THOMAS JEFFERSON MIDDLE SCHOOL

75 First Street • Lodi, New Jersey 07644 • Phone: (973) 478-8662 • Fax: (973) 478-0358

MEDICATION AUTHORIZATION FOR INSULIN COVERAGE

School Year: _____ School: _____

Physician's Order:

1. Name of Student: _____ **DOB:** _____
2. Medication _____
3. Dosage/Coverage: _____
4. Time: _____
5. Please indicate if insulin coverage is to be repeated and with what frequency: _____
6. Child may self-administer insulin: Yes_____ No_____

   Date: _____ Physician's Signature: _____

   Physician's Name Printed: _____

   Address: _____

   Please Stamp

   Telephone: _____
7. Physician's Comments *(if needed):*

_____

_____

_____

I give permission for my son/daughter, _____ to self-administer insulin coverage prescribed by his/her physician.

Date: _____ Signature: _____

SUGGESTED HEALTH CARE **PROVIDER** Orders

Student's Name._____ **Grade.**_____ School Year____ Date _____

TASK	ACTION(S)
Blood Glucose Testing	____for signs/symptoms of low blood sugar ___ for signs/symptoms of high blood sugar __ times/week before lunch (specify days) Mon Tues Wed Thurs Fri __ other (specify)_____ _ not applicable ___ notify parents immediately for blood sugar<___ mg/dl tor >___ mg/di ___ notify parents (specify) Daily Weekly Monthly of any resul ts done at school
Urine Ketone Testing	___ for blood sugar >___ mg/di ___ for acute illness, **i.e.** vomiting, fever, etc. ___ student must have unlimited access to restroom and g fountain/water bottle ___ notify parents immediately for _____ketones N o te: if parents cannot be reached and the student has ____ketones ,d is vomiting, contact paramedics for transport to E.R.) ___ notify parents (specify) Daily Weekly Monthly of any results done at school ___ other (specify),_____,_____ ____not applicable . ___ 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_____
Activity	no restrictions restrict gym/sports/etc. for _____ketones _ Medical ID must be worn at all times including during g}tm/sports/etc. ___ may attend class trips/field trips/etc.
	____other (specify)

SAMPLE HEALTH CARE PROVIDER ORDERS (Page 2)

Student• s Name_____ **Grade**_____**School Year**_____ **Date**_____

TASK	ACTION(S)
INSULIN	___ Administer _____ units of _____ insulin subcutaneously for blood sugar> ___ mg/di ___ Above dose may be repeated every ___ hours ___ Students with insulin infusion pumps shall be permitted to wear and attend to the pump. not applicable =other (specify) _____
Hypoglycemia/Glucagon	NOTE: all doses must be supervised or administered by school nurse ___ Treat all blood sugar <___ mg/di 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 parents___ contact paramedics immediately. ___ other (specify)_____
Absences	____for diabetes visits approximately every _ months ___ other (specify)_____ ___

Name (Please Print) _____ **Doctor's Stamp**_____

Phone Number_____

MD signature_____

Lodi Public Schools

Lodi, New Jersey

Glucagon Administration Permission Slip
And
Hold Harmless Agreement

I (we), the undersigned parent/guardian of _____request that the school nurse administers, as per the written orders of Dr. _____ glucagon injection for hypoglycemia, provided by me, to my child named above.

I have read the attached Lodi Board of Education Policy #5330 and fully understand that:

1. I must provide the glucagon emergency kit.
2. The doctor's orders must provide the name of the student, the name of the medication, the purpose of its administration, its proper timing, its dosage, its possible side effects and the date of discontinuance.
3. The written orders from your physician must state that the above-named student requires the administration of glucagon for hypoglycemia and is unable to self-administer.

I (we), _____hereby acknowledge that if the Lodi Board of Education procedures are followed, the Lodi Board of Education shall incur no liability whatsoever for any and all claims, damages, losses and expenses of any kind including reasonable attorney's fees as a result of any injury which arises from the emergency administration of glucagon prescribed by my physician. I hereby indemnify and hold harmless the Lodi Board of Education and its employees, officers, or agents against any and all claims arising from the emergency administration of glucagon.

You are hereby given NOTICE that none of the schools in the Lodi Public School District has an appointed designee to administer said glucagon if the school nurse is unavailable. In such an event the 911 procedure will be implemented. Your signature indicates you have read and are aware of the above and agree for the school nurse to release your child's name to the appropriate individuals in the school so that they are aware and can implement the 911 procedure in the event the school nurse is unavailable. These individuals may include but not be limited to the principal, vice principal, director of food services, physical education teachers and coaches, secretaries, guidance counselors and classroom teachers.

I hereby acknowledge our full understanding of and agree to the above by my signature below.

_____ _____

Date Signature of Parent/Guardian

PARENT/GUARDIAN PERMISSION TO RELEASE AND EXCHANGE
CONFIDENTIAL INFORMATION

I hereby authorize an exchange of information to occur between the School Health Services Nursing Staff and:

NAME: _____ PHONE: _____

ADDRESS: _____

Regarding: _____ any or all information

_____ Specific information regarding diabetes

Contained in the record of:

_____ _____

name date *of* birth

_____

school

This authorization is in effect for one calendar year from today: _____

Date

Signature of parent/guardian: _____

Appendix C

DIABETES SUPPLIES

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

INSULIN SUPPLIES

Insulin bottle(s)
Insulin syringes
Alcohol wipes/antiseptic wipes (optional)
Or
Insulin pen(s) with cartridge loaded
Pen needles
Alcohol wipes (optional)

Pump supplies, if needed

BLOOD SUGAR TESTING SUPPLIES

Blood glucose meter and manufacturer's instructions Test strips (with code information, if needed) Finger poking device
Lancets
Cotton balls (if needed)
Logbook to record blood sugar and amounts of insulin

FOOD SUPPLIES

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

OTHER Urine ketone test strips