HEALTH CARE PROVIDER AUTHORIZATION FOR SCHOOL MANAGEMENT OF DIAB ETES

STUDENT: _____ DOB: _____ DATE: _____

**BLOOD GLUCOSE (BG) MONITORING:** (Target range: _____ mg/dl to _____ mg/dl.)

- ☐ Before meals
- ☐ PRN for suspected low/high BG
- ☐ 2 hours after correction
- ☐ Midmorning
- ☐ Mid-afternoon

**INSULIN ADMINISTRATION:** Dose determined by: ❑ Student ❑ Parent ❑ School nurse

Insulin delivery system ❑ Syringe ❑ Pen ❑ Pump (Use supplemental form for Student Wearing Insulin Pump)

BEFORE MEAL INSULIN:

Insulin Type: ☐Humalog ☐Novolog ☐_____ Other

☐ Insulin to Carbohydrate Ratio: _____ unit(s) per _____ grams carbohydrate

☐ Give _____ units

CORRECTION INSULIN for high blood sugar (Check only those which apply)

☐Use the following correction formula: **BG** - _____ / _____ ( for pre lunch blood sugar over _____ )

❑ Sliding Scale:

BG from _____ to _____ = _____ u
BG from _____ to _____ = _____ u
BG from _____ to _____ = _____ u
BG from _____ to _____ = _____ u
BG from _____ to _____ = _____ u

Add before meal insulin to correction/ sliding scale insulin for total meal time insulin dose

**MANAGEMENT OF LOW BLOOD GLUCOSE :**

**MILD: Blood Glucose <_____**

- ☐ Never leave student alone
- ☐ Give 15 gms glucose; recheck in 15 min.
- ☐ If BG < 70, retreat and recheck q 15 min x 3
- ☐ Notify parent if not resolved.
- ☐ Provide snack with carbohydrate, fat, protein after treating and meal not scheduled > 1 hr

**SEVERE: Loss of consciousness or seizure**

- ☐Call 911. Open airway. Turn to side.
- Glucagon injection ☐0.25 mg ☐ 0.50 mg ☐ 1.0 mg IM/SQ
- ☐ Notify parent.

**MANAGEMENT OF HIGH BLOOD GLUCOSE (Above _____ mg/dl)**

- ☐ Sugar-free fluids/frequent bathroom privileges.
- ☐ If BG is greater than 300, and it's been 2 hours since last dose, give ☐ HALF ❑ FULL correction formula noted above.
- ☐ If BG is greater than 300, and it's been 4 hours since last dose, give FULL correction formula noted above.
- ☐ If BG is greater than 300 check for ketones. Notify parent if ketones are present.
- ☐ Note and document changes in status.
- ☐ Child should be allowed to stay in school unless vomiting and moderate or large ketones are present.

**EXERCISE:**

Faculty/staff must be informed and educated regarding management. Staff should provide easy access to fast-acting carbohydrates, snacks, and BG monitoring equipment during activities. Child should NOT exercise if blood glucose levels are below 70mg/dl or above 300 mg/dl and urine contains moderate or large ketones.

❑ Check blood sugar right before PE to determine need for additional snack.

☐ If BG is less than 70 mg/dl, eat 15-45 grams carbohydrate before, depending on intensity and length of exercise.

❑ Student may disconnect insulin pump for 1 hour or decrease basal rate by _____.

*My signature provides authorization for the above orders. I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.*

❑ If changes are indicated, I will provide new written authorized orders (may be faxed).

☐Dose/treatment changes may be relayed through parent

Healthcare Provider Signature: _____ Date: _____

Address: _____ Telephone: _____

INFORMATION FOR SCHOOL MANAGEMENT OF DIABETES MELLITUS
School Year: _____

Student's Name: _____ Date of Birth: _____ Effective Date: _____

School Name: _____ Grade: ____ Homeroom: _____

CONTACT INFORMATION:

Parent/Guardian #1: _____ Phone #: Home: _____ Work: _____ Cell/Pager: _____

Parent/Guardian #1: _____ Phone #: Home: _____ Work: _____ Cell/Pager: _____

Diabetes Care Provider: _____ Phone #: _____

Other emergency contact: _____ Relationship: _____

Phone Numbers: Home: _____ Cellular/Pager: _____

Insurance Carrier: _____ Preferred Hospital: _____

**EMERGENCY NOTIFICATION: Notify parents of the following conditions:**
a. Loss of consciousness or seizure (convulsion) immediately after calling 911 and administering Glucagon.
b. Blood sugars in excess of 300 mg/dl. With ketones present
c. Positive urine ketones.
d. Abdominal pain, nausea/vomiting, fever, diarrhea, altered breathing, altered level of consciousness

**STUDENT'S COMPETENCE WITH PROCEDURES:** (Must be verified by parent and school nurse)

- ❑ Blood glucose monitoring
- ❑ Determining insulin dose
- ❑ Measuring insulin
- ❑ Injecting insulin
- ❑ Independently operates insulin pump
- ❑ Carry supplies for BG monitoring
- ❑ Carry supplies for insulin administration
- ❑ Monitor BG in classroom
- ❑ Self treatment for mild low blood sugar
- ❑ Determine own snack/meal content

**MEAL PLAN:**

| | Time | Location | CHO Content | | Time | Location | CHO Content |
|---|---|---|---|---|---|---|---|
| ❑ Bkft | | | | ❑ Mid-PM | | | |
| ❑ Mid-AM | | | | ❑ Before PE | | | |
| ❑ Lunch | | | | ❑ After PE: | | | |

Meal/snack will be considered mandatory. Times of meals/snacks will be at routine school times unless alteration is indicated. School nurse will contact diabetes care provider for adjustment in meal times. Content of meal/snack will be determined by:
❑ Student ❑ Parent ❑ School nurse ❑ Diabetes provider
**Please provide school cafeteria with a copy of this meal plan order to fulfill USDA requirements.**
**Parent to provide and restock snacks and low blood sugar supplies box.**

**LOCATION OF SUPPLIES/EQUIPMENT:** (To be completed by school personnel)

**Blood glucose equipment:** ❑ Clinic/health room ❑ With student
**Insulin administration supplies:** ❑ Clinic/health room ❑ With student
**Glucagon emergency kit:** _____ **Glucose gel:** _____ **Ketone testing supplies:** _____
**Fast acting carbohydrate:** ❑ Clinic/health room ❑ With student **Snacks:** ❑ Clinic/health room ❑ With student

**SIGNATURES:** I understand that all treatments and procedures may be performed by the student and/or unlicensed personnel within the school or by EMS in the event of loss of consciousness or seizure. I also understand that the school is not responsible for damage, loss of equipment, or expenses utilized in these treatments and procedures. I give permission for school personnel to contact my child's diabetes provider for guidance and recommendations. I have reviewed this information form and agree with the indicated information. This form will assist the school in developing a health plan and in providing appropriate care for my child.

PARENT SIGNATURE: _____ DATE: _____

SCHOOL NURSE SIGNATURE: _____ DATE: _____