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: ________________

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
- ☐ Midmorning
- ☐ 2 hours after correction
- ☐ 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 ____________________

☐ Insulin to Carbohydrate Ratio: _______ units 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.
- ☐ IfBG 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/or 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 target range, eat 15-45 grams carbohydrate before, depending on intensity and length of exercise.
- ☐ Student may disconnect insulin pump for ______ hours 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: ____