Diabetic Medical Management for School

Student: ___________________________ **School:** ____________________ **School Year:** ___________
DOB: __________________ **Type of Diabetes:** Type 1/ Type 2 **Diagnosed:** _____________

Blood Glucose target range: _________-_________mg/dl

Student to check sugars: (circle) before lunch before/after PE feels low before boarding bus
Other: ____

Insulin used at school: Humalog Novolog Apidra Other: ______________________________________
Insulin delivery device: Syringe and vial Insulin pen Insulin pump
Insulin Pump/Brand __________ Type of insulin in pump __________ for blood glucose >_______ that has not decreased within ______ hrs after correction, consider pump failure or infusion site failure-Notify parents.

Insulin to carbohydrate ratio for breakfast: _____units of insulin for every _____grams of carbohydrate.
Ratio for lunch: _____units of insulin for every _____grams of carbohydrates.

Correction Scale: ___units of insulin for every ___md/dl above ___mg/dl (**before meals only** for hyperglycemia)

Correction Scale

Blood Glucose Level(mg/dl)	Units of Insulin
Less than 100	
100-150	
151-200	
201-250	
251-300	
301-350	
351-400	
Above 400	Call Parent

*Correction can only be given once during the school day, usually at lunch time.

Treatment for Hypoglycemia: Blood glucose <______md/dl. **Immediately** treat with 15 grams of carbohydrate from the following choices: ____
Recheck blood glucose in 15 minutes and repeat 15 grams of carbohydrate if sugar is <______.
If more than 1 hour until next meal or snack, student should have an additional 15 grams of carbohydrate.
Call parent if blood glucose is <______.

Treatment for Severe Hypoglycemia: If child is unconscious or having seizures due to low blood glucose, immediately administer injection of **Glucagon_____ mg** and then turn child onto their side in case vomiting occurs; **Call 911 and notify parent.**

Treatment for Hyperglycemia: Use Correction scale when blood glucose is >_________. Staff may only correct if student has **NOT** already received a correction dose at lunch.
Allow for unlimited bathroom access. **Notify parent if blood glucose is** >_____or if vomiting.

Plan for class treats: (mark one)
___Student may have treat, no action necessary
___Student may have treat if blood glucose is <_____ and carbohydrate information is available for insulin dosing.
___Student may cover treat with _____insulin per _____carbohydrates, no need to check blood sugar.
___Student may not eat treat without parent permission, please: (circle one) Call Parent /Send treat home

Plan for physical activity:
___Student to check sugar before/after physical activity
___Give _____ grams of carbohydrate (circle) before/after physical activity.
___Student should not participate in physical activity if blood glucose level is<_____or>______

***Parents to arrange for appropriate monitoring and access to diabetic supplies for all field trips.**

Student self-care diabetes management skills include: (mark all that apply)
____Identifying feelings of hypoglycemia
____Checking Blood glucose
____Measuring out insulin
____Administering insulin injection
_____Independently counts carbohydrates
_____May count carbohydrates with supervision
_____Requires carbohydrates to be counted by trained staff.

Notes____
____
____

______________________________	______________________________	___________
Signature of Physician	Printed name of Physician	Date
______________________________	____________________	___________________
Clinic Name	Phone	Fax
______________________________	____________________	___________________
School Nurse	Phone	Fax

I have read and approve of the above plan for diabetes management at school and I will notify the school of any changes that may occur during the school year. I give permission for this information to be shared with my child's teachers, substitute teachers, principal(s), and staff that may need to assist my child. I give permission for school personnel to release personal or medical information about my child in a health-related emergency situation if necessary. I also give my permission for the school nurse to contact my child's physician if clarification is needed regarding any medical or medication concerns:

______________________	___________________	___________________
Parent Signature	Phone	Date

Date __________.

Glucagon Authorization Form

In Accordance with Utah Code 53A-11-603

Name of Student __________________ Date of Birth ______________.

Name of School _____________________ Grade __________________ .

I __________________ parent__/guardian__ (check one) of above student certify that glucagon medication has been prescribed for him/her. I request that the student's public school identify and train school personnel who volunteer to be trained in the administration of glucagon medication in accordance with Utah Code 53A-11-603. I authorize the administration of glucagon medication in an emergency to the student in accordance with Utah Code 53A-11-603.

Parental Responsibilities:

- The parent or guardian is to furnish the glucagon medication and bring to the school in the current original pharmacy container and pharmacy label with the child's name, medication name, administration time, medication dosage, and healthcare provider's name.
- The parent or guardian, or other designated adult will deliver to the school and replace the glucagon medication within two weeks if the glucagon single dose medication is given.
- If a student has a change in his/her prescription, the parent or guardian is responsible for providing the newly prescribed information and dosing information as described above to the school. The parent or guardian will complete an updated Glucagon Authorization Form before the designated staff can administer the updated glucagon medication prescription.
- The parent or guardian will complete, sign and deliver a Diabetes Medication Form if the student is to posses glucagon medication at all times

I give permission for the school nurse to contact my child's healthcare provider if clarification is needed to administer glucagon. I agree to meet the parental responsibilities listed above. ***I give permission for school personnel to release personal or medical information about my child in a health-related emergency situation if necessary.*** *I understand this completed and signed form authorizes designated school personnel to administer glucagon in emergency situations consistent with Utah Law.*

Parent Signature ____ Date ____________

Phone Number ________________ Emergency Number __________________.

Date __________

Utah Department of Health/Utah State Office of Education
Diabetes Medication Form
In accordance with Utah Code 53A-11-604

____

Student Name Birth Date

____

Address City State Zip

EMERGENCY CONTACT INFORMATION:

Name ____ Phone ____________________

Health Care Provider Authorization

The above named student is under my care. I feel it is medically appropriate for the student to self-administer diabetes medication and be in possession of diabetes medication and supplies at all times. The medication prescribed for this student is:

Name of Medication ___Glucagon_____________________________

Dosage _____1 mg____

Possible Side Effects _Nausea and Vomiting_______________________

____

Signature of Health Care Provider Date

Parent/Guardian Authorization

☐ I authorize my child ______________to carry prescribed diabetes medication and supplies.

☐ I authorize my child to self-administer and carry the prescribed medication described above consistent with the Utah Code 53A-11-604.

☐ I do not authorize my child to carry and self-administer this medication. Please have the appropriate/designated school personnel maintain my child's medication for use in an emergency.

My child and I understand there may be serious consequences, including suspension/expulsion from school, for sharing any medications and/or supplies with other students or school staff.

____

Parent/Guardian Signature Date