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-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 DIAB ETES

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

DIABETES MELLITUS MEDICAL MANAGEMENT PLAN

School Year: **20___ to _____**

This student requires assistance by the School Nurse or Trained Diabetes Personnel with the following aspects of diabetes management:

- ❑ Monitor and record blood glucose levels
- ❑ Respond to elevated or low blood glucose levels
- ❑ Administer glucagon when required
- ❑ Administer insulin or oral medication
- ❑ Monitor blood or urine ketones
- ❑ Follow instructions regarding meals and snacks
- ❑ Follow instructions as related to physical activity
- ❑ Insulin pump management: administer insulin, inspect infusion site, contact parent for problems
- ❑ Provide other specified assistance:_____

_____

_____

This student may independently perform the following aspects of diabetes management:

Monitor blood glucose:
- ❑ in the classroom
- ❑ in the designated clinic office
- ❑ in any area of the school and at any school related activity

- ❑ Monitor urine or blood ketones
- ❑ Administer insulin
- ❑ Treat hypoglycemia (low blood sugar)
- ❑ Treat hyperglycemia (elevated blood sugar)
- ❑ Carry supplies for blood glucose monitoring
- ❑ Carry supplies for insulin administration
- ❑ Determine own snack/meal content
- ❑ Manage insulin pump
- ❑ Replace insulin pump infusion set

LOCATION OF SUPPLIES/EQUIPMENT: (To be completed by school personnel and parent. Parent to provide and restock snacks and low blood sugar supplies box.)

	Clinic room	With student		Clinic room	With student
Blood glucose equipment	❑	❑	Glucagon kit	❑	❑
Insulin administration supplies	❑	❑	Glucose gel	❑	❑
Ketone supplies	❑	❑	Juice / low blood glucose snacks	❑	❑

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, when ketones present.
c. Abdominal pain, nausea/vomiting, fever, diarrhea, altered breathing, altered level of consciousness.

Parent/Guardian: _____ Phone at Home: _____ Work: _____ Cell/Pager: _____

Parent/Guardian: _____ Phone at Home: _____ Work: _____ Cell/Pager: _____

Other emergency contact: _____ Phone #: _____ Relationship: _____

Insurance Carrier: _____ Preferred Hospital: _____

SIGNATURES: I understand that all treatments and procedures may be performed by the student and/or Trained Diabetes 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 document serves as the Diabetes Medical Management Plan as specified by Georgia state law.

PARENT SIGNATURE: _____ DATE: _____

SCHOOL NURSE SIGNATURE: _____ DATE: _____

My signature provides authorization for the above Diabetes Mellitus Medical Management Plan. I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.

- ❑ *Dose/treatment changes may be relayed through parent.*
- ☐ *Student is due for medical appointment for review of diabetes management plan.*

HEALTHCARE PROVIDER SIGNATURE: _____ Date: _____

Diabetes Care Provider: _____ Phone #: _____

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

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: _____

ARCHDIOCESE OF ATLANTA

MEDICATION PERMIT FORM

All medication should be given outside of school hours if possible. Three-times-a-day medications should be given before school, after school and at bedtime for optimal coverage. If necessary, medication can be given at school only under the following conditions:

1. If medication is needed in order for the student to remain in school, this form must be completed by the parent/guardian, signed by the physician, and returned with the medication to the school office or nurse.

2. All necessary medication prescribed for a student by a doctor or dentist must have this Medication Permit Form signed by the physician and parent. All prescription medication must be in the prescription bottle and labeled with a current pharmacy prescription label. "Over the counter" medication must be in original labeled container. Medications sent in baggies or unlabeled containers will not be given.

3. The parent is responsible to bring all medication to the clinic/office and to pick up unused medicine or it will be destroyed.

4. Experimental medication/dosages will not be given. Herbal medication, dietary supplements and other nutritional aids not approved as medication by the FDA, will not be administered at school.

5. Antibiotics will not be given at school by school personnel. If the parent feels the antibiotic must be given during the school day, the parent may come to the school office/clinic and administer it.

6. All medications must be kept in a locked cabinet/drawer in the school office/clinic and administered in the school office/clinic.

7. High School students whose doctor's written instructions require them to carry an inhaler on their person may do so. A second inhaler must also be kept in the clinic for use as needed. If a student allows another person to use the inhaler, the privilege of carrying one's inhaler may be revoked for both parties involved. Only those students in High School may transport their medication from home to the school office/clinic, and return unused medication home.

8. Only the parent or adult designee perform nebulizer treatments in school.

TO THE NURSE OR HEALTH REPRESENTATIVE OF: ST. PIUS X CATHOLIC HIGH SCHOOL

NAME OF STUDENT:_____ GRADE:____ ROOM:____

NAME OF MEDICATION:_____

DOSAGE AND DIRECTIONS FOR GIVING:_____

BEGINNING DATE:_____ ENDING DATE:_____

I hereby request that the medication specified above be given to the above named student, and that the medication may be given by someone other than a medically trained person.

I realize that the school does not have to agree to allow medication to be given to a student by school personnel. I understand that the school's agreeing to allow the medication to be given is for my benefit and the student's benefit. Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless the Archdiocese of Atlanta, its servants, agents, and employees, including, but not limited to the parish, the school, the principal, and the individuals giving the medication, of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Archdiocese of Atlanta, its agents, servants, or employees, including, but not limited to the parish (if applicable), the school, the principal, and the individual giving or failing to give the medication.

SIGNATURE OF PARENT/GUARDIAN:_____ DATE:_____

SIGNATURE OF PHYSICIAN:_____ DATE:_____
(STAMPED SIGNATURE NOT ACCEPTED)

PHYSICIAN'S TELEPHONE NUMBER:_____