Morris Hills High School

520 West Main Street • Rockaway, NJ • 07866-3799
Main: 973-664-2309 • School Counseling: 973-664-2329

Todd M. Toriello, Ed.D. *Principal* 973-664-2301	**Robert Merle, Jr.** *Assistant Principal* *Discipline Grades 9&11* 973-664-2303	**Gene Melvin** *Assistant Principal* *Discipline Grades10&12* 973-664-2357	**Emily Barkocy** *Assistant Principal* *Student Attendance* 973-664-2305	**Robert Haraka** *Athletic Director* 973-664-2307	**Yesenia Rivera - Carney** *School Counseling Supervisor* 973-664-2313

Dear Parent/Guardian:

Re: _____ Grade: _____

We would like to inform you of a change in the law regarding the **Care of Students with Diabetes in School**.

N.J.S.A. 18A:40-12.11-21 was adopted because a school nurse may not be immediately available to assess the severity of severe hypoglycemia. This law allows the certified school nurse the authority to designate and train a willing employee to administer glucagon (via injection) to a student with diabetes who is experiencing severe hypoglycemia.

Attached are the required forms for your health care provider, you and your child to complete and return as soon as possible to the health office.

Required forms to be completed:

_____ Completed Individual Health Care Plan (provided by the MD).
_____ Emergency Health Care Plan for the health care provider to complete.
_____ Completed Parent/Guardian section.
_____ Completed Student section.

If you have any questions or concerns, please call the phone number below.

Very truly yours,

Kim Auer RN, CSN

Cathy Leonard RN, CSN

Morris Hills High School
973-664-2333

MORRIS HILLS REGIONAL DISTRICT
EMERGENCY HEALTH CARE PLAN
FOR DIABETIC STUDENT WITH SEVERE HYPOGLYCEMIA

This form must be completed by your child's physician/advanced practice nurse and then signed by the parent/guardian and student.

Student Name _____ DOB_____

Emergency Contacts:

Name/Relationship	Phone Numbers (Home, Work, Cell)		
1._____ Parent/Guardian	1.)_____	2.)_____	3.)_____
2._____ Parent/Guardian	1.)_____	2.)_____	3.)_____
3._____ Emergency Contact	1.)_____	2.)_____	3.)_____
4._____ Diabetic Educator/MD	1.)_____	2.)_____	3.)_____

SECTION I: TO BE COMPLETED BY PHYSICIAN/ADVANCED PRACTICE NURSE
A. Symptoms:

Glucagon should be given if the student is unconscious, having a seizure, or unable to swallow

Dosage:

_____ Glucagon 1mg Intramuscular

Preferred Site for glucagon injection _____ Arm _____ Thigh

B. Treatment by Delegate When Nurse Not Present – NJ S A 18A:40-12.11-21 directs that the school nurse shall designate additional employees of the school district who volunteer to **administer glucagon** to a pupil for severe hypoglycemia when the nurse is not physically present at the scene; field trips, before and after school sponsored activities.

1. ___ Delegate Order – For severe hypoglycemia (unconscious, having a seizure, or unable to swallow)

2.___ This student's order should not be delegated.

C. Self-Management of Diabetes by Student- NJSA 18A: 40-12.11-21 directs that the student be permitted to manage and care for their diabetic needs in the classroom, in any area of the school or grounds, or at any school-related function. Self-management activities might include testing blood glucose levels, administering insulin, and treating hypoglycemia or hyperglycemia using universal precautions. These activities require written authorization from the student's physician or advanced practice nurse.

_ yes _no Student understands the purpose, proper technique and treatment outlined in diabetic self-management plan and is sufficiently responsible to self-manage.

_yes _no Student is aware that they must report to the school nurse or delegate if there are any deviations from the parameters set in self-management plan.

Diabetes Care Supplies that should be carried by the student in school or at school sponsored events (please check off all that apply).

- Blood glucose meter, blood glucose test strips, batteries for meter
- Lancet device, lancets, gloves
- Urine ketone strips
- Insulin pump and supplies
- Insulin pen, pen needles, insulin cartridges, syringes
- Fast-acting source of glucose
- Carbohydrate containing snack
- Glucagon emergency kit
- Bottled Water
- Log
- Other (please specify)

D. Emergency Procedure

1. Administer Glucagon
2. Call 911 and state that a student has severe hypoglycemia and request that paramedics transport the student to the nearest hospital.
3. Notify parents/guardians.
4. Notify diabetic educator/physician.

Physician Signature_____ Date: _____
Stamp or name, address and phone printed:

_____

_____

_____

MORRIS HILLS REGIONAL DISTRICT
EMERGENCY HEALTH CARE PLAN
FOR DIABETIC STUDENT WITH SEVERE HYPOGLYCEMIA

This form must be completed by parent/guardian and student.
Student Name _____ DOB_____

Emergency Contacts:

Name/Relationship	Phone Numbers (Home, Work, Cell)
1._____ Parent/Guardian	1.)_____ 2.)_____ 3.)_____
2._____ Parent/Guardian	1.)_____ 2.)_____ 3.)_____
3._____ Emergency Contact	1.)_____ 2.)_____ 3.)_____
4._____ Diabetic Educator/M	1.)_____ 2.)_____ 3.)_____

SECTION I – TO BE COMPLETED BY PARENT/GUARDIAN

A. Parent Authorization

I hereby give permission for my child to receive emergency glucagon at school as prescribed on the Healthcare Provider orders for Diabetes Management in School. I also give permission for the release and exchange of information between the school nurses and my child's health care provider concerning my child's health and medication. In addition, I understand that this information will be shared with school staff on a need to know basis.

_____ _____
Date Parent Signature

B. Parent authorization for the administration of Glucagon by designees/delegates:

I give consent for the administration of Glucagon by the district delegates trained by the certified school nurse to administer Glucagon in the event that the school nurse is not present at the scene. I understand that the district and its employees shall have no liability as a result of any injury arising from the administration of Glucagon to my child and that the parents and guardians shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the administration of Glucagon.

_____ _____
Date Parent Signature

C. Parent Authorization (for students with physician permission to self- manage diabetes in school) -

1. I understand that the district and its employees or agent shall incur no liability as a result of any injury arising from the self-management by the student of the prescribed diabetes plan and that I indemnify and hold harmless the district and its employees or agent against any claims arising out of the self-administration of plan by the student.

_____ _____
Date Parent Signature

2. I give permission for my child to self-manage their diabetes as prescribed for the current school year as I consider him/her to be responsible and capable of self-management. Self-management activities might include testing blood glucose levels, administering insulin, and treating hypoglycemia or hyperglycemia. These activities require written authorization from the student's physician or advanced practice nurse. Self-management supplies must be kept and used in an appropriate manner within the school setting, using universal precautions. I understand my child is to keep the supplies for self-management with him/her at all times. All medication mentioned in prescribed self-management plan must be in its original labeled container, at all times. Extra medication and supplies will be sent to school to be kept in the Health Office.

Date _____ Parent Signature _____

E. Parent Agreement to Notify School

I will notify the school at least 24hrs in advance if my child is going to attend a school sponsored event. In the event this does not occur I understand that a delegate may not be present to administer emergency Glucagon if necessary.

Date _____ Parent Signature _____

SECTION 11 – TO BE COMPLETED BY STUDENT

A. Student Agreement for Self-Administration –

- I understand and I will use this medication as directed by my physician.
- I will be responsible in carrying and using this medication as described while in school, on field trips, athletic events and at any other school sponsored event.
- I have been instructed on how to self-administer this medication and understand the side effects of improper use.
- I understand that my self-management supplies must be kept and used in an appropriate manner within the school setting, using universal precautions.
- I understand to keep the supplies for self-management with me at all times and that all medication mentioned in prescribed self-management plan must be in its original labeled container, at all times.
- I am aware that I must report to the school nurse or delegate if there are any deviations from the parameters set in self-management plan.

Date _____ Student Signature _____ Parent Signature _____

B. Student Agreement for Delegate

I understand that I will be assigned a delegate at school sponsored events.

Date _____ Student Signature _____ Parent Signature _____