Annual Diabetes Management Plan

Dear Parents/Guardians:

With this school year coming to an end it is time to assure your child's diabetes management plan is in place prior to the start of the next school year. ***According to the Revised Ohio Law your child cannot attend school without the completed plan.***

As an American Diabetes Association Accredited Center, patients are required to attend three to four clinic appointments per year. **Please note that if your child has not been seen in more than six months the diabetes management plan will not be completed.**

Please call our office at 330-543-3276 to schedule a follow up appointment if your child does not have an appointment currently scheduled to avoid any delay.

- Forms will be available for completion at our office for those who have an appointment scheduled within the next three months.

- Forms are also available online for completion on our website https://www.akronchildrens.org/cms/diabetes_endocrinology_center/ . Once completed they can be faxed to our office at 330-543-8489 or sent as an attachment in a MyChart message. *If you would like our office to fax your form to the school please include the school's fax number on your form.*

- The diabetes management plan and the authorization for release of information must be completed with the school information and must be signed and dated by a parent or legal guardian as well as witnessed. The forms are valid for one calendar year from the date it is signed.

- The diabetes management plan is the *only* form we will be providing to the school.

Thank you for your help in making your child's diabetes care successful during the upcoming school year.

The Staff of:
The Center for Diabetes and Endocrinology
Akron Children's Hospital

HIPAA AUTHORIZATION to RELEASE MEDICAL RECORDS

(Send Records **TO** Children's)

Facility Use Only
MRN ____________________

PATIENT Name ____ Date of Birth ____________________
Last First MI
Address ____ Phone ________________________
Street City State Zip

Release records TO: **AKRON CHILDREN'S HOSPITAL** ☐**Akron Campus** ☐ **Mahoning Valley Campus**

Name/Dept: ______________________________**Phone:** ________________ **Fax:** __________________
Address (circle one): One Perkins Square, Akron, OH 44308 or 6505 Market Street, Youngstown, OH 44512

Receive FROM the following Person(s) or Organizations:

Name:____

Address: ____
Street City State Zip
Phone:______________________________ ***Fax:***______________________________

Person or Place that is requesting records:
☐Patient/Parent/Guardian ☐Doctor/Hospital ☐Lawyer ☐Insurance Company ☐Other ____________________________

Reason records are needed:
☐Patient Care ☐Disability ☐Insurance ☐School ☐Legal ☐Other ____________________________________

Release the records checked below, ☐verbally ☐on paper **or** ☐electronically (if available)

☐Visit/Discharge summary ☐Lab results ☐Surgery report
☐Chart summary ☐Radiology reports or ☐images on disc ☐Billing records
☐Emergency room report ☐Doctor's office reports [Doctor name______________________________________]
☐Vaccination (shot) records ☐Entire chart
☐Pathology report ☐Other ____

Treatment dates: ____

This authorization expires one year from the date of signature, OR on this date / event: ______________________________

I understand that treatment does not depend on me signing this Authorization.

I understand that my/my child's/my ward's medical record might have information about sexually transmitted disease (STDs), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It might also have information about mental health problems or services, and/or treatment for alcohol or drug abuse.

I understand that if I release records to someone other than a doctor, insurance company, hospital or other health-related organization, these records may no longer be protected by the Federal privacy regulations, and this person or organization might release the records to someone else.

I understand that I can revoke or cancel this Authorization at any time, but this does not apply to records that were already released. If I want to revoke it, I must notify the Privacy Officer, in writing, at Akron Children's Hospital, One Perkins Square, Akron, OH 44308.

______________________________ ______________________________ ____________
Signature of Patient or Parent/Legal Guardian Printed Name Date

My relationship to the patient is:

☐Parent ☐ Legal Guardian * ☐Self ☐Other ______________________________

***Attach your Court Order to show your authority to sign.**

______________________________ ______________________________ ____________
Signature of Witness Printed Name Date

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PATIENT Name ____ Date of Birth ____________________

Last First MI

Address ____ Phone ______________________

Street City State Zip

Release TO the following Person(s) or Organizations:

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Phone:_______________________________ ***Fax:***_______________________________

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Reason records are needed:

☐Patient Care ☐Disability ☐Insurance ☐School ☐Legal ☐Other ______________________________

Release the records checked below, ☐verbally ☐on paper **or** ☐electronically (Cd or Jump Drive, if available) ☐to MyChart (if available. Parent/Legal Guardian needs to have MyChart Proxy access)

☐ Visit/Discharge summary
☐ Emergency room report
☐ Vaccination (shot) records
☐ Lab results (blood work)
☐Surgery report
☐Radiology reports (x-rays, MRI, CT scans) ☐images on disc
☐Doctor's office reports [Doctor or **Department** name_____________________________________]
☐Other ____
☐Pathology report
☐Billing records
☐ Entire chart* - includes all hospital departments and ACHP records (physician notes, surgery reports, consults, OT/PT/Speech ancillary records, emergency room reports, discharge summaries, after visit summaries, immunization records, radiology reports, labs reports)

***Please note**: This can be hundreds or thousands of pages.

Treatment dates *(if not specified, **the LAST 6 MONTHS** will be released)*:____

This authorization expires one year from the date of signature, OR on this date / event: ______________________________

I understand that treatment does not depend on me signing this Authorization.

I understand that my/my child's/my ward's medical record might have information about sexually transmitted disease (STDs), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It might also have information about mental health problems or services, and/or treatment for alcohol or drug abuse.

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______________________________ ______________________________ ____________

Signature of Patient or Parent/Legal Guardian Printed Name Date

My relationship to the patient is:

☐Parent ☐ Legal Guardian * ☐Self ☐Other ______________________________

***Attach Court Order to show your authority to sign.**

______________________________ ______________________________ ____________

Signature of Witness Printed Name Date

Health Care Provider Orders for Student with Diabetes on Injections

Student:	**DOB:**	**School District:**	**Grade:**
Address:		**Phone:**	**Fax:**

Notification to Parent/Guardian: | **Low Blood Glucose - less than _____ mg/dL** | **High Blood Glucose - greater than _____ mg/dL**

☐ **Continuous glucose monitoring:** Always Confirm glucose level with a fingerstick/meter prior to treatment

Hypoglycemia Mild/Moderate Treatment: ☐**less than 70 mg/dL** ☐ **less than ____ mg/dL** - Follow ***Rule of 15***: Treat with ☐ 2-4 Glucose Tabs
☒4 ounces juice ☒ Glucose gel (use finger, place in mouth between cheek & gum) ☒If no meal or snack within the next hour, give a 15 gram snack
IMPORTANT: Always RECHECK blood glucose in 15 minutes and repeat above if needed and NOTIFY PARENT/GUARDIAN IF BLOOD GLUCOSE LESS THAN _____ mg/dL.

Hypoglycemia Severe Symptoms with loss of consciousness/seizures:	**Call 911/Administer Glucagon** **Glucagon Dose:** ☐**0.5 mg** ☐**1 mg**	Intramuscular in: ☐Arm ☐ Buttocks ☐ Thigh

Hyperglycemia Treatment: ☒Provide water and access to bathroom	**If Blood Glucose is greater than 250 mg/dL twice in a row:** ☒Test urine ketones and call parent/guardian if ketones moderate to large ☒See below for insulin instructions if applicable

IMPORTANT: Student should not be sent home from school with an elevated blood glucose UNLESS student is too ill to participate in school activities and/or has moderate ketones and vomiting present.

When to Check Blood Glucose: For provision of student safety while limiting disruption to learning
☒**Always for signs and symptoms of low/high blood glucose, when not feeling well, and/or behavior concerns.**
☒ Before Breakfast ☐ Before Riding Bus/Walking Home: **Blood Glucose should be greater than _______ mg/dL**
☒ Before Lunch ☐ Before Recess
☐ Before Snacks ☒ Before PE ☐ Other ________________________________

Blood Glucose Correction and Insulin Dosage: **Insulin Type:** ☐ Apidra ☐ Humalog ☐ Novolog
Injection site: ☐ Abdomen ☐ Arm ☐ Buttock ☐ Thigh | *Injections should be given subcutaneously and rotated*
Insulin Administration: Give ☐ Prior to breakfast/lunch ☐ Immediately after breakfast/lunch ☐ Other: ___________________________
Correction Factor:
If Blood Glucose greater than ________ ADD ______ units
If Blood Glucose greater than ________ ADD ______ units
If Blood Glucose greater than ________ ADD ______ units
If Blood Glucose greater than ________ ADD ______ units
If Blood Glucose greater than ________ ADD ______ units
If Blood Glucose greater than ________ ADD ______ units
If Blood Glucose greater than ________ ADD ______ units
Do Not Exceed ______ units
☐ Parent/guardian authorized to increase or decrease correction insulin by ____ unit of insulin

Carbohydrates and Insulin Dosage: ☐ **Breakfast** ☐ **Snack** ☐ **Lunch** ☐ **Other:**

Breakfast:	**Insulin to Carbohydrate Ratio**	_____ **unit(s)** for every _____ **grams** of carbohydrate
Lunch:	**Insulin to Carbohydrate Ratio**	_____ **unit(s)** for every _____ **grams** of carbohydrate
Snack:	**Insulin to Carbohydrate Ratio**	_____ **unit(s)** for every _____ **grams** of carbohydrate

Student's Care: ☐ Full supervision
☐ Requires some supervision: ability level to be determined by Provider and parent/guardian unless otherwise indicated here:
____
☐ Student may carry insulin with them ☐ Student may carry diabetes monitoring supplies with them
☐ Student may carry treatment for hypoglycemia with them

Additional Information: Refer to student's 504 Plan for student specific accommodations.

Provider: (print and sign)	**Date:**

To be completed by parent/guardian: I give permission for my child to receive medication at school according to the school district policy and as instructed by the Health Care Provider and agree to:

- Assume responsibility for safe delivery of the medication in its original container to the school.
- Notify the school immediately if there is any change in the use of this medication.
- Notify the school of changes in Health Care Provider.
- Allow designated school staff to send and/or receive information related to my child's health as they deem appropriate.
- **This form is valid for one year from the date signed by Health Care Provider.**

Parent/Guardian:	**Date:**