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
- ❑ 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 _____

❑ 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.
- ❑ 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/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.

Diabetes Educator Signature: _____ Date: _____

Physician Signature: _____ Date: _____