INFORMATION FOR SCHOOL MANAGEMENT OF DIABETES MELLITUS
School Year: _____

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

School Name: _____ STUDENT ID: _____Grade**:** _____

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-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: _____

COUNTY 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: ☐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: _____

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

_____

Copy of this plan has been provided to Transportation Supervisor Yes □ No □

Effective Dates: From: _____ To: _____
Parent's Signature: _____ Date: _____
County School Nurse's Signature: _____ Date: _____
Diabetes Care Provider Signature: _____ Date: _____

Confidentiality must be upheld when talking to other parents or outside persons. Information about students and family is strictly confidential. 5/10