

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)

- | | |
|--|--|
| <input type="checkbox"/> Blood glucose monitoring | <input type="checkbox"/> Carry supplies for BG monitoring |
| <input type="checkbox"/> Determining insulin dose | <input type="checkbox"/> Carry supplies for insulin administration |
| <input type="checkbox"/> Measuring insulin | <input type="checkbox"/> Monitor BG in classroom |
| <input type="checkbox"/> Injecting insulin | <input type="checkbox"/> Self treatment for mild low blood sugar |
| <input type="checkbox"/> Independently operates insulin pump | <input type="checkbox"/> Determine own snack/meal content |

MEAL PLAN: Time Location CHO Content Time Location CHO Content

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Bkft _____ | <input type="checkbox"/> Mid-PM _____ |
| <input type="checkbox"/> Mid-AM _____ | <input type="checkbox"/> Before PE _____ |
| <input type="checkbox"/> Lunch _____ | <input type="checkbox"/> 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 DIABETES

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 < _____

SEVERE: Loss of consciousness or seizure

- 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
- 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: _____