DIABETIC

ST. LANDRY PARISH SCHOOL BOARD
PUPIL APPRAISAL CENTER
127 BLAIR STREET
OPELOUSAS, LA 70570

Dear Parent/Guardian:

We would like to inform you of the school policies that have been in place to ensure the health, safety and welfare of children who need medicine during the school day. Our school board requires that the following forms must be on file in your child's health record before we begin to give any medicine at school.

1. Consent from signed and dated by parent or guardian.
2. Medication order form filled out, signed, and dated by child's doctor.
3. Emergency plan filled out, signed and dated by parent.
4. Call school nurse for appointment time before reporting to the school.

When your child needs medication to be given during the school day, please refer to these simple rules to help make it a more pleasurable experience.

1. Medication must be brought in by a parent/guardian only. **No students are allowed to bring medication onto campus**. Only a 35 day supply of medicine will be accepted.
2. Each school has a designated time of receiving medication. Please check with your child's school personnel for these times.
3. Each school has designated times for given medications; please help the school personnel by following this policy.
4. Antibiotics, skin creams, pain medicine, or a.m. doses will have to be approved by the school nurse prior to administering in schools.
5. All doctor's orders and medicine bottle labels must match.
6. **Must meet with school nurse before medication can be given (exception: asthma inhalers and epi pens)**

I have read and understand the above rules that must be complied with for my child to receive medications at school.

_____ _____

Parent's/Guardian's Signature Date

Thank you for your cooperation in helping us give your child's medicine safely.

Alvado C. Willis

_____

School Nurse's Signature

Alvado C. Willis
Director of Special Education

ST. LANDRY PARISH SCHOOL BOARD
PUPIL APPRAISAL CENTER
127 BLAIR STREET
OPELOUSAS, LA 70570

Dear Parent or Guardian:

We would like to inform you of the Louisiana State Guidelines that are in place to ensure the health, safety, and welfare of children who need procedures during the school day. The following forms must be on file in your child's health record before we begin to train anyone to perform the procedures at school. We also require a meeting with the parent and the child prior to beginning procedure training.

1. Parental Consent Form signed and dated by the parent or guardian.

2. Procedure Order Form filled out, signed, and dated by child's doctor.

3. Emergency Plan filled out, signed, and dated by parent or guardian.

4. Transportation Plan filled out, signed, and dated by nurse and parent if school bus will be used.

Thank you for your cooperation in helping us provide safe procedures at school.

I have read and understand the above rules that must be complied with, in order for my child to receive a procedure at the school setting.

Parent's / Guardian's Signature

Date

School Nurse's Signature

Alvado C. Willis
Interim Special Education Director

ST. LANDRY PARISH SCHOOL BOARD
PARENT/GUARDIAN WRITTEN REQUEST AND CONSENT
FOR MEDICATION ADMINISTRATION

General Information

Name of Student: _____ School: _____
Date of Birth: _____ Sex: _____ Grade: _____ Teacher_____
Name of Parent / Guardian: _____
(Please Print)
Telephone Number – (Home) _____ (Work) _____
Telephone Number – (Where parent/guardian can be reached in case of emergency):_____
Other Persons to be notified in case of emergency if parent/guardian is unavailable:
Name:_____ Telephone:_____
Relationship:_____
Name:_____ Telephone:_____
Relationship:_____

My son / daughter is currently receiving the following medications: Please list all medications the child is receiving, including those given during the school day:
1._____ 2._____ 3._____ 4._____

My son / daughter is known to have the following allergies: _____

********** **********

Consent

1. I hereby give permission for the school nurse or the designated unlicensed school personnel to give the following medicine:_____ prescribed.
(Name of Medication)

_____ _____
(Licensed Prescriber) (Name of Student)

2. I give permission for my son / daughter to self-administer medication if the school nurse determines it is safe and appropriate in the school: Yes _____ No____

I acknowledge that the St. Landry Parish School Board and its employees shall incur no liability as a result of any injury sustained by the student from the self-administration of medications used to treat asthma or anaphylaxis. The parent or legal guardian shall indemnify and hold harmless the St. Landry Parish School Board and its employees against any claims that may arise relating to the self-administration of medications used to treat asthma or anaphylaxis. (***Health and Safety, Bulletin 135, Louisiana Department of Education***)

Signature of Parent/Guardian: _____
Signature of Student: _____

3. I give permission to the school nurse to obtain information relative to the prescribed medication from the above named physician and share it with appropriate school personnel (such as adverse effects).
Yes ___ No ___ Restrictions on release: _____

4. **I have administered the initial dose ordered at home and have allowed sufficient time for observation of adverse reactions before asking school personnel to administer the medication.**
Yes___ No___

5. I understand if there is a change in physicians, the medication order is no longer valid:
Yes___ No___

(Please note: I understand that I may retrieve the medication from the school at any time and that the medicine will be destroyed if it is not picked up within one week following termination of the order or _____ beyond the close of school.)

Signature of Parent / Guardian _____

Relationship to Student _____ Date:_____

ST. LANDRY PARISH SCHOOL BOARD
PUPIL APPRAISAL CENTER
127 BLAIR STREET
OPELOUSAS, LA 70570

PARENT / GUARDIAN CONSENT TO ADMINISTER PROCEDURE

NAME OF STUDENT _____

DATE OF BIRTH _____ SEX _____

SCHOOL _____

GRADE _____ TEACHER _____

1. I give permission for the school nurse or the designated unlicensed person, trained to administer procedures, according to the guidelines stated in Bulletin 1909, to perform the following procedure at school:

   _____
   NAME OF PROCEDURE

   to _____
   NAME OF STUDENT

   prescribed by _____
   NAME OF DOCTOR

2. **Parent is responsible for providing all medical supplies.**

3. I give permission to the school nurse to obtain information relative to the prescribed procedure, from the above named physician, and share it with appropriate school personnel.

   Restrictions on release _____ Yes__ No___

4. Mode of transportation: Private vehicle ____ School Bus _____ Other _____

   If riding bus, please give Bus# _____ Bus Driver _____

_____ _____
Signature of Parent / Guardian Date of Signature

ST. LANDRY PARISH SCHOOL BOARD

EMERGENCY PLAN

Name of Student_____ Teacher_____ Grade_____

Name of Parent / Guardian_____

Phone Numbers: Home _____ Work _____ Cell _____

Alternate Adult Contact Person: (1) _____ Phone#_____

Alternate Adult Contact Person: (2) _____ Phone#_____

Relationship of alternate persons to student: (1)_____ (2)_____

Physician's Name _____ Phone Number_____

Poison Control Number: 1-800-256-9822

Student's allergy history: _____

(List all medications, food, plants, insects, etc. that your child is allergic to)

Field Trip Designated Person: Trained Personnel_____

Parent/Guardian_____

Alternate Adult Person_____

I am aware that if my child has an emergency in school and I am not available, the school principal or alternate will have my child transported to the emergency room, and I will be responsible for payment of emergency care.

IF AN EMERGENCY OCCURS, SCHOOL PERSONNEL WILL DO THE FOLLOWING:

1. **If the emergency is life threatening, immediately call 9 – 1 – 1.**
2. **Stay with the student, or designate another adult to do so.**
3. **Contact the parent/guardian, or alternate adult (named above).**
4. **Follow school protocol.**
5. **Contact school nurse at your child's school.**

_____ _____

Signature of Parent/Guardian Date Signed

STUDENTS WITH SPECIAL HEALTH CARE NEEDS

TRANSPORTATION PLAN

Student's Name _____
School _____ Teacher's Name _____
School Bus# _____ a.m. _____ p.m. Bus Driver's Name _____
Parent/Guardian Name _____
Address _____
Telephone (home) _____ (cell) _____

Work Phone (dad) _____ (mom) _____

Babysitter's Name _____ Phone _____

Babysitter's Address _____

Disability / Diagnosis _____

Medication(s) _____

Side effects of Medication(s) _____

1. Mode of transportation on bus: (check one)
   _____wheelchair _____car seat _____seat belt _____chest harness _____regular seat

2. Walks up bus stairs independently: _____yes _____no

3. List student's method of communication _____

4. List any behavioral difficulties student displays _____

5. List equipment that must be transported on bus (such as oxygen, life sustaining equipment, wheelchair equipment, climate control, etc.) _____

6. Wheelchair restraint checklist (check all that apply)
   _____seat belt _____chest harness on _____wheelchair brakes on
   _____tray off _____headrest and hip abductor in place _____other: _____

_____ _____
School Signature Date

ST. LANDRY PARISH SCHOOL BOARD
SCHOOL NURSE PROGRAM
UNAVAILABLE MEDICATION TIMES

Date: _____

Student Name: _____

Date of Birth: _____

MD: _____

Please be aware that medications are unavailable after the school office closes and on the school bus (including Diastat®, Epi-Pens, Glucagon, and Inhalers), unless the student has orders to self-carry & administer medication without supervision.

_____ _____

Licensed Provider's Signature Date

_____ _____

Parent Signature Date

_____ _____

RN Signature Date

ST. LANDRY PARISH SCHOOL BOARD

ST. LANDRY PARISH PUPIL APPRAISAL CENTER
127 BLAIR STREET
OPELOUSAS, LA 70570
PHONE: (337) 948-3646 FAX: (337) 948-3644

DIABETIC MELLITUS PHYSICIAN ORDER

TO BE COMPLETED BY LA, TX, AR, OR MS LICENSED PRESCRIBER
TO BE USED WITH STATE OF LA MEDICATION ORDER

STUDENT _____ DATE OF BIRTH _____
SCHOOL _____ GRADE_____
DIAGNOSIS _____

TREATMENT PROTOCOL AT HOME:
Monitoring of Blood Sugar: _____
Medications: _____

For Students With Capillary Blood Glucose (CBG) CHECKS and/or Insulin Administration

GLUCOSE METER _____ **INSULIN TYPE/STRENGTH** _____/_____ units/milliliter

Can student administer own insulin ___YES ___NO Route of Administration: subcutaneous

BLOOD GLUCOSE MONITORING ___**YES** ___**NO**	**INSULIN TO CARBOHYDRATE COUNTING** ___**YES** ___**NO**	**INSULIN TO CORRECTION FACTOR** ___**YES** ___**N0**	**INSULIN TO SLIDING SCALE** ___**YES** ___**NO**	**Delivery of Insulin** ___ **Insulin Pen** ___ **Insulin Pump** ___ **Insulin Syringe**
Can student perform own blood glucose check? __**Yes** ___**No** When is student to assess blood glucose? ____ prior to lunch ____ for symptoms of hyperglycemia ____ for symptoms of hypoglycemia ____ other _____	Can student perform Self-Carbohydrate counting to insulin dosage? ___**Yes** ____ **No** **Insulin Sensitivity/ Carbohydrate Rate=** _____unit/_____gram Use Self-carbohydrate (CHO) counting to insulin dosage: _____Prior to Lunch _____Other_____	Can student calculate correction Factor dosage? ___**Yes** ___**No** Correction Factor: _____ Target Blood Glucose _____mg/dl Use Correction Factor : __ Prior to Lunch __ Other _____	Can student calculate Insulin according to sliding scale ___**Yes** ____**No** ****NOTE: COMPLETE SLIDING SCALE BELOW!!**	Is student competent in measuring and calculating insulin dose via **insulin pen**? ___**Yes** ___**No** _____ Type of Pump: _____ Is student competent regarding **pump**? ___**Yes** ___**No** Can student effectively troubleshoot problems? (e.g. ketones, pump malfunctions, etc.?) ___**Yes** ___**No** _____ Is student competent in measuring and calculating insulin dose via **syringe**? ___ **Yes** ___**No**

INSULIN ADMINISTRATION /SLIDING SCALE (follow scale below)
(Do not give insulin to cover carbohydrates given for hypoglycemia treatment.)

Dosage of Insulin	Blood Glucose Reading	Route of Administration
_____ units if blood glucose is	less than _____ mg/dl.	subcutaneous
_____ units if blood glucose is	_____ mg/dl. to _____ mg/dl.	subcutaneous
_____ units if blood glucose is	_____ mg/dl. to _____ mg/dl.	subcutaneous
_____ units if blood glucose is	_____ mg/dl. to _____ mg/dl.	subcutaneous
_____ units if blood glucose is	_____ mg/dl. to _____ mg/dl.	subcutaneous
_____ units if blood glucose is	_____ mg/dl. to _____ mg/dl.	subcutaneous
_____ units if blood glucose is	_____ mg/dl. to _____ mg/dl.	subcutaneous
_____ units if blood glucose is	_____ mg/dl. to _____ mg/dl.	subcutaneous

IF BLOOD SUGAR IS MORE THAN _____ mg/dl., CALL PARENT/GUARDIAN

MEALS AND SNACKS EATEN AT SCHOOL

Meal	Time	Number of Carbohydrate Grams	Food Content/ Amount
Breakfast			
AM Snack			
Lunch			
PM Snack			

Hypoglycemia Treatment	
Symptoms to treat:	
Glucose source to treat with:	
Hyperglycemia Treatment	
Symptoms to treat:	
Circumstances when urine ketones	
should be tested:	
Treatment for Ketones	
Negative	
Trace/Small	
Moderate/Large	
Additional Orders/Instructions	
Recheck Blood Sugar :	
Other Instructions:	

Any contraindications for administering medication: _____
Desired Effect: _____
Possible Side-Effects of Medication: _____
Duration of medication order: □ until end of school term □ other _____

_____ _____
Licensed Provider's Print Name Date

_____ _____
Licensed Provider's Signature Phone Number and Fax Number

STATE OF LOUISIANA
MEDICATION ORDER
TO BE COMPLETED BY LA, TX, AR, OR MS LICENSED PRESCRIBER

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE.

Student's Name: _____ DOB: _____

School: _____ Grade: _____

Parent or Legal Guardian Name (print): _____

Parent or Legal Guardian Signature: _____ Date: _____

(Please note: A parental/legal guardian consent form must also be filled out. Obtain from the school nurse.)

PART 2: LICENSED PRESCRIBER TO COMPLETE.

1. Relevant Diagnosis(es): _____
2. Student's General Health Status: _____
3. Medication: _____ Strength of medication: _____ Dosage (amount to be given): _____

   Route: ❑By mouth ❑By inhalation ❑Other _____ Frequency _____ Time of each dose _____

ALL PRN MEDICATION MUST DENOTE TIME INTERVAL BETWEEN DOSAGE

School medication orders shall be limited to medication that cannot be administered before or after school hours. Special circumstances must be approved by school nurse.

4. Duration of medication order: ❑Until end of school term ❑Other _____
5. Desired Effect: _____
6. Possible side-effects of medication: _____
7. Any contraindications for administering medication: _____
8. Allergies to food or medicine include: _____
9. Other medications taken at home: _____

   _____
10. Next visit is: _____

_____

Licensed Prescriber's Name (Printed) Address Phone and Fax Numbers

_____

Licensed Prescriber's Signature Credential (i.e., MD, NP, DDS) APRN # Date

Each medication order must be written on a separate order form. Any future changes in directions for medication ordered require new medication orders. Orders sent by fax are acceptable. Legibility may require mailing original to the school. Orders to discontinue also must be written.

PART 3: LICENSED PRESCRIBER TO COMPLETE AS APPROPRIATE

Inhalants / Emergency Drugs
Release Form for Students to be Allowed to Carry Medication on His/Her Person

Use this space only for students who will self-administer medication such as asthma inhaler.

1. Is the student a candidate for self-administration? ❑Yes ❑No
2. Has this student been adequately instructed by you or your staff and demonstrated competence in self-administration of medication to the degree that he/she may self-administer his/her medication at school, provided that the school nurse has determined it is safe and appropriate for this student in his/her particular school setting? ❑Yes ❑No

_____

Licensed Prescriber's Signature Credential (i.e., MD, NP, DDS) APRN # Date