

**HEALTH CARE PROVIDER AUTHORIZATION FOR SCHOOL MANAGEMENT OF DIABETES**

STUDENT: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

**BLOOD GLUCOSE MONITORING:** (Target range: \_\_\_\_\_ mg/dl to \_\_\_\_\_ mg/dl.)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> None required at this time. | <input type="checkbox"/> Before PE/activity time | <input type="checkbox"/> 2 hrs after correction        |
| <input type="checkbox"/> Before meals                | <input type="checkbox"/> After PE/activity time  | <input type="checkbox"/> PRN for suspected low/high BG |
| <input type="checkbox"/> Midmorning                  | <input type="checkbox"/> Midafternoon            |  |

**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**

- |  |   |
|--|---|
| <input type="checkbox"/> Never leave student alone   | <input type="checkbox"/> Call 911. Open airway. Turn to side. |
| <input type="checkbox"/> Give 15 gms glucose; recheck in 10 min.   | <input type="checkbox"/> Glucagon injection _____ mg IM/SQ    |
| <input type="checkbox"/> If BG < 70, retreat and recheck q 10 min x 3                                      | <input type="checkbox"/> Notify parent.                       |
| <input type="checkbox"/> Notify parent if not resolved.  |   |
| <input type="checkbox"/> Provide snack with CHO, fat, protein after treating and meal not scheduled > 1 hr |   |

**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: \_\_\_\_\_

**Any changes in treatment must be accompanied with a Doctors written order.**

**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: \_\_\_\_\_