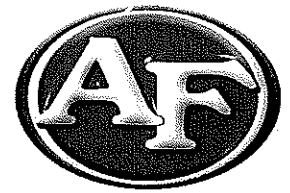




## Austintown Local Schools

700 South Raccoon Rd.  
Austintown, OH 44515  
330.797.3900  
330.792.8625 Fax



### DIABETES

Dear Parent/Guardian,

Our records indicate that your child has Diabetes. Our goal is for your child to have the best possible school year while managing their blood sugar. It is important that we have the necessary supplies and proper authorization to provide appropriate care and respond in case of an emergency. By the first day of school, we must have the **DIABETES MANAGEMENT PLAN FOR SCHOOLS**, which is provided by your doctor, in the school clinic. Complete the **SCHOOL DIABETIC RECORD** (attached), and bring needed **SUPPLIES**.

**A STUDENT WITH DIABETES WILL NOT BE PERMITTED TO ATTEND SCHOOL UNTIL PHYSICIAN'S ORDERS FOR THE CURRENT SCHOOL YEAR ARE IN PLACE. THIS INCLUDES STUDENTS AT THE HIGH SCHOOL LEVEL AND OTHER STUDENTS THAT ARE INDEPENDENT WITH THEIR CARE.**

**Your child's supplies should include:**

- Diabetes Management Plan for Schools signed by Physician
- Blood glucose meter and batteries
- Lancet device/lancets
- Test strips
- Insulin or pump supplies (**Insulin MUST be changed every 28 days**)
- Syringes or insulin pen with cartridges/needles
- Glucose tablets or glucose gel
- Ketone testing strips
- Snacks and juice for the clinic
- Snacks and juice for the bus driver
- 16 oz bottles of water for the clinic
- Plastic shoe box or storage container labelled with your child's name
- Current, reliable phone number for parent/guardian on Diabetes Management Plan
- Glucagon

**In addition, all parents with students in grades K-8 are REQUIRED to complete a daily food journal which will go between the school clinic and home each day. This is a small notebook, provided by the parent, in which the parent enters the foods to be eaten, carbohydrate count for each food, and the amount of insulin to cover those carbohydrates. (Once a member of the health care team checks the blood sugar at lunch, the insulin dose will be adjusted according to the sliding scale and doctor's orders).**

**Please inform the school's clinic of any changes in your child's health condition or medication/insulin schedule.**

Thank you,  
Austintown District Nurses



## ADMINISTRATION OF MEDICATION TO STUDENTS DURING SCHOOL HOURS



All medication should be given at home when possible. The administration of prescribed medication and/or medically-prescribed treatments to a student during school hours will be permitted only when failure to do so would jeopardize the health of the student, the student would not be able to attend school if the medication or treatment were not made available during school hours, or if the child is disabled and requires medication to benefit from his/her educational program. In the event that it is necessary for a student to receive medication during the school day, the following requirements must be met prior to the administration of medication:

- **PRESCRIPTION MEDICATION:** An Administration of Medication Request Form must be completed and signed by both the physician and parent/guardian.
- **OVER-THE-COUNTER MEDICATION (Nonprescription):** An Administration of Medication Request form must be completed and signed by the parent/guardian.
- The first dose of any new medication will not be administered at school in case of an allergic reaction.
- It is the student's responsibility (age appropriate) to report to the clinic at the designated time to receive the medication ordered.
- All medication **MUST** be brought to school by the parent/guardian. Students are not permitted to carry or transport medication unless previously authorized by the school, physician, and parent/guardian and is an Emergency medication (i.e.; Inhaler, EpiPen).
- All Prescription medication must be labeled appropriately by the pharmacist or physician and in its original container. The label must state the student's name, dosage, and time(s) to be taken and must match the Administration of Medication Request form.
- All Nonprescription medication must also be in its original container and labeled with a permanent marker indicating the child's name. Medication not in its original container will not be administered to the student.
- The recommended dosage on the box of the nonprescription medication will be reviewed and compared to the parent/guardian request. If the dosage exceeds amount recommended on the medicine container/box, it must be requested by a physician's order on an Administration of Medication Request form.
- The principal or appointed representative will supervise the administration of the medication in the absence of the school nurse.
- Any change to the medication must be submitted on a new Administration of Medication Request form. If a prescriptive medication is to be discontinued, a written note must be provided by the practitioner.
- New Request forms must be submitted for each new school year and for each medication.

**Parent/Guardian MUST pick up any unused medication. Medication will not be sent home with the child unless previously authorized and is an emergency medication. All medications not retrieved will be disposed of according to Ohio Revised Code.**



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**SCHOOL DIABETIC RECORD**  
(To be Completed by Parent/Guardian)

Child's Name \_\_\_\_\_ Grade \_\_\_\_\_ School Year \_\_\_\_\_

Parent/Guardians(s) Name \_\_\_\_\_ Cell \_\_\_\_\_

Home \_\_\_\_\_ Work \_\_\_\_\_

Physician Treating Child's Diabetes \_\_\_\_\_ Phone \_\_\_\_\_

\*\*\*\*\*

1. When was your child diagnosed with diabetes? \_\_\_\_\_ Type I or Type II? \_\_\_\_\_

2. Has your child ever been hospitalized because of diabetes? \_\_\_\_\_

If yes, when? \_\_\_\_\_

3. Can your child test his/her blood sugar level independently? \_\_\_\_\_

4. Does your child receive insulin injections? \_\_\_\_\_ If yes, who administers them? \_\_\_\_\_

5. Does your child understand the possible side effects of insulin if he/she does not eat? \_\_\_\_\_

6. Does your student need routine snacks at school? Yes/No \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

(Snacks to be provided from home)

7. Does your child experience frequent bouts of low and/or high blood sugar? Please describe:

\_\_\_\_\_

8. Please check your child's usual signs/symptoms of low blood sugar:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> hunger or "butterfly feeling" | <input type="checkbox"/> irritable                        | <input type="checkbox"/> difficulty w speech |
| <input type="checkbox"/> shaky/trembling               | <input type="checkbox"/> weak/drowsy                      | <input type="checkbox"/> uncoordinated       |
| <input type="checkbox"/> confused/disoriented          | <input type="checkbox"/> inappropriate crying or laughing | <input type="checkbox"/> dizzy               |
| <input type="checkbox"/> loss of consciousness         | <input type="checkbox"/> severe headache                  | <input type="checkbox"/> sweaty              |
| <input type="checkbox"/> rapid heartbeat               | <input type="checkbox"/> impaired vision                  | <input type="checkbox"/> seizure activity    |
| <input type="checkbox"/> pale                          | <input type="checkbox"/> anxious                          | <input type="checkbox"/> other               |

9. Does he/she recognize these signs/symptoms? \_\_\_ Yes \_\_\_ No \_\_\_ Sometimes

10. What is the most recent A1C lab value? Ranges are: 6-8 (good) 9-10 (fair) 11+ (poor)

11. Has your child and/or parent attended Diabetes Education classes? \_\_\_ Yes \_\_\_ No

12. If yes, who attended, where and when? \_\_\_\_\_

13. Does your child wear a medical alert bracelet/necklace? \_\_\_ Yes \_\_\_ No \_\_\_ Other I.D. \_\_\_\_\_

14. What concerns or questions do you have about your child's diabetes management while at school?

\_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_