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)

- ❑ 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

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 MONITORING: (Target range: _____ mg/dl to _____ mg/dl.

- ❑ None required at this time.
- ❑ Before meals
- ❑ Midmorning
- ❑ Before PE/activity time
- ❑ After PE/activity time
- ❑ Midafternoon
- ❑ 2 hrs after correction
- ❑ PRN for suspected low/high BG

INSULIN ADMINISTRATION: Dose determined by: ❑ Student ❑ Parent ❑ School nurse

Insulin delivery system: ❑ Syringe ❑ Pen ❑ Pump (Use supplemental form for Student Wearing Insulin Pump)

Insulin Type: _____ CHO Insulin Ratio: _____ units per _____ gms. CHO

Correction Bolus Dose: (Check only those which apply)

- ❑ Use the following formula: BG - _____ / _____
- ❑ Sliding Scale:
  - BG from _____ to _____ = _____ u
  - BG from _____ to _____ = _____ u
  - BG from _____ to _____ = _____ u
  - BG from _____ to _____ = _____ u
  - BG from _____ to _____ = _____ u

- ❑ Decrease correction dose by _____ units or _____% if PE/activity is anticipated < 1 hr after correction dose.
- ❑ Decrease correction dose by _____ units if given following a low blood glucose level.
- ❑ Add CHO bolus to correction bolus for total insulin dose.

MANAGEMENT OF LOW BLOOD GLUCOSE: (below _____ mg/dl)

MILD: BG < _____

- ❑ Never leave student alone
- ❑ Give 15 gms glucose; recheck in 10 min.
- ❑ If BG < 70, retreat and recheck q 10 min x 3
- ❑ Notify parent if not resolved.
- ❑ Provide snack with CHO, 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 _____ mg IM/SQ
- ❑ Notify parent.

MANAGEMENT OF HIGH BLOOD GLUCOSE: (Above _____ mg/dl)

- ❑ Sugar-free fluids/frequent bathroom privileges
- ❑ If BG is greater than _____ , initiate insulin orders
- ❑ If BG is greater than _____, check for ketones. Notify parent if ketones are present.
- ❑ May not need snack.
- ❑ Note and document changes in status.
- ❑ Notify parent per "Emergency Notification" Section.

EXERCISE:

Faculty/staff accompanying adult must be informed and educated regarding management. Easy access to sugar-free liquids, fast-acting carbohydrates, snacks, and BG monitoring equipment. Child should NOT exercise if blood glucose levels are below _____ mg/dl or above _____ mg/dl + ketones.

❑ Eat _____ gms. CHO for vigorous exercise ❑ Before ❑ During ❑ After exercise.

❑ Student may disconnect insulin pump for _____ hr. 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: _____

❑ I request that the school nurse provide me with a copy of the School Health Care Plan.2

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 ☐ Regular ☐
Insulin Correction Factor for Blood Glucose Over Target: _____
Insulin Carbohydrate Ratios: _____
(Student to receive insulin bolus for carbohydrate intake immediately before / _____ minutes before eating. Circle appropriate interval)
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.

- Insulin for meals and snacks will be given and verified as follows: _____
  _____
- Insulin for correction of blood glucose over _____ will be given 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
   - ☐ Cutting tubing
5. If pump was removed, send with EMS to hospital.

COMMENTS:

_____
_____
_____
_____

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