

TREATMENT & MANAGEMENT PLAN FOR THE DIABETIC STUDENT AT SCHOOL (revised 04/06 CCS/KCS)

Name of Student: _____ **D.O.B:** _____
School: _____ **Grade:** _____ **Teacher:** _____

PHYSICIAN'S AUTHORIZATION OF PRESCRIPTION MEDICATION FOR THE STUDENT WITH DIABETES AT SCHOOL

In order to keep this child in optimum health and to help maintain school performance and sustain attendance, it is necessary that the following medication be given during the school hours.

Type of Insulin: _____ To be administered via: needle/syringe insulin pen pump-type? _____ oral medication

To correct high BS, give _____ units for every _____ g/dl over _____. **** If the student is on an insulin pump, allow pump to calculate dose.**

Correction Scale: _____ to _____ = _____ units _____ to _____ = _____ units
 _____ to _____ = _____ units _____ to _____ = _____ units
 _____ to _____ = _____ units _____ to _____ = _____ units

Glucagon order will be given in case the student becomes unconscious, is seizing or is unable to swallow. **NO** **YES** If yes, give Glucagon _____ mg IM/SubQ and call 911.

Student's parent knows of this request and is in full agreement that this medication and all necessary supplies needed to administer it, to monitor blood sugar and to treat low blood sugar will be provided by the parent. (i.e. snacks, lancets, ketone sticks, insulin pen or syringes, batteries, etc.)

Physician's Name: _____ **Physician's Signature:** _____ **Date:** _____

Phone #: _____ **Fax #:** _____

PARENT/GUARDIAN PERMISSION (If student is completely independent in all aspects of his/her diabetes management, a Self-Medication order will need to be signed)

I hereby give my permission for my child (named above) to receive medication during school hours. I understand that the school undertakes no responsibility for the administration of the medication. This medication has been prescribed by a licensed physician. I hereby release the School Board, its agents and employees, from any and all liability that may result from my child taking prescription and non-prescription medication.

Signature of Parent/Guardian: _____ **Date:** _____ **Phone #:** _____

PHYSICIAN AND PARENT AUTHORIZATION FOR HAVING SPECIALIZED PHYSICAL HEALTH CARE SERVICES PROVIDED

The above named student has diabetes and requires the following procedures to be provided during the school day:

Blood Sugar Monitoring **NO** **YES** Insulin Administration via injection **NO** **YES** Urine Ketones Checked as needed **NO** **YES**
Insulin administered via pump **NO** **YES** Glucagon Injection as needed **NO** **YES**

Physician's Name: _____ **Physician's Signature:** _____ **Date:** _____

PARENT PERMISSION

I hereby request the procedures specified above on or for the above named child.

Signature of Parent/Guardian: _____ **Date:** _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize _____ to release to the school nurse specific, confidential, medical information contained in his/her record about my child. This information will be used by the school staff to deliver health care services to my child at school.

Child's name: _____ **D.O.B:** _____ **To:** _____
(Physician/Clinic)

Signature of Parent/Guardian: _____ **Date:** _____

TREATMENT & MANAGEMENT PLAN FOR THE DIABETIC STUDENT AT SCHOOL- Effective date: _____

Student's Name: _____ **D.O.B:** _____ **Grade:** _____ **Teacher:** _____

Type of Diabetes: _____ **Age when Diagnosed:** _____ **Transportation:** bus car driver

THIS STUDENT IS TOTALLY INDEPENDENT IN ALL ASPECTS OF HIS/HER DIABETIC MANAGEMENT: **NO** **YES** (if yes, may skip to signature lines)

BLOOD GLUCOSE MONITORING

Target Blood Sugar: _____ to _____
Needs to check blood sugar as needed if symptomatic and at what scheduled times? _____

Type of meter: _____ **Where will meter be stored?** School nurse's office classroom student's book bag
 Staff to perform until student is independent and then supervise Staff to supervise procedure performed by student Student is independent

Call parent if BS < _____ OR > _____ **Restrict exercise if BS < _____ until treated or if > _____**
Check ketones if BS > _____ If (+) for small amount: _____ **If (+) for moderate/large amount: _____**

HYPOGLYCEMIA (low blood sugar)

Common signs of low blood sugar for this student _____ **if exhibited, check BS.**

If BS < _____, treat with _____ grams of a fast sugar such as: _____ and recheck in 15 minutes. Repeat until target is reached. Follow with _____ grams of a protein snack such as: _____.

IF UNCONSCIOUS OR SEIZING ADMINISTER GLUCAGON: **NO** **YES** **If yes, dose to administer:** _____ **and CALL 911.**

SNACKS: Does student need regularly scheduled snacks? **NO** **YES** **If yes, at what times?** _____

HYPERGLYCEMIA (high blood sugar)

Common symptoms of high blood sugar for this student: _____ **if exhibited, check BS and repeat at _____ minute intervals.**

Check ketones as needed per order.

INSULIN ADMINISTRATION

Type of Insulin: _____ **Administered via:** needle/syringe insulin pen insulin pump-type? _____ oral medication
 Staff to perform until student is independent and then supervise Staff to supervise student insulin administration Student is independent

Carb: Insulin Ratio: _____: _____ **Diet:** Staff to supervise/assist with carbohydrate counting Student is independent

Correction Scale: **BLOOD SUGAR** **BREAKFAST** **LUNCH**

BLOOD SUGAR	BREAKFAST	LUNCH

Changes and updates to student's diabetic orders may be communicated in writing to the School Nurse by the parent: **NO** **YES** *If yes, the nurse should seek further clarification from the physician as needed.*

Physician's Signature: _____ **Date:** _____ **School Nurse** _____ **Date:** _____

Parent Signature: _____ **Date:** _____