

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
COORDINATED STUDENT HEALTH SERVICES
 Phone 754-321-1575 Fax 754-321-1692
Diabetes Medication/Treatment Authorization Form

Student's Name: _____ Date of Birth: _____ Date: _____
 School Name: _____ Grade _____ Homeroom _____

CONTACT INFORMATION

Parent/Guardian #1: _____ Phone Number _____
 Parent/Guardian #2: _____ Phone Number _____
 Emergency Contact: _____ Relationship: _____ Phone Number: _____
 Physician/Healthcare Providers: _____ Phone Number _____ Fax Number _____

Date of Diagnosis: _____ **Diabetes** Type 1 Type 2

BLOOD GLUCOSE MONITORING: At school: Yes No Type of Meter: _____

Student has been trained by Healthcare Professional Yes No Needs supervision: Yes No Independent

Time to be performed: Before breakfast Before PE/Activity Time
 Mid-morning (before snack) After PE/Activity Time
 Before lunch Mid-afternoon
 Dismissal Dinner
 As needed for signs/symptoms of low/high blood glucose

Place to be performed: Clinic/Health Room Classroom Other **Bus, Field Trips and Day Trips**

CONTINUOUS BLOOD GLUCOSE MONITOR (CGM) Yes No Brand/model _____

Alarms set for High _____ Low _____ Ok to use CGM result for insulin coverage

Recheck CGM result if blood sugar is greater than _____ or less than _____ *Note: ****Only confirm CGM results with finger stick if ordered by healthcare provider.***

Target range for blood glucose (if applicable) _____ mg/dL to _____ mg/dL N/A

INSULIN ADMINISTRATION DURING SCHOOL: Yes No

Student has been trained by Healthcare Professional Yes No Needs supervision: Yes No Independent Yes No

Insulin Delivery: Syringe/Vial Pen Pump (If pump worn, use "Student With Insulin Pump" section")
 InPen (student may self-carry) Ok to use InPen for insulin coverage Yes No

Standard daily insulin at school: Yes No Type: _____ Dose: _____ Time to be given: _____

Mealtime: Insulin/Carbohydrate Ratio + Blood Glucose Correction OR Sliding Scale = Total Insulin dose

Insulin/Carbohydrate Ratio Insulin: Humalog Novolog Apidra Fiasp Admelog Other _____

Breakfast _____ # unit(s) per _____ grams of carbohydrates **Ex: 1. I/CR is 1 unit of Insulin per 15 grams of carbs. Total meal carbs are 60 grams. 60 % 15= 4 units of Insulin**

Lunch _____ #unit(s) per _____ grams of carbohydrates **2. Blood Glucose Correction Ex: 200 - 150 % 50 =1 unit**

Snacks _____ #unit(s) per _____ grams of carbohydrates **3. **** Total Insulin Dose is 5 units for the meal ******

Dinner _____ #unit(s) per _____ grams of carbohydrates

Blood Glucose Correction: Blood Glucose Minus _____ Divided By _____ Equals # Unit (s) Of Insulin

Correction dose of Insulin for High Blood Glucose: (*)OUTSIDE OF MEALTIMES(***)** Yes No

BLOOD GLUCOSE MINUS _____ DIVIDED BY _____ EQUALS # UNIT(S) OF INSULIN

OR

Sliding Scale

Blood sugar: _____ to _____ Insulin Dose: _____

Insulin correction dose for blood glucose greater than _____ mg/dl and at least _____ hours since last insulin dose.

****If a blood sugar correction is administered _____ hour(s) prior to lunch only administer insulin to cover carbohydrates****

If the insulin dose is 0.5 should insulin dose be rounded: Up OR Down to the nearest whole number?

Example: Insulin calculated dose is 4.5 units should trained personnel round down to 4 or up to 5?

STUDENT WITH INSULIN PUMP

Brand/Model of pump: _____

Type of infusion set: _____

Type of insulin in pump: _____

Basal rates during school: _____

Student to receive insulin bolus for carbohydrate intake _____ prior to mealtime

Student's self-care pump skills:	Independent?	Student's self-care pump skills:	Independent?
Count carbohydrates	<input type="checkbox"/> Yes <input type="checkbox"/> No	Disconnect pump	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bolus correct amount for carbohydrates consumed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reconnect pump to infusion set	<input type="checkbox"/> Yes <input type="checkbox"/> No
Calculate and administer correction bolus	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prepare reservoir and tubing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Calculate and set a temporary basal rate	<input type="checkbox"/> Yes <input type="checkbox"/> No	Insert infusion set	<input type="checkbox"/> Yes <input type="checkbox"/> No
Change batteries	<input type="checkbox"/> Yes <input type="checkbox"/> No	Troubleshooting alarms and malfunctions	<input type="checkbox"/> Yes <input type="checkbox"/> No

*****For pump failure please refer to insulin administration orders and call parents*****

Comments/Special Instructions:

Please fax log to Dr. _____ at Fax: _____ at the end of each weekly monthly.

Thank You!

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
COORDINATED STUDENT HEALTH SERVICES
Phone 754-321-1575 Fax 754-321-1692
Diabetes Medication/Treatment Revision Form

Dose change Overnight field trips

Student's Name: _____ Grade: _____ Date of Birth: _____ Date: _____
School Name: _____ School Number: _____ School Fax: _____
Parent(s) Name and Contact Information: _____

INSULIN ADMINISTRATION DURING SCHOOL: Yes No

Student has been trained by Healthcare Professional Yes No Needs supervision: Yes No Independent

Insulin Delivery: Syringe/Vial Pen Pump (If pump worn, use "Insulin Pump Medication/Treatment Plan")

InPen Ok to use InPen for insulin coverage Yes No

Standard daily long-acting insulin: Yes No Type: _____ Dose: _____ Time to be given: _____

Insulin/Carbohydrate Ratio + Blood Glucose Correction OR sliding scale = Total Insulin dose

Insulin/Carbohydrate ratio: Insulin: Humalog Novolog Apidra Other _____

Breakfast _____ # unit(s) per _____ grams of carbohydrates

Lunch _____ #unit(s) per _____ grams of carbohydrates

Snacks _____ #unit(s) per _____ grams of carbohydrates

Dinner _____ #unit(s) per _____ grams of carbohydrates

Blood Glucose Correction:

BLOOD GLUCOSE MINUS _____ DIVIDED BY _____ EQUALS # UNIT(S) OF INSULIN **OR**

Sliding Scale

Blood sugar: _____ Insulin Dose: _____

Correction dose of Insulin for High Blood Glucose: Yes No (**OUTSIDE OF MEAL TIMES**)

Blood Glucose Correction

BLOOD GLUCOSE MINUS _____ DIVIDED BY _____ EQUALS # UNIT(S) OF INSULIN

Insulin correction dose for blood glucose greater than _____ mg/dl and at least _____ hours since last insulin dose.

PHYSICIAN AUTHORIZATION:

Physician's Name (PLEASE PRINT / STAMP)

Signature

Date

Address: _____

Telephone: _____

Fax: _____

Parent Name: _____

Parent Signature: _____

Date _____

DIABETES EMERGENCY CARE PLAN
LOW BLOOD SUGAR (HYPOGLYCEMIA)

IF STUDENT EXHIBITS ANY OF THE FOLLOWING:	DO THESE:
Change in personality, behavior Pallor Weak, shaky or dizzy including staggering walk Tired, drowsy or fatigue Headache Rapid heart rate Nausea, vomiting or loss of appetite Clammy or sweating Blurred vision Inattention or confusion Slurred speech Loss of consciousness/seizures	Check blood glucose level If blood glucose level below 70 <ul style="list-style-type: none"> Give 15 grams of carbohydrates such as 3-4 glucose tablets, 4 ounces of juice or glucose gel Recheck blood glucose 15 minutes after treatment Repeat above treatment if blood glucose has not increased by 15 points If blood glucose is not above 70 mg after second treatment NOTIFY PARENT AND CALL 911 IF STUDENT IS SYMPTOMATIC Follow treatment with snack of 15-20 grams of complex carbohydrates IF more than 1 hour till next meal/snack or if going to an activity (i.e. P.E. or recess) Child should not exercise if blood glucose level is <u>BELOW 70mg/dL</u>
IF CHILD IS UNCONSCIOUS OR HAVING A SEIZURE	CALL 911 IMMEDIATELY AND NOTIFY PARENT/GUARDIAN Glucagon administration by trained personnel only (if ordered and provided by parent): Route: <input type="checkbox"/> SQ <input type="checkbox"/> IM <input type="checkbox"/> Intranasal Dose: <input type="checkbox"/> 1/2 mg <input type="checkbox"/> 1mg <input type="checkbox"/> 3mg OR Glucose gel 1 tube may be administered inside cheek and massaged from outside while waiting for help to arrive or during administration of Glucagon Student should be turned on his/her side and maintained in the "recovery" position until fully awake.
HIGH BLOOD SUGAR (HYPERGLYCEMIA)	
IF STUDENT EXHIBITS ANY OF THE FOLLOWING:	DO THESE:
Increased thirst, urination, appetite Tired/drowsy Blurred vision Warm, dry, or flushed skin Nausea/Vomiting	If blood glucose is between <u>250 mg/dL and 300mg/dl</u> <ul style="list-style-type: none"> Drink 8-16 ounces of water as tolerated Administer insulin as ordered Check ketones if ordered Blood sugar should be repeated after 30-60 minutes to ensure downward trend If student is asymptomatic, contact parent (as requested) and continue to monitor as per healthcare provider orders. If blood glucose is above <u>300 mg/dL ALSO:</u> <ul style="list-style-type: none"> Check urine ketones (If ketones are present, CALL PARENT IMMEDIATELY) Administer insulin as ordered If student exhibits nausea, vomiting, stomachache, lethargy, or any other abnormal symptoms contact parent/healthcare provider Immediately. If student is asymptomatic and NO ketones are present student may return to class Continue to monitor as per healthcare providers orders

A copy of this plan will be kept in the school office and copies will be given to the school administrative staff. Teachers will be notified if a student has a plan on file in the office. The following staff members have been trained to deal with an emergency, and initiate the appropriate procedures as described above. See attached sheet for additional names:

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |

PHYSICIAN AUTHORIZATION:

Student Name : _____ **School Name:** _____

Physician's Name (PLEASE PRINT/STAMP)

Signature

Date

Address: _____ **Telephone:** _____

Fax: _____

PARENT/ GUARDIAN PERMISSION: I understand that:

- This *Diabetes Medication/Treatment Authorization Form* is valid for one full year from the date signed by the healthcare provider.
- Any changes in the medication, dosage, or frequency of treatment will require a signed *Diabetes Medication/Treatment Revision Form* to be completed by healthcare provider
- Medications/equipment must be in original container and labeled to match healthcare provider order for use in school
- The parent/guardian is responsible for providing medication(s) and supplies as needed
- The parent will utilize the posted lunch menu to guide meal planning and carbohydrate counting with student

I grant the licensed nurse or health support technician permission to assist with or perform the administration of each prescribed medication, including insulin either by injection or pump, and treatments/procedures for my child during their school day. This includes when he/she is away from school property for official school events. I have reviewed, understand and agree with the medications/treatments prescribed by the healthcare provider on this form. It is my responsibility to notify the school if there is a change in the medication/treatment plan prior to its expiration date.

Parent/Guardian Signature: _____

Date: _____