Center for Diabetes & Endocrinology
215 West Bowery Street, Suite 6400
Akron, Ohio 44308

Phone 330.543.3276
Fax: 330.543.8489

Dear Parents,

It is time to be sure your child's Diabetes Medical Management Plan is in place **prior** to the 2021-2022 school year. Completed school forms and release of information forms are due to the office before Friday**, August 6th**. If you have an office visit prior to your child's first day of school, we can complete the school form packet at the office visit.

School forms received **after** Friday August 6th, 2021,
may take 5 business days to complete.

Once signed by your child's provider, the completed school form can be picked up at the office or faxed to the school. Please indicate your preference by checking the box in the upper right corner on the form. **The school cannot provide diabetes care until the completed form has been returned to the school.** Included in this packet are the documents you will need to provide to your child's school.

- **Authorization for Release of Information from Children's Hospital** [2 forms]
  Both forms must be completed with patient information, the school information and be signed and dated by a parent or legal guardian. If the signature, date and relationship are missing the form is not valid. The signature on these forms must be witnessed by someone other than an immediate family member. **Both forms are required for communication to and from our office and the school**. School forms will only be faxed from our office to your child's school if both Authorizations for Release of Information from Children's Hospital are on file.

- **Diabetes Medical Management Plan for Schools** [1 form]
  This is the only form we will be providing to the school. If your school system is asking for additional forms to be completed, please complete those forms with information you have available and submit it along with your completed Diabetes Medical Management Plan for Schools from our office. **A parent's signature is required on this form.**

- **CGM (Continuous Glucose Monitor)** [1 form]
  If your child wears a CGM device, please also complete the CGM Management Plan specific to CGM use.

You may also want to work with the school to set up a 504 Plan. This plan spells out the school's responsibilities when it comes to your child's diabetes and how it affects their learning/education. It is developed between the family and the school and can address things such as bathroom privileges, standardized test accommodations, field trips, absences, etc. The attached Diabetes Medical Management Plan signed by your child's provider can be included in a 504 Plan. You can find examples on the American Diabetes Association website (www.diabetes.org) or the Children with Diabetes Website (www.childrenwithdiabetes.com).

Please return the completed packet to our office by mail, email at endocrine@akronchildrens.org, fax to 330.543.8489 or by attachment in a My Chart message.

The Center for Diabetes and Endocrinology
Akron Children's Hospital

Akron Children's Hospital

☐Fax to School

☐Family to Pick up

Diabetes Medical Management Plan for the Student with Diabetes on Injections

Student:	**DOB:**	**School:**	**Grade:**
Home Address:		**Home Phone:**	

Notification to Parent/Guardian: **Low Blood Glucose - less than_____mg/dL** **High Blood Glucose - greater than_____mg/dL**

Continuous glucose monitoring: See continuous glucose monitoring orders ☐

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 between check & gum in mouth) ☒ 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, Gvoke or Baqsimi**	**Glucagon:** ☐ 0.5 mg ☐ 1 mg **Intramuscular:** ☒ Arm ☒ Buttocks ☒ Thigh **Gvoke:** ☐ 0.5 mg ☐ 1 mg **Subcutaneous:** ☒ Arm ☒ Thigh **Baqsimi:** ☐ 3 mg **Intranasal**
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 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: ☒**Always for signs and symptoms of low/high blood glucose, when not feeling well, and/or behavior concerns.**

Before Meals:
☐ Breakfast
☐ Lunch
☐Snacks

Before Activity/Dismissal from school:
☐ Gym / ☐ Recess **Blood Glucose/Sensor Glucose should be greater than _____mg/dL**
☐ Walking home / ☐ Riding bus **Blood Glucose/Sensor Glucose should be greater than _____mg/dL**
See continuous glucose monitoring (CGM) orders if applicable

Blood Glucose Correction and Insulin Dosage **Insulin Type:** ☐ Apidra / Humalog(Lispro) / Novolog (Aspart) / Admelog / Fiasp

Injection site: ☐ Abdomen ☐ Arm ☐ Buttock ☐ Thigh *Injections should be given subcutaneously and rotated*

Correction Factor: Give ☐ Prior to breakfast/lunch ☐ Immediately after breakfast/lunch ☐ Other: _

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.	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.	

☐ Parent/guardian authorized to increase or decrease total dose of insulin by ☐1/2 unit ☐1/2 -1 unit ☐ 1-2 units

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:**

Akron Children's Hospital

☐Fax to School
☐Family to Pick up

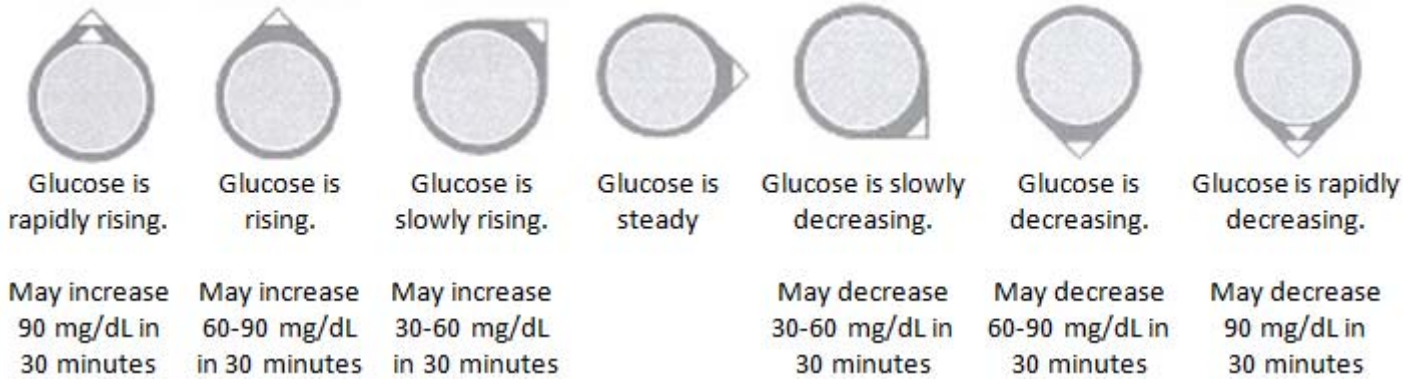
Diabetes Medical Management Plan for the Student with Diabetes on Continuous Glucose Monitor (CGM)			
Student:	**DOB:**	**School:**	**Grade:**
Address:		**Home Phone:**	

What is a CGM?
A Continuous Glucose Monitor (CGM) reads glucose levels from a sensor in the interstitial fluid (under the skin). It usually reads within 20% of a finger stick blood sugar value. It can be programmed to alert (vibrate or alarm) for high and low glucose levels. The Dexcom G5, Dexcom G6 and Freestyle Libre are FDA approved as a replacement to finger sticks for use in making diabetes treatment decisions including dosing. A finger stick blood glucose value is required for calibration or if symptoms don't match sensor glucose reading. **Student should not dose off of a CGM value unless both a blood glucose reading and trending arrow are present.**

CGMs contain three parts: 1) **Glucose sensor:** Placed just under skin by the user. The sensor contains an electrode that detects changes in glucose levels, 2) **Transmitter:** Connects to the sensor and sends results to the receiver. 3) **Receiver:** Shows the glucose result and allows operation of the CGM. Receiver may be within a pump, phone, or electronic device. Most CGMs have software, which allows the user to track trends and communicate data to parent(s)/guardian/healthcare providers.

Alert Settings: A CGM may alert audibly if interstitial glucose is outside the parameters set by parent(s)/guardian.

Arrows: Arrows on the screen indicate the speed at which the glucose levels are changing.



Use of a CGM at School

When to check a finger stick blood glucose:

- When the sensor values is less than_____ or greater than _____
- If a trend arrow or sensor glucose is absent. (Both a trend arrow and glucose reading are necessary)
- If symptoms do not match presentation
- During sensor warm up period
- If device indicates a blood glucose check is required

Notify Parent/Guardian:

- Glucose Sensor becomes dislodged (***If transmitter falls off do not throw away! Give to family***)
- Soreness, redness or bleeding at site
- CGM Malfunction

Additional Information:

- **An individualized treatment plan in response to trend arrows will be developed between the school and the parent(s)/guardian.**
- Parent(s)/guardian will ensure calibration of CGM daily per manufacturing recommendations
- CGM reading can be used for ☐Pre-activity ☐Dismissal from school ☐Pre-meal glucose ☐Snack glucose☐Other
- **If your school has a metal detector or body scanner contact manufacturer for guidance**

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- 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:**
Provider:	**Date:**

Akron Children's Hospital

HIPAA AUTHORIZATION to RELEASE MEDICAL RECORDS (FROM Children's)

Please PRINT and fill out entirely.

MRN

_____

Facility Use Only

Patient Information

Patient Name: _____
Last First Middle (any previous name) Date of Birth

_____
Patient Street Address City State Zip Phone

Release To

Release Information TO the following Person(s) or Organizations:

Name/Organization: _____ /School /School Attention: _____

_____
Address City State Zip

_____ _____ _____
Phone Fax Email Address

Purpose

Person/Place requesting records (check all that apply):
☒ Patient/Parent/Legal Guardian ☐ Doctor/Hospital ☐Lawyer ☐ Insurance Company ☐ Other _____

Purpose of Release (check all that apply):
☒ Patient Care ☐ Disability ☐ Insurance ☒ School ☐ Legal ☐ Personal Use ☐ Other _____

Method of Release

Format of records to be released:
☒ on paper ☒ PDF [on CD or Jump Drive (if available)] ☒ Verbal communication only with person or agency listed above

Information May Be Sent Via: (*Note: Radiology images can only be placed on CD and mailed or picked-up)*
☒ Mail Delivery ☒ Fax ☒ Pick Up ☒ Encrypted Email* ☒ to MyChart* (*electronic records only, size restrictions apply)

Information to Release

Dates of Treatment Requested: _____ (If not specified, the **LAST 6 MONTHS** will be released)

☒ **Medical Record Abstract** – pertinent information generally used for continued care/personal use/disability.
The following items are included in a Medical Record Abstract:
After Visit/Discharge Summary, Emergency Record
History & Physical, Inpatient Consult Report(s)
Operative Report(s), Radiology Reports,
Lab or Other Tests

Other Information Requested (choose any to release):
☐ Vaccination (shot) records ☐ Billing Records
☐ Radiology Reports ☐ Appointment list
☐ Radiology Images on disc ☒ Demographics page
☐ Lab results (blood work)
☐ Pathology Report
☐ ACHP Records (specify ACHP): _____

☒ **Doctor's Office Reports** (Doctor or Department Name) Center for Diabetes & Endocrinology

☒ **Other**: (please list exact documents) AVS, School Form, Current Orders _____

Patient/Parent/Legal Guardian

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, except as prohibited by 42 CFR Part 2 or other applicable law. 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.

By signing below, I affirm that I am the patient and/or the patient's personal representative, and have the authority to authorize who may access or receive the patient's health information.

_____ _____
Signature of Patient or Parent/Legal Guardian **Printed Name** **Date**
My relationship to the patient is ☐ Self ☐ Parent ☐ Legal Guardian – Attach Court Order to show your authority to sign

_____ _____
Signature of Witness **Printed Name** **Date**

Submit

Submit **completed form** AND a **copy of a valid Photo ID (if a current one is not on file with us)** to:

Mail form to:	**Fax** form to:	**Email** form to:	**Questions? Call**:
Akron Children's Hospital ENDO Dept 215 W. Bowery Suite 6400 Akron, OH 44308	330-543-8489	Endocrine@akronchildrens.org	330-543-3276

Rev. 7/2019

Akron Children's Hospital

HIPAA AUTHORIZATION to RELEASE MEDICAL RECORDS (TO Children's)

Please PRINT and fill out entirely.

MRN

_____

Facility Use Only

Patient Information

Patient Name: _____
Last First Middle (any previous name) Date of Birth

_____
Patient Street Address City State Zip Phone

Release TO

Release Information TO Akron Children's Hospital

Choose one: ☑ Akron Campus ☑ Mahoning Valley Campus

Address: One Perkins Square, Akron, OH 44308 — 6505 Market Street, Youngstown, OH 44512

Name/Dept: Center for Diabetes & Endocrinology Attention: _____

(330) 543-3276 (330) 543-8489 Endocrine@akronchildrens.org
Phone Fax Email Address

Release FROM

Release FROM the following Person(s) or Organizations:

Name: /School _____
Phone

_____
Street Address City State Zip Fax

Purpose

Person/Place requesting records (check all that apply):

☐ Patient/Parent/Legal Guardian ☐ Doctor/Hospital ☐Lawyer ☐ Insurance Company ☐ Other _____

Purpose of Release (check all that apply):

☒ Patient Care ☐ Disability ☐ Insurance ☒ School ☐ Legal ☐ Personal Use ☐ Other _____

Information to Release

Dates of Treatment Requested: _____

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The following items are included in a Medical Record Abstract:

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History & Physical, Inpatient Consult Report(s)
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Radiology Reports, Lab or Other Tests

Other Information Requested (choose any to release):

☐ Vaccination (shot) records
☐ Radiology Reports
☐ Radiology Images on disc
☐ Lab results (blood work)
☐ Pathology Report
☐ Billing Records
☐ Appointment list
☒ Demographics page

☐ **Doctor's Office Reports** (Doctor or Department Name) _____

☒ **Other**: (please list exact documents) Any Treatment by School Personnel

Patient/Parent/Legal Guardian

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Signature of Patient or Parent/Legal Guardian **Printed Name** **Date**

My relationship to the patient is ☐ Self ☐ Parent ☐ Legal Guardian – Attach Court Order to show your authority to sign

_____ _____
Signature of Witness **Printed Name** **Date**