Montgomery County Department of Health and Human Services
School Health Services

Montgomery County Public Schools

Date: _____

Dear Parent/Guardian:

The school health team, including the School Community Health Nurse (SCHN) and School Health Room Technician (SHRT) will work with you, your student and your child's health care provider to assure the well-being and safety of your child at school, and to foster your child's self-management of diabetes.

Parents/guardians are responsible for providing the following:

- Maryland State Diabetes Medical Management Plan (DMMP)/Health Care Provider Order form, completed by your child's medical provider, including orders for:
  - Insulin dosing
  - Glucose monitoring
  - Hypoglycemia management, including Glucagon
  - Hyperglycemia management
  - Exercise, sports and bus transportation
  - Disaster Plan
- Diabetes Questionnaire. Please complete and return to the Health Room to assist in determining diabetes needs.
- Authorization to Administer Prescribed Medication Form (MCPS 525-13). Parent/guardian completes and signs Part I only.
- Diabetes supplies, equipment and medications, including:
  - Glucometer and testing strips
  - Ketone testing strips
  - Snacks and fast acting carbohydrates such as juice or glucose tabs.
  - Medications, including insulin and Glucagon. Medications must include original pharmacy labels.
  - Students receiving insulin at school require at least one of the following:
    - Vial and insulin syringes
    - Insulin pen refills or additional insulin pens if using disposable pens
    - Pump supplies, including alternate insulin delivery method (vial and syringe or insulin pen).
  - User manuals or links to on-line user manuals for diabetes related equipment such as glucometers, insulin pumps and continuous glucose monitors.

Throughout the school year parents/guardians should consult and work with health room staff at your child's school. It is important to:

- Notify the school health team of any changes in the management of your child's diabetes.
- Let the school nurse know if your child is participating in school-sponsored events and activities.
- Understand that information will be shared with school staff on an as needed basis to ensure your child's safety.

Please return completed forms, supplies and medications to the Health Room. Please call if you have any questions.

Sincerely,

_____ _____

School Community Health Nurse Telephone

Enclosures: Maryland Diabetes Medical Management Plan (DMMP)/Health Care Provider Order Form
Authorization to Administer Prescribed Medication Form (MCPS 525-13)
Diabetes Questionnaire
Montgomery County DHHS Authorization to Release/Receive Information

Montgomery County Department of Health and Human Services
School Health Services

Diabetes Questionnaire: Please complete and return to the Health Room at your student's school.

Student Name: _____ DOB: _____ MCPS ID#: _____

School Name: _____ Parent/Guardian: _____ Date: _____

Transportation to/from school: ☐ car rider ☐ bus ☐ walker ☐ drives self

Preferred Contact Person	Relationship	Preferred contact: phone, e-mail or notes	Comments

Student's age at diagnosis: _____ Last diabetes appt: _____ Medical alert ID ☐ **Y** ☐ **N**

Meals and snacks (*snacks need to be provided by the family).*

☐ Breakfast at school ☐ Bringing lunch ☐ Buying lunch ☐ Regular snacks & time: _____

What would you like done about birthday treats and/or party snacks? _____

Low Blood Sugar (Hypoglycemia) and High Blood Sugar (Hyperglycemia)

How often does your student typically have low blood sugar? ☐ Daily ☐ Weekly ☐ Monthly

When does your student typically have low blood sugar? ☐ Mid-morning ☐ Lunch ☐ Afternoon ☐ After exercise

What are usual symptoms of low blood sugar? (circle all that apply)

Hungry	Headache	Tired	Fast Heartbeat	Irritable
Shaky	Blurred Vision	Flushed	Can't concentrate	Spacing Out
Weak	Sweaty	Hot	Behavior changes	Poor Coordination
Dizzy	Clammy		Anxious	Tingly around lips

Does your student recognize low blood sugar? ☐ **Y** ☐ **N**

What do you usually do to treat low blood sugar? *Be specific about exact amount of food/beverage used. All supplies needed for school must be provided by the family.* _____

In the past year, has your student been treated for severe low blood sugar? ☐ **Y** ☐ **N**

☐ Health care provider's office ☐ Emergency room ☐ Overnight in hospital

In the past year, has your student been treated for severe high blood sugar/diabetic ketoacidosis? ☐ **Y** ☐ **N**

☐ Health care provider's office ☐ Emergency room ☐ Overnight in hospital

Diabetes Skills	*Dependent Done by Adult*	*Supervision Does with Help*	*Independent Does Alone*	*Comments*
Blood glucose testing				
Continuous Glucose Monitoring				
Insulin dose calculations				
Carbohydrate counting				
Measuring insulin				
Insulin administration				
Insulin pump operation				
Self-management of mild hypoglycemia				
Safe disposal of diabetes supplies & sharps				

Testing ketones				

Has your student received diabetes education? ☐ By health care provider ☐ At support group ☐ At diabetes camp

Please add anything else you would like school personnel to know about your student's diabetes. Include medications for other health conditions.