HUMBLE ISD HEALTH SERVICES

Student: _____
DOB: _____
Student ID #: _____

DIABETES ASSESSMENT

Please complete and return to the School Nurse.
The following information is helpful in determining any special needs. School year: _____

Person to contact:	Relationship:	Work Phone:	Home Phone:
1.			
2.			

Preferred Communication method: ☐ Phone ☐ Written ☐ In Person ☐ Email: _____

Health Care Provider	Clinic:	Phone:

Hospital:	Phone:

Child's age at diagnosis of diabetes: _____

Does your child wear a medical alert bracelet/necklace? ☐ Yes ☐ No

Will your child need routine snacks at school? ☐ A.M. ☐ P.M. ☐ as needed
(Snacks will need to be provided by the family)
What would you like done about birthday treats and/or party snacks? _____

What time should your child's blood sugar be monitored? ☐ A.M. ☐ P.M. ☐ as needed
(Authorization by a health care provider is required.) ☐ not needed

Does your child know how to check his/her own blood sugar? ☐ Yes ☐ No

Will your child need to test his/her urine for ketones at school? ☐ Yes ☐ No

Will your child need to test his/her blood for ketones at school? ☐ Yes ☐ No

What blood sugar level is considered low for your child? below _____

How often does your child typically experience low blood sugar? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____

When does he/she typically experiences low blood sugar:
☐ mid A.M. ☐ before lunch ☐ afternoon ☐ after exercise ☐ other _____

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

☐ hunger or "butterfly feeling"	☐ irritable	☐ difficulty with speech
☐ shaky/trembling	☐ weak/drowsy	☐ difficulty with coordination
☐ dizzy	☐ inappropriate crying or laughing	☐ confused/disoriented
☐ sweaty	☐ severe headache	☐ loss of consciousness
☐ rapid heartbeat	☐ impaired vision	☐ seizure activity
☐ pale	☐ anxious	☐ other

Does he/she recognize these signs/symptoms? ☐ Yes ☐ No

In the past year, how often has your child been treated for severe low blood sugar? _____

In a health care provider's office ☐ In the emergency room ☐ Overnight in the hospital ☐

In the past year, how often has your child been treated for severe high blood sugar or diabetic ketoacidosis? _____

In a health care provider's office ☐ In the emergency room ☐ Overnight in the hospital ☐

DIABETES ASSESSMENT

What do you usually do to treat low blood sugar at home? Please be specific and state exact amount of food, beverage, glucagon, etc. (All supplies must be provided by the family if needed at school.) _____
Please indicate your child's skill level for the following:

Skill	Does alone	Does with help	Done by adult	Comments
Obtain glucose sample				
Reads meter and records				
Counts carbs for meals/snack				
Interprets sliding scale				
Selects insulin injection site				
Measures insulin				
Administers insulin				
Measures ketones				
Pump skills				

Insulin taken on a regular basis:

Name	Type	Units	Time of day	Delivery Method (Pen, syringe, pump)

Does your child use an insulin to carbohydrate ratio? Yes ☐ No ☐ Ratio: _____

Does your child adjust the insulin dose for high or low blood sugar? Yes ☐ No ☐ Correction factor (insulin sensitivity): _____

Other medication taken on regular basis:

Name	By (mouth, injection, etc)	Dose	Time of Day

As needed medication:

Name	By (mouth, injection, etc)	Dose	Time of Day

Please list any known medication side effects that may affect your child's learning and/or behavior:

_____

_____

If a medication is to be given at school, a medication authorization form must be completed yearly. A prescribing health professional may authorize self-administration of medication if the student is deemed capable. The medication must be in the original labeled container. When you get the prescription filled, please ask the pharmacist to put it into two containers so the student will have one for school and one for home use.

What action do you want school personnel to take if your child's does not respond to treatment/medication?

_____

_____

In an acute emergency, the student will be transported by paramedics to the hospital. Transportation in a non-acute situation is the responsibility of the parent/guardian. Any charges incurred are the responsibility of the parent/guardian.

Has your child received diabetes education? ☐ by health care provider ☐ at support group ☐ at camp ☐ other

Please add anything else that you would like school personnel to know about your child's diabetes (or related health conditions).

_____

_____

Information was provided by _____ (Name) _____ (Relationship to Student) _____ (Date)

I authorize reciprocal release of information related to diabetes mellitus between the school nurse and the health care provider.

_____ (Parent/Guardian) _____ (Date)

Adapted with permission from National Association of School Nurses, 2014

Feb 2017

Humble Independent School District Health Services

Authorization and Permission for Administration of Medication

☐ In eSchool
Nurse Initial_____
Expiration Date
_____

Guidelines for acceptance and administration of medications in Humble ISD are available from the campus nurse.

Students Name_____ **DOB**_____
Last **First** **MI**

PARENT/GUARDIAN SECTION

Medication name **Strength** **Dosage** **Route** **Time**

Start Date_____ Allergies_____

Special Instructions/Duration_____

Condition for which drug is to be given_____

Medications currently taken at home_____

Note: Non-prescription medications taken more than 4 times in a month and prescription PRN medication will require a physician's order (signature is required) indicating maximum dosage allowed per month.

PARENT: PLEASE SIGN AT THE BOTTOM OF THE MEDICATION FORM

PHYSICIAN'S SECTION: PLEASE WRITE ORDER FOR SCHOOL ADMINISTRATION

Parent approval for release of information indicated below. Prescription medication given more than 10 days, non-prescription medication given more than 4 times in a month, or in excess of recommended dosage on the container and all prescription PRN medications require a physician's order.

Medication name **Strength** **Dosage** **Route** **Time**

Start Date_____ Allergies_____

Special Instructions/Duration_____

Condition for which drug is to be given_____

Medications currently taken at home_____

Physician's name (print)_____ **Physician's signature**_____

Phone number_____ **Fax number**_____ **Date**_____

I request the above named student be given the medication at school by qualified staff, according to the prescription or non-prescription instructions and a record maintained. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the physician as needed and that medication information may be shared with school personnel who need to know. I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication.
Completion of this form acknowledges your review of and agreement to follow all district medication guidelines.

Parent's Signature _____ **Date**_____
Daytime Phone_____ Alternate phone _____

Humble Independent School District Health Services

Authorization for Release of Medical Records

Student_____ DOB_____ Date_____

Campus_____ Grade_____

I grant permission for the release of medical information and physician recommendations as it pertains to the student's accommodations which will allow for participation in the educational process with minimal disruption.

Information requested_____

_____

_____

From: (Physician Name & Address)

_____

_____

_____

_____

To: (School Nurse)

_____

_____

_____

_____

_____ _____

Signature of Parent/Guardian, (Student if 18 years or older)

Date

The mission of Humble ISD Health Services is to enhance the health and well being of the students, staff, and community thus supporting the education of all students through maximizing their educational time.

HUMBLE INDEPENDENT SCHOOL DISTRICT

Authorization for Administration of Diabetes Management and Care Services By Unlicensed Diabetes Care Assistant

Information to Parents: The health and safety of each student is always of paramount importance to every Humble ISD employee. The District is committed to providing a high level of care to meet any special medical needs students' exhibit. To help carry out that commitment, Humble ISD ensures that a Registered Nurse is assigned to each campus. The 79th Texas Legislature, through Houses Bill 984, amended the Health and Safety Code to provide more specific requirements for the provision of diabetes management and care services to students in public schools who seek care for the student's diabetes while at school. The school, in conjunction with the parent, will develop for each student who seeks care for diabetes at school an Individualized Health Plan that will specify the diabetes management and care services the student requires at school. Traditionally, the school nurse has provided any medical care students might require at school. Under HB 984, each school also must train other employees to serve as Unlicensed Diabetes Care Assistants who can provide diabetes management and care services if a nurse is not available when a student needs such services. Such services include the administration of insulin or, in an emergency, glucagon. Humble ISD has trained staff at each school to provide such services. HB 984 further specifies that an Unlicensed Diabetes Care Assistant exercises his or her judgment and discretion in providing diabetes care services and that nothing in the statute limits the immunity from liability afforded to employees under section 22.0511 of the Texas Education Code.

Under HB 984, an Unlicensed Diabetes Care Assistant may only administer diabetes care and management services if the student's' parent/guardian authorizes an Unlicensed Diabetes Care Assistant to assist the student and confirms his or her understanding that an Unlicensed Diabetes Care Assistant is immune from liability for civil damages under section 22.0511 of the Texas Education Code.

Please check the appropriate boxes below to indicate your election whether to allow: 1. an Unlicensed Diabetes Care Assistant to provide services to your child; 2. self-care; 3. disclosure of your child's condition:

_____**YES** Agreement for Services: I authorize an Unlicensed Diabetes Care Assistant to provide diabetes management and care services to my child at school. I understand that an Unlicensed Diabetes Care Assistant is immune from liability for civil damages under section 22.0511 of the Texas Education Code.

_____**NO** I **DO NOT** authorize an Unlicensed Diabetes Care Assistant to provide diabetes management and care services to my child at school. In the absence of the nurse, the parent and/or 911 will be called for care or diabetic emergency.

_____**YES** I request that my child's classmates be informed that my child has diabetes, and given age appropriate instruction regarding diabetes care, so that they understand the importance of symptoms and the types of intervention that may occur in the classroom.

_____**YES** My child can manage his/her diabetes independently and will not seek assistance for his/her diabetes while at school. I understand the school nurse will provide emergency care as needed. This information will be shared with school district personnel as needed.

_____ _____

STUDENT NAME *(Please Print)* SCHOOL

_____ _____

Signature of Parent/Legal Guardian Date Signed