Health Services
4280 N. James H. McGee Blvd.
Dayton, OH 45417
(937) 542-3346

Health Forms for Students with Diabetes

Please complete packet and return to your child's school nurse.

What is in this packet?

1. **DIABETES MANAGEMENT FOR STUDENTS – INTRODUCTION LETTER FOR PARENTS**

2. **STUDENT DIABETES HISTORY -** for parent to describe student's diabetes history and list current medications.
   - Your school nurse will complete a Diabetes Emergency Action Plan for your child based on their physician's orders (*Diabetes Medical Management Plan*), and the information parents provide on their Student Diabetes History form. This Emergency Action Plan will be shared with appropriate school personnel to ensure the safe management of your child's diabetic condition during the school day.

3. **MEDICATION AUTHORIZATION FORM / GENERAL MEDICATION FORM**
   - **Guidelines for Medications at School** – on page 2 of Medication Authorization Form
   - Most oral diabetic medications can be given at home before or after school, but if an oral diabetic medication must be given at school, please complete this form.
   - Must be signed by parent and Health Care Provider (HCP)
   - Signed form and medication should be brought to school by a responsible adult

4. **AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION for:**
   - Dayton Children's Hospital
   - Cincinnati Children's Hospital

Questions? - Please call your school nurse

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Diabetes Management at School – Introduction Letter for Parents

Hello Parents/Guardians,

Dayton Public Schools is here to support your child and their diabetic care at school. Children spend about half of their waking hours in school, therefore reliable diabetes care during their school day really matters.

Your child's school nurse will work diligently with your child's teacher(s) and other school staff in managing your child's diabetes care, but you will want to first share important information with the school nurse.

Important information to share with your school nurse:

1. Before the year begins, **meet with your child's diabetes healthcare provider to develop a personalized Diabetes Medical Management Plan (DMMP).**
   - The DMMP contains all orders from your child's diabetic physician and should explain everything about diabetes management and treatment including:
     - Target blood sugar range and whether your child needs help checking his or her blood sugar
     - How to treat hypoglycemia
     - Insulin or other medication used
     - Meal and snack plans, including for special events
     - How to manage physical activity/sports
   - The DMMP works with your child's daily needs and routine. ***Please share any updates whenever treatment changes are made by your child's physician.***
   - After seeing the diabetic physician, please visit the school and submit and review the DMMP with the school nurse. The school nurse will collaborate with your child's teacher(s) and other staff who may have responsibility for your son or daughter during the day and after school.

2. **Please complete the "Student Diabetes History" form** and return to the school nurse. This questionnaire for parents will help your child's school nurse provide care and create an emergency care plan if needed.

3. **You may want to work with the school to set up a 504 plan.** The 504 plan will explain what the school will do to make sure your son or daughter is safe and has the same education opportunities as other students. The 504 plan makes the school's responsibilities clear and helps avoid misunderstandings. A new plan should be set up each school year. Please see your child's teacher or school nurse to set up a 504 plan.

4. Please note that the **school nurse** at DPS is the main staff member in charge of your student's diabetes care, but may not always be available when needed. **One or more**

backup school employees will be designated by your child's principal for diabetes care tasks and should be on site at all special functions.

5. **Review the Diabetes Checklist**
   - Review all necessary supplies needed for the school day. Your child MUST have the following items to ensure safe diabetes management at school:
     - Blood sugar meter and extra batteries, testing strips, lancets
     - Ketone testing supplies
     - Insulin and syringes/pens (include for backup even if an insulin pump is used)
     - Antiseptic wipes
     - Glucose tablets or other fast-acting carbs like fruit juice or hard candy (about 10 to 15 grams or whatever the physician orders) that will raise blood sugar levels quickly

   - **Also make sure your child:**
     - Wears a medical ID necklace, bracelet (or other option) every day.
     - Tests blood sugar according to schedule; older students can set phone reminders.
     - Knows where and when to go for blood sugar testing if help is needed.
     - Knows who to go to for help with hypoglycemia and to never go alone for help if there are others around

6. **Make a "Hypo" Kit for your child's field trips, sports, & other special events.** Kids with diabetes can participate in all school related activities.
   - In case of hypoglycemia, keep a go-to box of supplies in the school office or nurse's office and/or with your child. Label it with your child's name and remember to keep it stocked! Important items to include:
     - Glucagon (Emergency med)
     - Test strips
     - Lancets
     - Blood sugar monitor
     - Glucose tablets
     - Juice boxes
     - Crackers

7. **Treating Hypoglycemia – Important!**
   - Hypoglycemia MUST be treated immediately. It's most often caused by too much insulin, waiting too long for a meal or snack, not eating enough, or getting extra physical activity. Since hypoglycemia symptoms can vary, please share your child's specific low blood sugar symptoms with the school staff. Most common hypoglycemia symptoms are:

     - Shakiness
     - Nervousness or anxiety
     - Sweating, chills, or clamminess
     - Irritability or impatience
     - Dizziness and difficulty concentrating

- Hunger or nausea
- Blurred vision
- Weakness or fatigue
- Anger, stubbornness, or sadness

- You must inform your child's physician if he/she has hypoglycemia several times a week, to see if the treatment plan needs to be adjusted. The school nurse will be happy to fax diabetic documentation records to the physician as ordered or when asked by the parent.

8. **Stay Well All Year**
   - Make sure your child has had all recommended shots, including the flu shot. Sickness causes blood sugars to fluctuate making diabetes management more difficult!
   - Regular hand washing, especially before eating and after using the bathroom, is one of the best ways to avoid getting sick and spreading germs to others.

Please contact your school nurse if you have any questions or concerns. Thank you!

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STUDENT DIABETES HISTORY

Parent: Please complete information below so your school nurse can provide care and create an Emergency Action Plan for your child. Please return this form to your school nurse.

CONTACT INFORMATION:

Student's Name: _____Date of Birth: _____School Year: _____
School: _____Grade: _____Homeroom: _____
Parent/Guardian Name: _____Email: _____
Parent Guardian Tel: (H) _____(W) _____(C) _____
Diabetes Physician: _____ Tel: _____
Primary Care Doctor: _____ Tel: _____
Significant medical history or conditions: _____

DIABETES INFORMATION:

1. When was your child diagnosed with diabetes: Year _____ or Age _____ ❑Type 1 Diabetes ❑Type 2 Diabetes
2. Student Skill/Ability (Place a X to indicate your child's skill/ability to complete task listed.

Student Skill/Abilities	Adult Needs to Complete	Adult Needs to Assist	No Assistance Needed
Blood sugar check?			
Count carbs?			
Calculate carb and correction bolus?			
Insulin Pen: Dial correct units on Insulin Pen			
Insulin Pen/Syringe: Give own insulin injections?			
Insulin Syringe: Draw up own insulin using syringe from a vial (if ordered)?			
Insulin Pump: Bolus correct amount of carbs?			
Insulin Pump: Calculate and administer correction bolus?			
Insulin Pump: Disconnect pump?			
Insulin Pump: Reconnect pump at infusion site?			
Insulin Pump: Prepare reservoir and tubing?			
Insulin Pump: Insert infusion set?			
Insulin Pump: Troubleshoot alarms?			

3. Hypoglycemia (low blood sugar): My child's usual symptoms are _____
4. Hyperglycemia (high blood sugar): My child's usual symptoms are _____
5. Any special considerations & safety precautions for school activities: ❑ General health ❑ Gym/ sports (physical activity) ❑ Physical functioning ❑ Learning ❑ Field trips ❑ Recess ❑ Bus transportation ❑ Mood / coping ❑ Behavior ❑ Other Explain:_____
6. During classroom parties, my child will:
   ❑ participate by eating the treat and receive a carb bolus following carb content and physician's orders
   ❑ replace the treat with an alternate treat from home
   ❑ not eat the treat

I authorize Dayton Public Schools to communicate and share health information with appropriate school personnel to create an emergency action plan if necessary and to aid in present and future educational decisions.

Parent Signature: _____Date: _____ Date Updated: _____

Reviewed by School Nurse: _____Date: _____ Date Updated: _____

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dayton children's

Authorization for Release of Dayton Children's Information

Patient Information	Last Name	First Name	Middle	
	Address	City	State	Zip
	Birth Date	Other Possible Names	Phone #	

Please select the box or boxes indicating which record(s) will be released/disclosed.

- ☐ Inpatient Records ☐ Abstract — Date(s):
- ☐ Test Results — Date(s):
- ☐ Almost Home Records ☐ Abstract — Date(s):
- ☐ Radiology Reports ☐ CD of image — Date(s):
- ☐ Emergency Department Records — Date(s):
- ☐ Outpatient Clinic Records — Date(s): Area:
- ☐ Operative Reports — Date(s):
- ☐ Psychological/Psychiatric — Date(s):
- ☐ Discharge Summary — Date(s):
- ☐ Other — Notes:

Please check the box indicating the method to receive copies of the records.		
	☐ Mail Copies (**Complete address in box below**)	☐ Pick up Copies (**Photo ID required**) Date:
	☐ Review Only (**Photo ID required**) Date:	☐ Fax (**Patient Care Only**)

The following individual or organization is authorized to receive the information:			**The following individual or organization is authorized to make the disclosure:**		
Name			*Name* Dayton Children's Hospital/ _____ Dept.		
Address			*Address* One Children's Plaza		
City	*State*	*Zip*	*City* Dayton	*State* Ohio	*Zip* 45404-1815
Phone #	*Fax #*		*Phone #*	*Fax #*	

Please check the box indicating the reason for the request. For medical treatment, please indicate the appointment date.		
	☐ Medical Treatment, **Date of appointment:**	
	☐ Disability	☐ Legal
	☐ Insurance	☐ School
	☐ Other:	

I hereby authorize, Children's Medical Center (Dayton Children's), to release and/or receive medical information, as indicated herein, to/from the above party. This authorization includes release of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions of the above-mentioned patient.

I understand that this authorization shall remain in effect for 1 year from the date of my signature below unless an earlier expiration date is specified in this space (_____). I also understand that except to the extent that action has been taken based on my authorization, I may withdraw this authorization at any time by written notification to the parties involved.
I further agree that Dayton Children's may charge me or other designated recipients cost incurred in preparing the copy of the requested medical records. Dayton Children's will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this authorization.

I understand that if the person or entity that receives the above information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

Signature of Patient or Guardian	Date	
Relationship to Patient	Medical Record #	
Signature of Witness	Verification of Requestor ☐ By Signature ☐ By Photo ID	Copy given to Requestor? Y / N

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Cincinnati Children's

Authorization for Use and/or Disclosure of Protected Health Information (PHI)

MEDICAL RECORD #: _____ CSN / ACCT #: _____ (completed by CCHMC)

This form authorizes Cincinnati Children's Hospital Medical Center (CCHMC) to use and/or disclose protected health information in the manner described below and is voluntary. CCHMC will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The information used or disclosed as a result of this Authorization may be subject to re-disclosure by the person or entity receiving such information, and no longer protected by the federal privacy regulations. Please see the back of this form for tips for requesting medical record copies.

NOTE: Failure to complete each section of this form in its entirety *(including dates needed) may significantly delay the processing of your request.*

Patient Information

Patient (Pt) Name: _____ Gender: ☐ Male ☐ Female
Last First Middle Maiden (if applicable)

Date of Birth: _____ Phone: ( ) _____

Name of Patient/Parent/Legal Guardian (LG) Completing Form: _____

Patient/Parent/Legal Guardian Email Address: _____

Patient/Parent/Legal Guardian Address: _____

Release To

Name: _____ Organization (if applicable): _____

Street Address: _____

City/State: _____ Zip Code: _____ Telephone: ( ) _____

Information May Be Sent Via (*Note: Radiology images can only be placed on CD and mailed or picked-up*):

☐ US Mail ☐ MyChart (released to Patient/Parent/Legal Guardian only) ☐ Picked Up (Individual to Pick-up): _____

☐ Reviewed in Health Information Management (HIM) (Appointment Necessary)

I would like copies provided in the following format: ☐ Paper- see fees on back of form ☐ CD- cost not to exceed $50 plus shipping and handling.

☐ Verbal communication only between CCHMC care providers and person/entity named above. (HIM Department does not release PHI over the phone).

Purpose *(Optional for Patient/LG)*

Records are to be released for the following purpose(s): (*please select all that apply*)

☐ Medical Care, patient has an appointment on the following date: _____

☐ Attorney/Legal ☐ Personal ☐ Insurance ☐ Disability/SSI ☐ Education ☐ Military ☐ Other: _____

Information to Release

Dates of Treatment Requested: Last 2 years of active treatment will be provided unless specified. Dates: _____

☐ Medical Record Abstract – pertinent information generally used for continued care/personal use/disability. (*The following items are included in a Medical Record Abstract.*)

- ☐ Discharge Summary
- ☐ Emergency Department Record
- ☐ History & Physical
- ☐ Inpatient Consult Reports, Specify MD/Specialty: _____
- ☐ Outpatient Clinic Notes, Specify Clinic(s): _____
- ☐ Other Tests, please specify: _____
- ☐ Operative Reports
- ☐ Radiology Reports
- ☐ Lab Reports

Other Information Requested:

- ☐ Immunizations
- ☐ Radiology Images
- ☐ Registration Sheets
- ☐ Other: _____
- ☐ Other: _____

Patient/Parent/Legal Guardian

Unless otherwise revoked, this Authorization will expire one (1) year from the date signed or, if specified on the following date (optional): _____
Unless otherwise noted, records documented after the signature date below will be released upon verbal or written request of the Patient/Parent/Legal Guardian for up to one year from the date of signature. This Authorization may be revoked at any time. However, the revocation will not apply to uses or disclosures occurring prior to our receipt of your revocation request. To revoke the Authorization the patient/parent/legal guardian must submit a revocation request in writing to the HIM department at the address below. If CCHMC requests this Authorization for its own use or disclosure, a copy of this Authorization must be provided. Please refer to the CCHMC Notice of Privacy Practices.

I, the undersigned, hereby authorize CCHMC to use and/or disclose information from the medical or financial record as specified above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity.

Signature of Patient: _____ **Date:** _____
(If 18 years of age or older OR is an emancipated minor)

Signature of ☐ **Parent** ☐ **Legal Guardian** ☐ **GAL/CASA:** _____ **Date:** _____
Note: If Legal Guardian, GAL/CASA is checked, documentation establishing relationship must be provided, or on record, in order to comply with this request.

Submit

Verify that all sections are completed in full, signed and dated. Upon completion, please do one of the following:

Mail the completed form via US Mail to:	Fax the Form to:	E-mail the Form to:
Cincinnati Children's Hospital Medical Center 3333 Burnet Avenue, ML 5015 Cincinnati, Ohio 45229-3039	(513) 636-6729	him1@cchmc.org

Request Has Been Fulfilled: ☐ Yes, Name _____ Date _____ Page Count _____

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Form F01a

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