: _____ Date of Birth: ___/___/___
Medication: _____
Directions: _____
Reason for giving: _____
Date: ___/___/___ Telephone number of physician or health care provider: _____

_____
(Signature of Physician or Health Care Provider)

PERMISSION TO ADMINISTER

Date: ___/___/___ I hereby give my permission for _____ to take the above prescription at school as directed.

_____
(Signature of Parent/Guardian)

PERMISSION TO TEST BLOOD SUGAR LEVEL

Date: ___/___/___ I grant permission for the school nurse or designee to test my child's blood sugar level at school during a crisis or emergency situation.

_____
(Signature of Parent/Guardian)

Date: ___/___/___ I grant permission for the school nurse or designee to test this child's blood sugar level during a crisis or emergency situation.

_____
(Signature of Physician or Health Care Provider)

Source: "Diabetes Management in the School Setting", 1998, Missouri Association of School Nurses.