STATE OF HAWAII
DEPARTMENT OF EDUCATION

REQUEST FOR DIABETES CARE AND MEDICATION ADMINISTRATION

School: _____ School Year: _____

Please complete this form in black or blue ink

Student Name (Last, First):			Date of Birth:
Home Address:			Grade/Rm #:
Parent/Legal Guardian Name:	Cell:	Work:	Home:
Parent/Legal Guardian Name:	Cell:	Work:	Home:
Medical Insurance: ☐ Medicaid (QUEST) ☐ Tricare ☐ HMSA-Private ☐ Kaiser-Private ☐ None ☐ Other: _____			

I. PARENT'S/LEGAL GUARDIAN'S REQUEST, AUTHORIZATION, and WAIVER OF LIABILITY

Request and Authorization:

I, the undersigned, request and authorize the following individuals to administer medication to my child as specified in medication orders on this form prescribed by my child's physician or other practitioner with prescribing authority: personnel of the Hawaii Department of Education (DOE), and their employees or agents, including nurses and their supervised delegates assigned by the DOE pursuant to written agreement. If specified and certified by the physician, advanced practice registered nurse, or physician assistant completing this form, I also request and authorize my child to self-manage diabetes care or self-administer medications.

I request and authorize the DOE to release education records of the above named student pursuant to this request, including health information, to the prescribing physician or other practitioner with prescribing authority completing this form, the dispensing pharmacist, and as applicable to the Hawaii State Department of Health (DOH) Public Health Nurse (PHN). I understand that a separate release of information request may be required by my physician or other healthcare provider to facilitate this request.

Waiver of Liability:

NOTICE: The DOE, the DOH, and their employees and/or agents shall not incur any liability as a result of any injury arising from the administration of medications specified on this form, or in cases where students have been permitted to self-manage diabetes care as specified on this form, pursuant to Hawaii Revised Statutes (HRS) §302A-1164.

My initials and signature below indicate that:

_____ (initials) I consent to the policy and procedures set forth on page 2 of this form, "Notice to Parents/Legal Guardians and Healthcare Providers;"

_____ (initials) I agree to follow the instructions on page 2 of this form, "Notice to Parents/Legal Guardians and Healthcare Providers;"

_____ (initials) I understand and agree I am responsible for providing a recent photograph of my child, as well as appropriately labeled medications in accordance with the instructions on page 2 of this form;

_____ (initials) I understand and agree that this request for diabetes care and medication administration may be performed by unlicensed personnel who have volunteered and received training for safe medication administration and assisting with glucose monitoring as permitted under HRS §302A-853, §302A-1164 and §457;

_____ (initials) I have read and acknowledge the above notice, "Waiver of Liability." I shall indemnify and hold harmless the DOE and its employees or agents, including nurses and their supervised delegates assigned by the DOE pursuant to written agreement, against any claims arising out of compliance with medical orders specified on this form.

Parent/Legal Guardian Signature:	Parent/Legal Guardian Printed Name:	Date:

NOTICE TO PARENTS/LEGAL GUARDIANS AND HEALTHCARE PROVIDERS
(Please keep this page for your future reference.)

Please note: School Health Assistants (SHA) are not licensed health professionals but are specifically trained in medication administration under predictable circumstances. SHAs and other DOE personnel who are not licensed health professionals may volunteer to assist with diabetes care. They are not able to perform clinical assessments which may be necessary to determine the need for medication or response to medication. They are provided training for protocols to follow in situations where the need for medication is explicit, straightforward and can be strictly defined.

1. This form represents my consent and request for health services described on this form. It is not an agreement by Hawaii DOE to provide the requested services. Only medications that have been approved pursuant to this form may be stored in the school.
2. Completion of a "Special Dietary Needs Medical Form (Attachment J1)" may be needed to request School Food Services Branch accommodations for school-provided meals.
3. Certain emergency rescue medications may be administered by unlicensed personnel such as a SHA, in accordance with Hawaii Revised Statutes (HRS) §302A-853 and §302A-1164, on an emergency basis if they have been prescribed by a physician or other practitioner with prescriptive authority, and the parent/legal guardian has requested their administration in accordance with this form.
    a. Glucagon: When administered, the school will call 911 and notify the parent/legal guardian. The school will defer to Emergency Medical Service (EMS) personnel with respect to whether transport to a medical facility is needed. If EMS personnel determine that transport to a medical facility is not needed, the parent/legal guardian will be informed to pick up the student.
4. No student-specific medications will be administered by the authorized DOE employees or agents without the completion and approval of this SH36DM "Request for Diabetes Care and Medication Administration" form which includes the following requirements:
    a. Parent/legal guardian must complete and sign section I, PARENT'S/LEGAL GUARDIAN'S REQUEST, AUTHORIZATION, and WAIVER of LIABILITY;
    b. Physician or other practitioner with prescriptive authority must complete section II, PHYSICIAN'S OR OTHER HEALTHCARE PROVIDER'S REQUESTED MEDICAL ORDERS;
    c. Section III, AUTHORIZED APPROVAL, must be completed by a health care professional (as defined by HRS §302A-853) indicating approval of the request; and
    d. The completed and approved form must be submitted to the school and maintained on file in the student's record.
5. Students who have been provided with attestation that they may self-manage diabetes care or self-administer medications by the physician or other practitioner with prescriptive authority completing this form will be permitted to self-carry medications and/or supplies on school campus or during DOE activities. If a self-carrying student's conduct or behavior endangers the student's person or other persons through the misuse of these medications or supplies, then the DOE, its employees or agents may confiscate the student's medication or supplies.
6. In order for medications to be stored in school and administered by the DOE SHA, the medications must:
    a. Be dispensed by a pharmacist in accordance with HRS §328-16(a)(1)-(11). This includes container/vial labeling with the name of the student, name of the medication, strength and instructions for use of the medication, and name of the prescribing physician or other practitioner with prescriptive authority;
    b. The instructions on the container must be consistent with a completed Form SH36 or SH36DM; and
    c. Be designated on a completed and approved Form SH36 or SH36DM.
7. Parent/legal guardian is responsible for:
    a. Providing a recent photo of their child to the health room at school;
    b. Providing appropriately labeled medications and adequate medical supplies necessary for diabetes care specified on this form;
    c. Maintaining in good working order any devices for blood glucose monitoring and insulin delivery method(s) specified on this form; and
    d. Retrieving or picking up from the school any medications or supplies that are discontinued, or unused at the end of the school year.

    This should be coordinated with the school health assistant, the child's teacher(s), and the school principal.
8. In cases where a student with approved SH36DM medication(s) or diabetes care orders plans to participate in a DOE sponsored activity off campus or outside of normal school hours, prior arrangements must be made between the parent/legal guardian and the school to ensure the student will receive the care described in this form.
9. Any new diabetes care or medication order(s) or changes to a previously approved SH36DM form, will require a new SH36DM "Request for Diabetes Care and Medication Administration" form (SH36DM, Revised 2024) to be completed and approved as specified in this form. However, prescription refills for an approved SH36DM medication request do not require a new form.
10. This form is applicable only for the current school year and must be renewed yearly. Parent/legal guardian is responsible for submitting requests for the following school year.

Student's Name: _____ Date of Birth: _____

II. PHYSICIAN'S or OTHER HEALTHCARE PROVIDER'S REQUESTED MEDICAL ORDERS

Diagnosis: ☐ Type 1 (IDDM) ☐ Type 2 (NIDDM) ☐ Other:_____ICD-10: _____ Weight: _____ (kg)

Allergies: _____

GLUCOSE MONITORING

Blood Glucose (BG) Testing ☐ No BG testing at school

- ☐ Before meals or when insulin ordered (see below)
- ☐ PRN (as needed) for suspected hypoglycemia or hyperglycemia (observed or reported symptoms)
- ☐ Before PE (gym class) or sports participation
- ☐ At dismissal or before bus rides > 30 minutes
- ☐ Use continuous glucose monitor (CGM) unless:
  - ☐ for BG readings **<**_____ (mg/dl) or **>**_____ (mg/dl) THEN please check finger-stick blood glucose

Expected blood glucose (BG) range while at school:

_____ **–** _____ (mg/dl)

Meal/Snack Times

- ☐ Adult supervision to assure student eating
- ☐ AM snack time: _____ ☐ PM snack time: _____
- ☐ Other: _____
- ☐ Extra carbohydrates pre-exercise
- ☐ Allow snack for Bus rides > 30 min

Please Note: Breakfast and lunch times are determined by school

INSULIN

Please Note: For students who self-administer with supervision, orders below are for confirmation of appropriate insulin use by a trained responsible adult.

Insulin Administration Time(s):

- ☐ Before: OR ☐ After:
  - ☐ Breakfast ☐ AM SNACK ☐ LUNCH ☐ PM SNACK
- ☐ Every 2 hours PRN (as needed) for hyperglycemia
- ☐ Other: _____

Insulin Type: _____

Insulin Administration via:

☐ Insulin pump ☐ Insulin pen ☐ Smart pen ☐ Syringe

Note: Pump to be used 1st when available and pen or syringe as back-up

Dosage

- ☐ As determined by insulin pump/smart pen (Use first, and if device fails use orders)
- ☐ Give (meal) Carbohydrate Coverage
- ☐ Give (BG) Correction Dose (if ≥2 hours from last rapid acting insulin)
- ☐ Parent/legal guardian may give directions on dosing

Correction Dose

☐ Sliding Scale based on Blood Glucose (BG) testing:

BG from _____(mg/dl) to _____(mg/dl) = _____ units
BG from _____(mg/dl) to _____(mg/dl) = _____ units
BG from _____(mg/dl) to _____(mg/dl) = _____ units
BG from _____(mg/dl) to _____(mg/dl) = _____ units
BG from _____(mg/dl) to _____(mg/dl) = _____ units
BG from _____(mg/dl) to _____(mg/dl) = _____ units
BG from _____(mg/dl) to _____(mg/dl) = _____ units

Carbohydrate Coverage

- ☐ Standard dose with lunch: _____ units
- ☐ 1 unit for every _____ (g) carbohydrate

Please Note: Carbohydrate count shall be the responsibility of parent/legal guardian or self-administering student.

HYPO/HYPER-GLYCEMIA

Hypoglycemia - Refer to EAP

For BG < _____ (mg/dl):

- ☐ **IF** able to swallow, give oral rapid carbohydrate 1st
- ☐ **IF** unable to swallow OR **IF** unconscious, unresponsive, seizure, or inability to swallow EVEN if BG is unknown, **GIVE PRN** (as needed):
  - ☐ Glucagon injection **IM** ☐ 0.5 mg ☐ 1 mg
  - ☐ Basqimi (glucagon) **Intranasal**, 3 mg
  - ☐ GVOKE (glucagon auto-injector) **Subcut**, ☐ 0.5 mg ☐ 1 mg
  - ☐ Zegalogue (glucagon auto-injector) **Subcut**, 0.6 mg (may repeat once in 15 minutes if poor response)

Hyperglycemia - Refer to EAP

If pre-gym BG >_____ (mg/dl): ☐ No PE (gym class) or sports

If BG >_____ (mg/dl), recheck in 2 hours, if BG >_____ (mg/dl)

OR

If BG >_____ (mg/dl), "Hi" or "HIGH" (Give insulin if ordered above):

- ☐ Check ketones: ☐ Urine ☐ Blood
  - ☐ If ANY ketones: rest, drink water, recheck ketones every 2h, call parent/legal guardian
  - ☐ If ketones moderate/large (urine) / >0.6 (blood): call parent/legal guardian *for pick up within one hour*

Call 911 if vomiting, labored breathing, confusion, lethargy or unconscious while awaiting parent/legal guardian pick-up

(Options below require initial attestation in the next column to the right)

☐ **Student may perform and self-manage blood glucose monitoring**

☐ **Student may self-administer insulin**:
☐ with adult supervision ☐ without supervision

☐ **Student may carry and self-administer glucagon**

_____ (initials)

The above named student may perform the student's own blood glucose checks, administer glucagon and/or insulin through the student's insulin delivery system as indicated on this form, and otherwise attend to the care and management of the student's diabetes during all school-related activities. I attest that I have confirmed the student is capable of, and has been instructed in the proper method of medication self-administration and/or blood glucose monitoring. The student may possess on their person all necessary supplies and equipment for this purpose during all school-related activities.

Request for Skilled Nursing Services: Due to the need for clinical decision making and/or complexity of diabetes care needs, I am requesting assignment of a Registered Nurse (RN): ☐ Continuous **OR** ☐ Limited to scheduled insulin administration times

Healthcare Provider
(Please stamp or print legibly)
Name: Phone: Fax:
Address:

Signature:_____ Date:_____

III. AUTHORIZED APPROVAL:

Review completed by the following health care professional within the DOE, DOH, or a health care service pursuant to written agreement with DOE:
See consultation report for complete details

Glucagon administration by School Health Assistant (SHA):
☐ is approved ☐ is NOT approved

Name:

Signature:_____ Date:_____