HASBROUCK HEIGHTS PUBLIC SCHOOL SCHOOL HEALTH SERVICES

DIABETIC PACK

TO BE COMPLETED BY THE DOCTOR

Diabetes Medical Management Form
Insulin Orders (doctor will have their own form)
Physician's Order for Medication - Glucagon

TO BE COMPLETED BY THE PARENT

Quick Reference Emergency Plan Health History Form Authorization to Exchange

Medication Policy

HASBROUCK HEIGHTS BOARD OF EDUCATION
Hasbrouck Heights, New Jersey 07604 File Code: 5141.21
Exhibit

PHYSICIAN'S ORDER FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL

STUDENT'S NAME	DOB	GRADE
NAME OF DRUG		
DOSAGE	_ TIME(S) TO BE ADMINISTERED)
DIAGNOSIS / REASON FOR ME	EDICATION	
POSSIBLE SIDE EFFECTS		
DURATION OF USE		
PHYSICIAN'S SIGNATURE		DATE
PLEASE PRINT OR STAMP: PHYSICIAN'S NAM ADDRESS PHONE NUMBER	Л Е	
<u>!</u>	PARENT AUTHORIZATION NISTRATION OF MEDICATION	
understand that a certified school service utilizing the order provide employees and agents shall incu	eation, in the original container, but nurse or her designated nurse sued by my physician. I acknowledge our no liability as a result of administ ermission to contact the physician ion.	ubstitute will be performing this that the school district and its tration of this medication to my
PARENT / GUARDIAN'S SIGNATURE	DΔ	TE
	WORK / CELL PHONE_	
INITIAL MEDICATION SUPPLY:		
Name of medicine	# of pills/tablets/capsule	es/ml
Nurse signature	Parent signature	

STUDENT'S NAME	DOB	GRADE

MEDICATION	SUPPLY	RECORD:

DATE	MEDICINE	#	PARENT SIGNATURE	NURSE SIGNATURE

Quick Reference Emergency Plan for a Student with Diabetes

Hypoglycemia (Low Blood Sugar) Photo

Student's Name						
Grade/Teacher				Date of Plan	1	
Emergency Contact I	nformation:					
Mother/Guardian			Father/Guardian			
Home phone Work phone Cell			Home phone	Work phone	Cell	
School Nurse/Trained	Diabetes Personnel		Contact Number(s	s)		
	Never send a	child with suspect	ted low blood sugar a	anywhere alone.		
Causes of Hypoglycemia • Too much insulin • Missed food • Delayed food • Too much or too intense exercise • Unscheduled exercise			Onset Sudden			
		Svi	mptoms	7		
			¥			
 Shakiness Weakness Paleness Inability to Behave change change Poor 		HeadacheBehavior change	Blurry vision Weakness Slurred Speech Confusion Other	• Seizu	Severe • Loss of consciousness • Seizure • Inability to swallow	
Circle student's usu	al symptoms.	Circle studer	nt's usual symptoms.	Circle stu	Circle student's usual symptoms.	
Y		A 40	Ψ		*	
Actions Needed Notify School Nurse or Trained Diabetes Personnel. If possible, check blood sugar, per Diabetes Medical Management Plan. When in doubt, always TREAT FOR HYPOGLYCEMIA.						
Y			<u> </u>		*	
Provide quick-sugar source. 3-4 glucose tablets or		Someone assiGive student				
6 oz. regula	4 oz. juice 6 oz. regular soda or Or A Pachaek bloo				Contact school nurse or trained diabetes personnel.	
Wait 10 to 15 minutes. Package blood glyngsg		or blood glue	f symptoms persist ose is less than	prescribed. • Call 911.	glucagon, as	
l		Follow with a	snack of	Contact par	rents/guardian.	

• Stay with student.

• Follow with a snack of

cheese and crackers).

carbohydrate and protein (e.g.,

• Follow with a snack of

cheese and crackers).

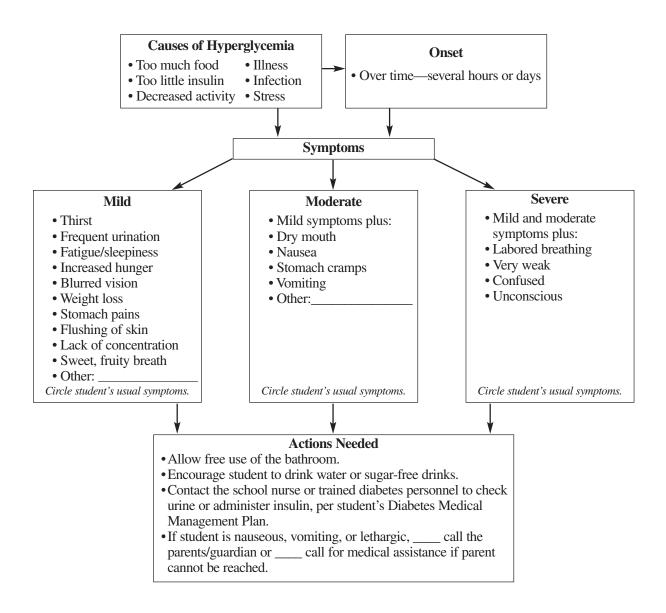
carbohydrate and protein (e.g.,

Quick Reference Emergency Plan for a Student with Diabetes

Hyperglycemia (High Blood Sugar)

Photo

Student's Name						
Grade/Teacher				Date of Plan		
Emergency Cont	act Information:					
Mother/Guardia	n		Father/Guardian			
Home phone	Work phone	Cell	Home phone	Work phone	Cell	
School Nurse/Trained Diabetes Personnel			Contact Number((c)		



HASBROUCK HEIGHTS PUBLIC SCHOOLS SCHOOL HEALTH SERVICES

Health History Questionnaire

To the parents or guardians of
It is important we have this information for your child's well-being during his/her school hours. Please complete and return this form to the School Nurse as soon as possible.
1. Does he/she have a medical Problem? If yes, please state problem:
2. Is he/she on medication? If yes, pleas list medication(s):
3. Are there any restrictions? If yes, please list restrictions:
4. Does your child have any allergies to food or medication? If yes, what:
This information will be shared with staff as necessary. If you DO NOT want this information shared, please notify me immediately. Thank you for your cooperation in this matter.
Parent Signature: Date:

Hasbrouck Heights Public School School Health Services

AUTHORIZATION

FOR THE EXCHANGE OF CONFIDENTIAL INFORMATION

STUDENT	DATE OF BIRTH	
	nt, I hereby authorize the release of pertinent medical cations and treatment regimes) to be exchanged among e of the above named student.	
	nool in the Hasbrouck Heights Public School and is ild. If you have any questions or concerns, please contact	
Signature of Parent / Guardian	Date	
Print name of Parent / Guardian	Telephone Number	
Thank you,		
The Nursing Department Hasbrouck Heights Public School		

updated 1/23/09