

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

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

To be done 30 minutes prior to getting on the bus to go home. (Important: the patient must have a blood sugar > 80 mg/dL to ride home on bus. Follow hypoglycemia guidelines if BS < 80 mg/dL).

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 < _____

SEVERE: Loss of consciousness or seizure

- 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
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 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
 - Cutting tubing
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: _____