Medical records/forms Fax # 812-274-8791

RE: Diabetes

Date:

Student: _____ DOB: _____.

Dear Parent or Guardian,

Our records indicate that your child has diabetes. To ensure we provide the necessary accommodations, we require an updated care plan from your child's physician each year. Please follow these steps:

1. Complete the attached form and have your child's physician review, sign, and finalize it.
2. Return the signed form to the school office.
3. Provide your child's insulin, glucagon pen, and any other necessary medical supplies to the school.

If you do not have an upcoming appointment, your physician can fax this form (or their own action plan) directly to Madison Consolidated Schools at 812-274-8791.

If you have any questions, please feel free to contact your School Nurse. Thank you for your help in keeping your child safe at school.

Madison Consolidated Schools

Renee James, RN

District Nursing Coordinator

Fax #: 812 274 8791

RJ 2026

Medical Forms/Records to Nursing Fax # 812-274-8791

CARE OF STUDENTS WITH DIABETES

Agreement for Parents, Student, and School

Student Name and Grade

Student Name: _____ Grade: _____

School Responsibility

Diabetes management in the school is a collective effort between the parents, the nurse, school staff, and most importantly the student. What happens in the home will affect what happens at school and vice versa. Communication amongst all parties is key to creating a safe and well-managed environment for your child. While your child attends school, his/her management will include:

- Nursing guidance for diabetic management throughout the school day,
- Communication with your child's diabetic management team to clarify orders as needed,
- Communication through a daily log book/electronic log if requested,
- An emergency care plan, individualized health plan and/or 504,
- Resources for locating nutritional content from school menu selections.

Parent/Guardian Agreement

Please initial the following statements to indicate your agreement and understanding.

- _____ (initial) In order to provide the best care for your child, you will need to provide current medical treatment orders from your child's health care provider as well as the following supplies:
    - Glucometer with back up batteries
    - Test strips and Lancets
    - Ketone strips and Insulin supplies
    - Glucagon pen and Fast acting sugar sources
- _____ (initial) **Notifications:** Parents/Guardian will be contacted if ketones are present, supplies are low, or for hypo/hyperglycemia.
- _____ (initial) **Student Safety:** *Student may be sent home due to health and safety reasons when:*
    - **Supplies:** Necessary supplies and/or insulin are not at school and parent/guardian is unable to bring them immediately.
    - **Unsafe State:** If your child's blood sugar is unmanageable or unsafe as determined by the school nurse. Arrangements should be available for your student to be picked up from school, if necessary, whenever it is determined that their current diabetic state is unsafe and unmanageable for the school or bus setting.
    - **Communication:** Parents should provide one or more phone contacts where they can be reached during the school day and are expected to immediately return phone calls related to the management of their child's diabetes.
    - **Emergency Contacts:** If parent/guardian does not call back, the nurse will start calling down the emergency contact list.
    - **911 Protocol:** If there is no answer from any contact person, or as deemed appropriate by the school nurse, 911 may be called.
- _____ (initial) **Exercise and Activity:** *Exercise improves insulin sensitivity, and the duration/intensity of exercise will influence blood glucose levels. If a child will be exercising for 30-60 minutes, to avoid hypoglycemia, the student may need to eat an additional carbohydrate snack (approx. 15 grams) before exercising, without insulin coverage:*
    - **Restrictions:** Students may not be allowed to participate in physical education class or after school activities when ketones reach the level for restrictions per provider orders.
    - **Monitoring:** Due to fluctuating recess, gym class, and lunch times the nurse will determine if additional glucose monitoring will take place.
- _____ (initial) **Nutrition and Lunches:** *Carbohydrate counting for home lunches will, in most cases, be the responsibility of the student and parent. Special considerations or accommodations for tracking carbohydrates may be made due to the student's age or other limitation or disability. For school lunches, menus and nutritional information are provided by nutrition services and will be made available to parents upon request. The school nurse will keep a current copy of school lunch nutritional information in the nurse's office.*

- _____ (initial) **Self-Management Agreement:** *In order for a student to be allowed to self-manage their diabetes at school, the provider, parent, student, and school nurse must all agree and sign off on the plan.*
    - **Independence Levels:** Self-management orders vary in levels of student independence. The plan will be discussed directly with the student, parent, and school nurse to clarify boundaries.
    - **Nurse Check-ins:** The school nurse will check in with the student and parent periodically throughout the school year.
    - **Safety Review:** If the school nurse determines at any time that a student's self-management agreement is no longer safe, it may be discontinued. This will be communicated to the parent/guardian. A self-management agreement can be reinstated per the school nurse's and/or the student's provider's assessment.
- _____ (initial) **Field Trips:** *Field trips occur on occasion throughout the school year.*
    - **Attendance:** If the parent/guardian is willing, they may be permitted to attend the field trip. If a parent does not attend the field trip, the school will provide a diabetic trained staff member to accompany the student.
    - **Self-Management:** With provider, parent, and school nurse approval the student can have authorization to self-manage their diabetes while on field trips.
    - **Emergencies:** 911 would be called for emergencies during field trips.
- _____ (initial) **Bus Transportation:** *Your child rides the bus:* _____*Yes* _____*No*
    - **Glucose Checks:** Per provider orders or if symptomatic, the student's blood glucose will be checked prior to getting on the bus.
    - **Treatment:** Any glucose reading that falls below the goal range will require hypoglycemic treatment in the health office.
    - **Notifications:** The parent will be notified of below-goal glucose readings if their child is not safe to take the bus home.
    - **Accessibility:** Students with diabetes will be allowed to have a drink or snack on the bus.
- _____ (initial) **School Functions:** *If there is a function or activity where parents/guardians/family members are invited to the school campus during regular school hours, the school nurse will remain solely responsible for the student's diabetic care during that time unless prior arrangements have been made. If the student is checked out through the main office, student care is assumed by the parent/guardian/responsible adult at that time.*
- _____ (initial) **Nursing Practice:** *The school nurse is responsible for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide appropriate care.*
    - **Authorization:** The school nurse must have signed provider orders and parent authorization in place before management at school can begin.
    - **Updates:** A new order must be provided at the start of the school year and at any time updates occur. Parents giving medical orders to the school nurse verbally will not be accepted. With a signed provider order, the parent can adjust insulin doses within the parameters given by the provider if needed.

- **Professional Judgement:** Appropriate times for checking blood glucose levels include before and after meals, when feeling high, when feeling low, per provider orders, and at the nurse's discretion. The school nurse adheres to State Nurse Practice Laws as well as their nursing judgement and will be permitted to contact the provider or diabetic educator with questions regarding diabetic management as needed.

Statements and Signatures

_____ (initial) The Parents/Guardians are aware that the school nurse has the obligation to contact the provider or diabetic educator with questions regarding the diabetes care of this student and by initialing and signing this form, the parent/guardian gives the school nurse permission to do so.

_____ (initial) Student insubordination or noncompliance with the healthcare plan may result in disciplinary action by administration, along with reinforcement of diabetes education by the school nurse.

_____ (initial) The Parents/Guardians are aware that failure to supply a child under their care with necessary medicine, medical supplies and/or care can constitute child maltreatment and may result in a mandated report to the proper authorities.

I, as the parent/guardian for this student, understand that these are the expectations for management of my child while in school and I agree and give my consent for these expectations to apply to my child.

_____ _____

Parent Signature Date

_____ _____

Student Signature (if 18 or older) Date

_____ _____

School Nurse Signature Date

Non-Acceptance of Terms

Should the Parent/Guardian decline the terms outlined in this agreement, please execute the signature line below:

A copy of the document entitled "Care of Students with Diabetes Agreement for Parents, Students and School" has been received. I choose to waive the provision of daily diabetic oversight by the school nurse for my child. By providing my signature, I recognize that the school nurse is not accountable for the

routine management of my child's diabetes, which includes regular monitoring of blood glucose and the dispensing of diabetic medications. It is understood that a plan for emergency healthcare remains in effect, and in the event that emergency aid is required during school hours, the nurse along with other qualified personnel will provide appropriate care.

_____ _____

Parent Signature Date

_____ _____ Student Signature, if 18 or older Date

_____ _____ School Nurse Signature Date

MADISON CONSOLIDATED SCHOOLS STUDENT INDIVIDUALIZED HEALTH CARE PLAN

Includes applicable physician orders and EAPs
(emergency action plans)

SCHOOL YEAR: 2026-2027

STUDENT INFORMATION: 504 Plan Yes.___ No____ **ALLERGIES:** _____			
Student:	D.O.B.	**Grade:**	**School:**
Counselor:	**BUS:**		**Driver:**
Parent:	**Phone:**		**Email:**
Physician:	**Phone:**		**Fax:**
Physician:	**Phone:**		**Fax:**
School Nurse:	**School Phone:**		**Fax:**

Medical Diagnosis:

Daily Medications	Notable side effects	Time of Admin

Symptom(s) of Concern:	Intervention:

Goals:	Evaluation:

DIET:	ACTIVITY:	ENVIRONMENTAL MODIFICATIONS:

SCHEDULE OF DAILY CARE:

Breakfast	
Lunchtime:	
Afternoon:	

FIELD TRIP/EXTRA-CURRICULAR ACTIVITY CONSIDERATIONS:

CONTINGENCY PLANNING: (Who will provide care in event of the nurse absence)

Trained VHA:	Sub Nurse	Health Room Assistant
Yes or No	Yes or No	Yes or No

SUPPLIES NEEDED: Parents will provide all needed supplies for treatments and orders i.e wipes, diabetic supplies, snacks or food, emergency meds,cath supplies, gtube supplies, etc.

"I give permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact my licensed healthcare provider if necessary, and for this healthcare information to be shared with pertinent school staff per FERPA guidelines. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices."

RN Signature:_____Date: _____

Parent Signature: _____ Date: _____

Diabetic Medical Management Plan

Medical form/records Fax # 812-274-8791

(Health Care Provider: may use their own Emergency Action Plan)

The student's personal health care team and parents/guardian should complete this plan. It should be reviewed with relevant school staff and copies should be kept in a place that is easily accessed by the school nurse, trained diabetes personnel, and other authorized personnel.

Students Name:_____ Date of Birth: _____
Date of Diagnosis: _____ Grade:_____ Teacher:_____

Physical Condition (please circle): Type 1 or Type 2

Contact Info:

Mother/Guardian:_____
Address:_____
Telephone Home: _____ Cell:_____ Work:_____
Father/Guardian:_____
Address:_____
Telephone Home: _____ Cell:_____ Work:_____

Students Doctor/Health Care Provider:

Name: _____ Location_____
Phone Number:_____ Fax:_____

Emergency Contacts:

Name:_____ Relationship:_____
Telephone: Home: _____ Cell:_____ Work:_____

Diabetic Information (circle one)

- Is the student independent? Yes or No
- Does the student need supervision? Yes or No
- Can the student draw the correct dose of insulin? Yes or No

Students with Insulin Pumps

- Type of Pump:_____ Basal Rates:_____
- Type of Insulin:_____Type of Infusion Set:_____
- Insulin/Carb Ratio:_____ Correction Factor: _____

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Student Pump Abilities/Skills

	Needs Assistance	Needs Supervision
Count Carbohydrates	Yes or No	Yes or No
Bolus correct amount for carbs	Yes or No	Yes or No
Calculate/Administer bolus	Yes or No	Yes or No
Calculate and set basal profiles	Yes or No	Yes or No
Calculate/Set temp basal rate	Yes or No	Yes or No
Disconnect Pump	Yes or No	Yes or No
Reconnect Pump At Infusion Set	Yes or No	Yes or No
Prepare Reservoir and Tubing	Yes or No	Yes or No
Insert Infusion Set	Yes or No	Yes or No
Troubleshoot Alarms/Notifications	Yes or No	Yes or No

Oral Diabetic Medications

Type of Medication: _____ Time:_____

Other Medications: _____ Time:_____

Meals and Snacks Eaten At School (snacks provided by parent)

Independent in carbohydrate calculations and management? Yes or No

Snack before exercise? Yes or No Snack after exercise? Yes or No

Supplies to be Kept at School (parent must provide)

- Blood glucose meter, blood glucose test strips, batteries for meter
- Lancet device, lancets, gloves, ect.
- Urine Ketone Strips
- Insulin pump and supplies
- Insulin pen, pen needles, and insulin cartridges
- Fast acting source of glucose
- Carbohydrate containing snack
- Glucagon Emergency Kit

Signatures: Physician

Physician Name: _____ Date:_____

Physician signature: _____

Madison Consolidated Schools acknowledge that the above medical orders may change throughout the school year. When changes are required, written communication must occur between the health care provider and the school nurse.

Signatures: Parent/Guardian

I give permission to the school nurse, trained diabetes personnel, and other designated staff members of Madison Consolidated Schools to perform and carry out the diabetes care tasks as outlined by _____'s Diabetes Medical Management Plan.

Acknowledged and received by:

Name: _____ Date:_____

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AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION 2026/2027

Student Name: _____ DOB: _____
Parent or Legal Guardian:_____Phone: _____
Address: _____ City/State/Zip: _____
School: _____Grade: ___ Teacher: _____

Medical Condition(s): _____
_____

Authorization for the exchange of information is hereby granted between Madison Consolidated Schools and the following agency(s) and/or individual(s):

1._____ _____
Name of physician, agency, individual, etc. Phone Fax

2._____ _____
Name of physician, agency, individual, etc. Phone Fax

3._____ _____
Name of physician, agency, individual, etc. Phone Fax

Effective: 2026-2027 School year
Purpose: The purpose of the use and/or disclosure of this information is to best provide for the student's educational, physical and emotional adjustment between the hospital/ Medical office setting and the school setting.

Treatment Orders:____ Emergency Action Plans _____Health/Medical Record Information: _____

• This authorization is valid for twelve (12) months from the date of signing. At any time, I may revoke this release in writing. If I want it to expire on a different date, then that date is:___ . Revocation does not affect release of medical records made prior to the revocation. I understand that I have a right to receive a copy of this form after signing.
• I recognize that these records, once received by the school district, may not be protected by the Health Insurance Portability and Accountability Act (HIPAA), but will become education records protected by the Family Educational Rights and Privacy Act (FERPA).

• Signing this release is voluntary. Refusing to sign it will not affect the school or district's commitment to provide a quality education for the student. However, the requested records may be required in order for the school to implement an appropriate plan of education, learning accommodations/modifications, and or health care.
• I understand for the purpose of providing the most appropriate instruction and assistance in school, I am giving my permission for mutual exchange of educational evaluations or medical evaluations.
• Parents of a student with a disability have protection under the procedural safeguards described in the law: 511 IAC-7-37-1. If I have not previously received a copy of written notice of procedural safeguards and a list of resources for help in understanding my rights, I understand these can be obtained from my child's teacher or the Special Education office.
• By my signature below, I indicate that I am the parent or legal guardian of the above named child. I authorize the release and use of the information in accordance with the rights,restrictions and understandings above to ensure health, safety and continuity of care for my child.

Parent or Legal Guardian's Signature: Date:

_____ _____