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:______________ Home Phone:______________ Work:______________ Cell:______________

Parent/Guardian #2:______________ Home Phone:______________ Work:______________ Cell:______________

Diabetes Care Provider:______________________ Phone:______________

Other emergency contact:______________________ Relationship:______________

Phone Numbers: Home:______________ Work:______________ Cell: ______________

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 300 mg/dl with ketones present.
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

Please provide school cafeteria with a copy of this meal plan in order to fulfill ESDA requirements.
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 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 Signatures:______________________________ Date:______________

*Refer to 504 coordinator if appropriate

HEALTH CARE PROVIDER AUTHORIZATION FOR SCHOOL MANAGEMENT OF DIABETES

Student's Name:________________________________ Date of Birth:______________________ Date:_______________

Blood Glucose (BG) Monitoring: (Target range:______________mg/dl to ___________________mg/dl)

- ☐ Before meals
- ☐ PRN for suspected low/high BG
- ☐ 2 hours after correction
- ☐ Midmorning
- ☐ Mid-afternoon

INSULIN ADMINISTRATION: Dose determined by: ☐ Student ☐ Parent ☐ School Nurse ☐ Student / School Nurse

Insulin delivery system: ☐ Syringe ☐ Pen ☐ Pump (Use supplemental form for Student Wearing Insulin Pump)

BEFORE MEAL INSULIN:

Insulin Type:_______________________

- ☐ Insulin to Carbohydrate Ratio:_________units per ___________________grams carbohydrate
- ☐ Give______________units

CORRECTION INSULIN for high blood sugar (Check only those which apply)

- ☐ Use the following correction formula: BG – ____________/_____________(for pre-lunch blood sugar over) __________
- ☐ Sliding Scale:

BG from ________to ___________ = ____________ u
BG from ________to ___________ = ____________ u
BG from ________to ___________ = ____________ u
BG from ________to ___________ = ____________ u
BG from ________to ___________ = ____________ u

Add before meal insulin to correction /sliding scale insulin for total meal time insulin dose.

MANAGEMENT OF LOW BLOOD GLUCOSE:

Mild: Blood Glucose < _______

- ☐ Never leave student alone
- ☐ Give 15 gms glucose; recheck in 15 minutes
- ☐ If BG < 70, retreat and recheck in 15 min. x 3
- ☐ Notify parent if not resolved.
- ☐ Provide snack with carbohydrate, fat, protein after treating and meal not scheduled > 1 hour.

SEVERE: Loss of consciousness or seizure

- ☐ Call 911, open airway, turn to side.
- ☐ Glucagon injection ☐ 0.25 mg ☐ 0.50 mg ☐1.0 mg IM/SQ
- ☐ Notify parent

MANAGEMENT OF HIGH BLOOD GLUCOSE (Above____________mg/dl)

- ☐ Sugar-free fluids/frequent bathroom privileges.
- ☐ If BG is greater than 300, and it's been 2 hours since last dose, give ☐ HALF ☐ FULL correction formula noted above.
- ☐ If BG is greater than 300, and its' been 4 hours since last does, give FULL correction formula noted above.
- ☐ If BG is greater than 300 check for ketones. Notify parent if ketones are present.
- ☐ Note and document changes in status.
- ☐ Child should be allowed to stay in school unless vomiting and/or moderate or large ketones are present.

EXERCISE:

Faculty/staff must be informed and educated regarding management. Staff should provide easy access to fast-acting carbohydrates, snacks, and BG monitoring equipment during activities. Child should NOT exercise if blood glucose levels are below 70 mg/dl or above 300 mg/dl and urine contains moderate or large ketones.

- ☐ Check blood sugar right before PE to determine need for additional snack.
- ☐ If BG is less than target range, eat 15-45 grams carbohydrate before, depending on intensity and length of exercise.
- ☐ Student may disconnect insulin pump for ________ hours 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 indicates, I will provide new written authorized orders (may be faxed).
- ☐ Dose/treatment changes may be relayed through parent.

Health Care Provider Signature:____ Date:_____________________

Address:____

REQUEST FOR ADMINISTRATION OF MEDICATION

If medications can be given at home or after school hours, please do so. However, if medication administration is absolutely necessary to be given during school hours, this form must be completed.
Permission is hereby granted to the local school principal or his/her designee to supervise my child in taking the following prescribed medication.

I hereby release and discharge the Forsyth County Board of Education and its employees and officials from any and all liability in case of accident or any other mishap in supervising said medication due to any side effects, illness, or other injury which might occur to my child through supervising said medication. I hereby release aforementioned officials from any liability because of any injury or damage which might occur.

I give the above-mentioned personnel permission to contact my child's health care provider and/or pharmacy to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required.

I understand that:

All medications, herbals, and supplement must be approved by the U.S. Food and Drug Administration and appear in the U.S. Pharmacopeia

Medications must be in the original container.

Parent/Guardian must provide specific instructions (including drugs and related equipment) to the principal or his/her designee.

It will be the responsibility of the parent/guardian to inform the school of any changes in pertinent data. New medications will not be given unless a new form is completed.

All medication will be taken directly to the office by the parent or guardian. Students may not have medication in their possession, except with a physician's request or a physician's order on a Forsyth County care plan.

Students who violate these rules will be in violation of the Alcohol/Illegal Drug Use Policy (JCDAC).

A daily record shall be kept on each medication administered. This record will include student's name, date, medication administered, time, and signature of school personnel who supervised.

MEDICATIONS MUST BE PICKED UP BY PARENT/GUARDIAN. Any medication not picked up from the school by the end of the last school day of the year will be considered abandoned. Abandoned medication will be properly discarded in accordance with local, state, and federal laws/rules by the school nurse and an administrator.

NAME OF STUDENT ________________________________ **BIRTHDATE** ______________
SCHOOL________________________ **GRADE** __________ **TEACHER** ______________
MEDICATION______________________________ **DATE OF PRESCRIPTION** ______________
PHYSICIAN'S NAME__________________________ **PHYSICIAN'S PHONE** ______________
DOSAGE & TIME OF ADMINISTRATION____
ALLERGIES ______________________________ **STOP MEDICATION ON**______________

STATEMENT OF PARENT OR GUARDIAN

I hereby give my permission for my child to receive this medication at school.

SIGNATURE OF PARENT/GUARDIAN__________________________ **DATE** ____________
HOME PHONE ______________ **WORK PHONE** ______________ **CELL** ______________

To be completed by Physician for long-term medications (more than two weeks):
"Physician" as defined in Article 2 of the Medical Practice Act of Georgia

CONDITION/ILLNESS REQUIRING MEDICATION ____________________________________
POSSIBLE SIDE EFFECTS OF MEDICATION______________________________________
OTHER MEDICATION STUDENT IS TAKING_______________________________________

PHYSICIAN'S SIGNATURE ______________________________ **DATE** ______________

Parent/Guardian Picked Up Medication Date ________________

Parent Signature____________________ **Nurse**________________ **Date**__________

ADMINISTRATION OF MEDICATION INFORMATION

(This information is on the reverse side of the Request for Administration of Medication Form)

The administration of medication to students during the school day presents an increased concern and awareness of the need to have written procedures.

Medication may be dispensed to students with the assistance of school personnel whenever physicians find it necessary to prescribe medication to be taken during school hours. School personnel will cooperate with parents in this regard by providing a place for the medication to be stored; however, *the major responsibility for a child taking medication at school rests entirely with the child's parents.*

A nurse is not always available to assist in the administration of the medication. The student may be assisted by an adult designated by the principal.

Prescription and non-prescription medication will be given to students by school personnel only when the following guidelines are observed:

***All medication MUST be in its original container and MUST be brought to school by the parent or guardian.** Medications brought in baggies or other unmarked containers will not be given. Prescription medication must be in the pharmacy container labeled with the child's name, date, name of medication, name of the prescribing physician, time(s) the medication is to be given and name of the pharmacy filling the prescription. We request that you ask the pharmacist to give you two labeled prescription bottles so that you have one bottle at home and one at school.

*A "Request for Administration of Medication" form (see back) must be completed by the parent/guardian (and physician if the medication needs to be given for longer than two weeks - such as (Ritalin) and sent to school along with the medication.

***Do not send medication to school which needs to be given daily or two/three times a day unless the physician specifically states a time during the school day which it is to be given.** An antibiotic which is to be given three times daily can be given before the child leaves for school, when he/she gets home, and at bedtime.

*School personnel cannot give medication that contains aspirin to students under 18 years old due to the correlation with Reyes Syndrome. Examples are Pepto Bismol, Excedrin Migraine, Goody's Powder.

The safety and well-being of your child are our concern. With your understanding and cooperation, we can eliminate much of the unnecessary medications that are brought to school and ensure that our students who do need to take medication at school will receive it appropriately. If you have any questions regarding medications, please call your child's school or you may call the school nurse.

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AUTHORIZATION FOR STUDENTS TO CARRY A PRESCRIPTION INHALER, EPINEPHRINE AUTO INJECTOR, INSULIN, AND DIABETIC SUPPLIES, OR OTHER APPROVED MEDICATION

____ needs to carry the following prescription labeled inhaler, epinephrine auto injector, insulin, and diabetic supplies, and/or__________________________ prescription medication with him/her. The above-named student has been instructed in the proper use of the medication and fully understands how to administer this medication.

It is preferable that a second prescription inhaler, epinephrine auto injector, additional insulin, and diabetic supplies or other prescribed medication be kept in the school in case the first is lost or left at home.

Name of Medication: ____

____ ________________
Physician's Name *Date*

____ ________________
Physician's Address *Phone*

____ ________________
Physician's Signature *Date*

I have been instructed in the proper use of my prescription labeled medication and fully understand how it is administered. I will not allow another student to use my medication under any circumstances. I also understand that should another student use my prescription, the privilege of carrying my medication may be altered. I also accept responsibility for notifying the School Nurse each time I take my medication.

____ ________________
Student's Signature *Date*

I hereby request that the above-named student, over whom I have legal guardianship, be allowed to carry and use this prescribed medication at school:

- I accept legal responsibility should the medication be lost, given to, or taken by another person other than the above-named student.
- I understand that if this should happen, the privilege of carrying the medication may be altered.
- I release Forsyth County School System and its employees of any legal responsibility when the above-named student administers his/her own medication.

____ _____________________
Parent/Guardian Signature *Date*