

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 #2: _____ 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)

- | | |
|--|--|
| <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 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 Clinic Assistant

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 < _____

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/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.

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 out 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: _____
Parent's Signature: _____
School Nurse's Signature: _____
Diabetes Care Provider Signature: _____

To: _____
Date: _____
Date: _____
Date: _____