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 _____ mg/dl.
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-AM _____ _____ _____
- ❑ Lunch _____ _____ _____
- ❑ Mid-PM _____ _____ _____
- ❑ Before PE _____ _____ _____
- ❑ 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.)

None required at this time.
- ❑ Before meals
- ❑ Midmorning
- ❑ 2 hrs after correction
- ❑ PRN for suspected low/high BG
- ❑ 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 sugar-free liquids, fast-acting carbohydrates, snacks, and BG monitoring equipment during activities. Child should NOT exercise if blood glucose levels are below _____ mg/dl or above _____ 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.*~~

*Our school nurses are governed by the Georgia Nurse Practice Act and APS Policy JGCD – Medication, and they will only administer medication in accordance with written medical orders signed by a licensed physician, dentist, or podiatrist. APS nurses will not modify any dosage of medicine based solely on a request or recommendation by a parent or guardian. A parent or guardian seeking a dosage modification must provide the nurse with an appropriate medical order.

Healthcare Provider Signature: _____ Date: _____

Address: _____

SUPPLEMENTAL INFORMATION FOR STUDENT WEARING AN INSULIN PUMP AT SCHOOL

School Year _____

Student's Name: _____ Date of Birth: _____ Pump Brand/Model:_____
Pump Resource Person: _____ Phone/ Beeper _____ (See diabetes care plan for parent phone #)
Blood Glucose Target Range: _____ Pump Insulin: ☐ Humalog ☐ Novolog
Insulin Correction Factor for Blood Glucose Over Target: _____
Insulin Carbohydrate Ratios: _____

(Student to receive insulin bolus for carbohydrate intake immediately ☐ before (_____ minutes before eating) ☐ after (_____ minutes after eating).
Location of Extra Pump Supplies _____

☐ **INDEPENDENT MANAGEMENT**

This student has been trained to independently perform routine pump management and to troubleshoot problems including but not limited to:

- Giving boluses of insulin for both correction of blood glucose above target range and for food consumption.
- Changing of insulin infusion sets using universal precautions.
- Switching to injections should there be a pump malfunction.

Parents will provide extra supplies to include infusion sets, reservoirs, batteries, pump insulin and syringes.

☐ **NON-INDEPENDENT MANAGEMENT (Child Lock On? ☐ Yes ☐ No)**

Because of young age or other factors, this student cannot independently evaluate pump function nor independently change infusion sets.

☐ Pump calculates insulin dose

☐ Insulin for meals and snacks will be given and verified as follows: _____

_____

☐ Insulin for correction of blood glucose over _____ will be give and verified as follows:

_____

PARENT NOTIFICATION: (*Refer to basic diabetes care plan and check ✓ all others that apply. Contact the Parent in event of:*

☐ Pump alarms / malfunctions ☐ Corrective measures do not return blood glucose to target range within ___ hrs.
☐ Soreness or redness at site ☐ Student has to change site
☐ Detachment of dressing / infusion set our of place
☐ Leakage of insulin
☐ Student must give insulin injection
☐ Other: _____

_____

MANAGEMENT OF HIGH / VERY HIGH BLOOD GLUCOSE: Refer to previous sections and to basic Diabetes Care Plan

MANAGEMENT OF LOW BLOOD GLUCOSE *Follow instructions in basic Diabetes Care Plan, but in addition:*

If low blood glucose recurs without explanation, notify parent / diabetes provider for potential instructions to suspend pump.

If seizure or unresponsiveness occurs:

1. Give Glucagon and / or glucose gel (See basic Diabetes Health Plan)
2. CALL 911
3. Notify Parent
4. Stop insulin pump by:
   - ☐ Placing in "Suspend" or stop mode
   - ☐ Disconnecting at pigtail or clip
5. If pump was removed, send with EMS to hospital.

COMMENTS:

_____

_____

_____

Effective Dates: From: _____ To: _____
Parent's Signature: _____ Date: _____
School Nurse's Signature: _____ Date: _____
Healthcare Provider Signature: _____ Date: _____