Bethel SCHOOLS

Dear Parents,

A law has been enacted in Washington that requires children with life-threatening conditions to have a medication or treatment order on file prior to attending school. This law, calledSubstitute House Bill 2834, took effect on June 13, 2002.

The medication or treatment order must address the life-threatening condition and itmust be on file with the school prior to the child attending school. Under the law, "life-threatening condition" means a health condition that will put the child in danger of death during the school day if a medication or treatment order is not in place. In addition, our school nurses will be responsible for putting a nursing care plan in place. The law providesthat a child may not attend school in the absence of a medication or treatment order if the child has a life-threatening condition that might require medical services to be provided at school.

Having reviewed the information you provided regarding your child's health it appears that your child has a life-threatening condition that requires a medication or treatment order.

Please have your health care provider complete the **Health Care Provider Orders for Students with Diabetes in Washington State Schools** and sign the **Parent Permission**. Return this form to your child's school nurse as soon as possible.

At the start of every school year you will need new medication order forms filled out by your health care provider for the next school year to comply with Substitute House Bill 2834, commonly known as the "Life Threatening Condition" law. I am enclosing new forms for your convenience.

Included in your packet are:

- Life threatening law letter.
- Diet Prescription for Meals at School.
- Health Care Provider Orders for Students with Diabetes in Washington State Schools. This needs to be completed by doctor and parent and brought to school before the first day with medication.

Upon receipt of the information from your health care provider, the school nurse will contact you to develop an appropriate nursing plan.

Sincerely,

School Nurse

Bethel Public Schools Nutrition Services
Diet Prescription for Meals at School

Student Name: _____Date of Birth: _____ Age: ____

Name of School: _____ Grade: _____

Section A: To be completed by parent or guardian. Please check box(es) and sign below:

☐ I understand that if my child's medical or health needs change, it is my responsibility to notify my child's school nurse/health clerk and have a new Diet Prescription for Meals at School form completed.

☐ I give Nutrition Services permission to speak with the Physician or Authorized Medical Authority named below to discuss the dietary needs described below.

_____ _____ _____
Parent/Guardian Signature | Home Phone Number | Date Signed

Section B: To be completed by child's Physician / recognized Medical Authority (if describing a disability).

Does the child have a disability? ☐ Yes ☐ No
If yes, describe the major life activity affected by the disability _____
_____

Does the child have a non-disabling medical condition? ☐ Yes ☐ No
If yes, describe the medical condition _____
_____

Does the child have special nutritional or feeding needs? ☐ Yes ☐ No
If yes, describe the specific need _____
_____

If you answered YES to any of the questions above, complete Section C and return to the nurse/health clerk at the child's school.

Section C: **PHYSICIAN REQUEST** Diet Prescription:
(To be completed by the child's Physician or a recognized Medical Authority).

Note: For any food item to be omitted from diet, a substitute **must** be listed.

Foods to Omit:	Foods to Substitute:
_____	_____
_____	_____
_____	_____
_____	_____

Please attach additional instructions if necessary.

I certify that the student noted above needs special school meals prepared as described above because of the student's disability or chronic medical condition.

_____ _____
Health Care Provider Signature | Date Signed

Name: _____ Office Phone: _____ Fax:_____
Type or Print

HEALTH CARE PROVIDER ORDERS FOR STUDENTS WITH DIABETES IN WASHINGTON STATE SCHOOLS

STUDENT'S NAME_____Student's birthdate__/__/__School_____Grade___

Emergency numbers for parents (phone) ____-____-____ (Cell contact 2)e____-____-____ (//Cell)e____-____-____

Doctor's phone number____-____-____ Other contacts_____, ____-____-____e

HYPOGLYCEMIA (fill in individualized instructions on line or use those in parenthesis)

Unconscious--_____**(phone 911)** (Other orders)_____

Blood sugar < 60 and symptomatic _____e (juice, pop, candy) _____

Blood sugar < 100 and symptomatic _____(crackers/cheese) _____

Blood sugar < 80 and asymptomatic _____(feed partial meal) _____

Blood sugar > 100 and symptomatic _____(feed partial meal)

Blood sugar at which parent should be notified–low _____ high _____

BLOOD SUGAR AND INSULIN DOSAGE prior to lunch (R is regular and H is lis-pro,) _____ any other insulin requested

Blood sugar	< 100	_____ units R - H - other _____	(see hypoglycemia above)
Blood sugar	100–149e	_____ units R - H - other _____	
Blood sugar	150–199e	_____ units R - H - other _____	
Blood sugar	200–249	_____ units R - H - other _____	
Blood sugar	250–299	_____ units R - H - other _____	(check ketones)
Blood sugar	300–349	_____ units R - H - other _____	(check ketones)
Blood sugar	350–399e	_____ units R - H - other _____	(check ketones)
Blood sugar	> 400	_____ units R - H - other _____	(check ketones)

- Licensed medical personnel allowed to give _____ units (minimum) of insulin to _____ units (maximum) of R, H, othere _____ insulin after consultation with the parent/guardian.e
- Other insulin instructions (i.e., CHO counting):_____e e e e
- If urine ketones (trace, small, moderate, large) call parents (circle one or moree

DISASTER INSULIN DOSAGE-in case of disaster how much insulin should be given? Recommend **80%** of usual dose.

A.M.	_____ units R - H - other	_____ units	Lente	NPH	Ultralente	Lantus	other
Noon	_____ units R - H - other	_____ units	Lente	NPH	Ultralente	Lantus	other
P.M.	_____ units R - H - other	_____ units	Lente	NPH	Ultralente	Lantus	other
Bedtime	_____ units R - H - other	_____ units	Lente	NPH	Ultralente	Lantus	other

STUDENT'S SELF-CARE (ability level)

	Initials of: Parent	HCP	School Nurse
Totally independent management or			
1.eStudent tests independently ore			
student needs verification of number by staff or			
assist/testing to be done by school nursee			
2.eStudent administers insulin independently ore			
student self-injects with verification of number or			
student self-injects with nurse supervision ore			
injection to be done by school nursee			
3.eStudent self-treats mild hypoglycemiae			
4.eStudent monitors own snacks and mealse			
5.eStudent tests and interprets own urine ketonese			
6.eStudent tests and interprets own blood ketonese			
7.eStudent carries own suppliese			

HCP _____e (print/type) ____e_____signature ____/____/____ date

Parent _____(print/type) _____signature ____/____/____ date

School Nurse _____(print/type) _____signature ____/____/____ date

Start date: ____day ____mo. ____yr. **Termination date**: _____day _____mo. _____yr. **or End of school year**: _____

Must be renewed at beginning of each school year.