

Sterling House Day Camp

Medical Form Cover Sheet

Packet F

DIABETES

Dear Families,

Attached you will find the Diabetes Action Plan to be filled out by your child's doctor. There is also the Medication Administration Authorization Form. Make a separate copy of this form for each medication that the doctor prescribes for your child.

The camp administrative staff needs to be aware of your child's condition *immediately upon registration* so that we can have staff prepared to make sure your child has a safe summer experience. We need to request special training before your child can attend camp.

This needs to be turned in AT LEAST one week before your camp session begins along with the medication(s).

Thank you,

Camp Directors & First Aid Staff

Child Care Diabetes Medical Management Plan

Name of Child: _____ DOB: _____ Dates Plan in Effect: _____

Parent or guardian Name(s)/Number(s): _____

Diabetes Care Provider Name/Number: _____

Diabetes Care Provider Signature: _____ Date: _____

Location of diabetes supplies at child care facility: _____

Blood Glucose Monitoring

Target range for blood glucose is: 80-180 Other _____

When to check blood glucose: before breakfast before lunch before dinner before snacks

When to do extra blood glucose checks: before exercise after exercise when showing signs of low blood glucose
 when showing signs of high blood glucose other _____

Insulin Plan: Please indicate which type of insulin regimen this child uses (check one):

Insulin Pump Multiple Daily Injections Fixed Insulin Doses

Specific information related to each insulin regimen/plan is included below for this child.

Type of insulin used at child care (check all that apply): Regular Apidra Humalog Novolog NPH
 Lantus Levemir Mix Other _____

Plan A: Insulin Pump*

- Always use the insulin pump bolus wizard: Yes No
If no, use Insulin:Carbohydrate Ratio and Correction Factor dosage on Plan B:
- Blood glucose must be checked before the child eats and will (check one):
 Be sent to the pump by the meter
 Need to be entered into the pump
- The insulin pump will calculate the correction dose to be delivered **before** the meal/snack.
- After the meal/snack**, enter the total number of carbohydrates eaten at that meal/snack. The insulin pump will calculate the insulin dose for the meal.
- Contact parent/guardian with any concerns.

For a list of definitions of terms used in this document, please see the *Diabetes Dictionary*.

***Providers should complete Insulin:Carbohydrate ratio and Correction dosage under Plan B section for ALL pump users.**

Plan B: Multiple Daily Injections

- Child will receive a fixed dose of _____ long-acting insulin at _____ Yes No
 - Follow blood glucose monitoring plan above.
 - Use _____ insulin for meals and snacks. Insulin dose for food is _____ unit(s) for meals OR _____ unit(s) for every _____ grams carbohydrate.
- Give injection after the child eats.
- If blood glucose is above target, add correction dose to:
 Breakfast Snack
 Lunch Snack
 Other: _____
- Use the following correction factor _____ or this scale:
_____ units if BG is _____ to _____
_____ units if BG is _____ to _____
_____ units if BG is _____ to _____
_____ units if BG is _____ to _____

Only add correction dose if it has been 3 hours since the last insulin administration.

C: Fixed Insulin Doses

- Child will receive a fixed dose of long acting insulin? Yes No
If yes, give child _____ units of _____ insulin at _____.
 - Insulin correction dose at child care (_____ insulin)?
 Yes No
 - If blood glucose is above target, add correction dose to:
 Breakfast Snack
 Lunch Snack
 Other: _____
- Use the following correction factor _____ or the following scale:
_____ units if BG is _____ to _____
_____ units if BG is _____ to _____
_____ units if BG is _____ to _____
_____ units if BG is _____ to _____

Only add correction dose if it has been 3 hours since the last insulin administration.

Managing Very Low Blood Glucose

Hypoglycemia Plan for Blood Glucose less than _____ mg/dL

1. Give 15 grams of fast acting carbohydrate.
2. Recheck blood glucose in 15 minutes.
3. If still below 70 mg/dL, offer 15 grams of fast acting carbohydrate, check again in 15 minutes.
4. When the child's blood glucose is over 70, provide 15g of carbohydrate as snack. Do not give insulin with this snack.
5. **Contact the parent/guardian** any time blood glucose is less than _____ mg/dL at child care.

Usual symptoms of hypoglycemia for this child include:

- | | | |
|-----------------------------------|---|--|
| <input type="checkbox"/> Shaky | <input type="checkbox"/> Fast heartbeat | <input type="checkbox"/> Sweating |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Hungry | <input type="checkbox"/> Weakness/Fatigue |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Irritable/Grouchy |
| <input type="checkbox"/> Dizzy | <input type="checkbox"/> Other _____ | |

1. If you suspect low blood glucose, check blood glucose!
2. If blood glucose is below _____, follow the plan above.
3. If the child is unconscious, having a seizure (convulsion) or unable to swallow:
 - Give glucagon. Mix liquid and powder and draw up to the first hash mark on the syringe. Then inject into the thigh. Turn child on side as vomiting may occur.
 - If glucagon is required, administer it promptly. Then, call 911 (or other emergency assistance). After calling 911, contact the parents/guardian. If unable to reach parent, contact diabetes care provider.

Managing Very High Blood Glucose

Hyperglycemia Plan for Blood Glucose higher than _____ mg/dL

Usual symptoms of hyperglycemia for this child include:

- | | | |
|---|--|--|
| <input type="checkbox"/> Extreme thirst | <input type="checkbox"/> Very wet diapers, accidents | |
| <input type="checkbox"/> Hungry | <input type="checkbox"/> Warm, dry, flushed skin | <input type="checkbox"/> Tired or drowsy |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Vomiting** |
| <input type="checkbox"/> Fruity breath | <input type="checkbox"/> Rapid, shallow breathing | |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Unsteady walk (more than typical) | |

**If child is vomiting, contact parents immediately

Treatment of hyperglycemia/very high blood glucose:

1. Check for ketones in the:
 - urine
 - blood (parent will provide training)
2. If ketones are moderate or large, contact parent. If unable to reach parent, contact diabetes care provider for additional instructions.
Contact parent if ketones are trace or small: Yes No
3. Children with high blood glucose will require additional insulin if the last dose of insulin was given 3 or more hours earlier. Consult the insulin plan above for instructions. If still uncertain how to manage high blood glucose, contact the parent.
4. Provide sugar free fluids as tolerated.
5. You may also:
 - Provide carbohydrate free snacks if hungry
 - Delay exercise
 - Change diapers frequently/give frequent access to the bathroom
 - Stay with the child

Diabetes Dictionary

Blood glucose - The main sugar found in the blood and the body's main source of energy. Also called blood sugar. The **blood glucose level** is the amount of glucose in a given amount of blood. It is noted in milligrams in a deciliter, or mg/dL.

Bolus - An extra amount of insulin taken to lower the blood glucose or cover a meal or snack.

Bolus calculator - A feature of the insulin pump that uses input from a pump user to calculate the insulin dose. The user inputs the blood glucose and amount of carbohydrate to be consumed, and the pump calculates the dose that can be approved by the user.

Correction Factor - The drop in blood glucose level, measured in milligrams per deciliter (mg/dl), caused by each unit of insulin taken. Also called **insulin sensitivity factor**.

Diabetic Ketoacidosis (DKA) - An emergency condition caused by a severe lack of insulin, that results in the breakdown of body fat for energy and an accumulation of ketones in the blood and urine. Signs of DKA are nausea and vomiting, stomach pain, fruity breath odor and rapid breathing. Untreated DKA can lead to coma and death.

Fixed dose regimen - Children with diabetes who use a fixed dose regimen take the same "fixed" doses of insulin at specific times each day. They may also take additional insulin to correct hyperglycemia.

Glucagon - A hormone produced in the pancreas that raises blood glucose. An injectable form of glucagon, available by prescription, is used to treat severe hypoglycemia or severely low blood glucose.

Hyperglycemia - Excessive blood glucose, greater than 240 mg/dL for children using insulin pump and greater than 300 mg/dL for children on insulin injections. If untreated, the patient is at risk for **diabetic ketoacidosis (DKA)**.

Hypoglycemia - A condition that occurs when the blood glucose is lower than normal, usually less than 70 mg/dL. Signs include hunger, nervousness, shakiness, perspiration, dizziness or light-headedness, sleepiness, and confusion. If left untreated, hypoglycemia may lead to unconsciousness.

Insulin - A hormone that helps the body use glucose for energy. The beta cells of the pancreas make insulin. When the body cannot make enough insulin, it is taken by injection or through use of an insulin pump.

Insulin Pump - An insulin-delivering device about the size of a deck of cards that can be worn on a belt or kept in a pocket. An insulin pump connects to narrow, flexible plastic tubing that ends with a needle inserted just under the skin. Pump users program the pump to give a steady trickle or constant (basal) amount of insulin continuously throughout the day. Then, users set the pump to release bolus doses of insulin at meals and at times when blood glucose is expected to be higher. This is based on programming done by the user.

Ketones - A chemical produced when there is a shortage of insulin in the blood and the body breaks down body fat for energy. High levels of ketones can lead to **diabetic ketoacidosis** and coma.

Multiple Daily Injection Regimen - Multiple daily insulin regimens typically include a basal, or long acting, insulin given once per day. A short acting insulin is given by injection with meals and to correct hyperglycemia, or elevated blood glucose, multiple times each day.

Type 1 Diabetes - Occurs when the body's immune system attacks the insulin-producing beta cells in the pancreas and destroys them. The pancreas then produces little or no insulin. Type 1 diabetes develops most often in young people but can appear in adults. It is one of the most common chronic diseases diagnosed in childhood.

Physician Signature _____



Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student _____ Date of Birth ____/____/____ Today's Date ____/____/____

Address of Child/Student _____ Town _____

Medication Name/Generic Name of Drug _____ Controlled Drug? YES NO

Condition for which drug is being administered: _____

Specific Instructions for Medication Administration _____

Dosage _____ Method/Route _____

Time of Administration _____ If PRN, frequency _____

Medication shall be administered: Start Date: ____/____/____ End Date: ____/____/____

Relevant Side Effects of Medication _____ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs _____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number (____) _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____ Date ____/____/____

School Nurse Signature (if applicable) _____

Parent/Guardian Authorization:

- I request that medication be administered to my child/student as described and directed above
- I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)
- I have administered at least one dose of the medication with the exception of emergency medications to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature _____ Relationship _____ Date ____/____/____

Parent /Guardian's Address _____ Town _____ State _____

Home Phone # (____) _____ - _____ Work Phone # (____) _____ - _____ Cell Phone # (____) _____ - _____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: YES NO _____
Signature Date

Parent/Guardian authorization for self-administration: YES NO _____
Signature Date

School nurse, if applicable, approval for self-administration: YES NO _____
Signature Date

Today's Date _____ Printed Name of Individual Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink or electronic) _____

Note: This form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)

Medication Administration Record (MAR)

Name of Child/Student _____ Date of Birth ____/____/____

Pharmacy Name _____ Prescription Number _____

Medication Order _____

Date	Time	Dosage	Remarks	Was This Medication Self Administered?	Signature of Person Observing or Administering Medication
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

*Medication authorization form must be used as either a two-sided document or attached first and second page.

- | | |
|--|--|
| <input type="checkbox"/> Authorization form is complete | <input type="checkbox"/> Medication is appropriately labeled |
| <input type="checkbox"/> Medication is in original container | <input type="checkbox"/> Date on label is current |

Person Accepting Medication (print name) _____ Date ____/____/____