Floresville Independent School District

Preparing You for a Prosperous Life

DIABETES MANAGEMENT AND TREATMENT PLAN
Physician/Parent Authorization for Diabetic Care
***This form is to be renewed annually.**
Prescribed in-school medication or procedures may be administered by a school nurse or a non-health professional designee of the principal.

Student: _____Date of Birth: _____

Authorized Health Care Provider Opinion on student's competence with Procedures:

[ ] Blood Glucose Testing
[ ] Testing in classroom
[ ] Measuring and injecting insulin
[ ] Carry Supplies for insulin administration
[ ] Carry supplies for blood glucose monitoring
[ ] Self-treatment for mild lows
[ ] Independent operation insulin pump
[ ] Self-manage diabetes if policy allows

Blood glucose testing: (Desired range _____mg/dl to _____mg/dl)

[ ] Before AM snack **[ ]** Before lunch **[ ]** 2 hrs after lunch. **[ ]** 2 hrs after a correction dose **[ ]** For suspected hypoglycemia/hyperglycemia

[ ] At student's discretion **[ ]** Always check BS for suspected hypoglycemia **[ ]** NO blood glucose testing at school at this time
[ ] Pump [ ] Continuous Glucose Monitor *May use sensor reading between meals, verify with finger stick if concerns

HYPOGLYCEMIA:

Signs of hypoglycemia include trembling, sweating, shaking, pale, weak, dizzy, sleepy, lethargic, confusion, coma, or seizures.
Student must never be alone when hypoglycemia is suspected and should be treated on-site.

Mild hypoglycemia: [ ] BG < 70 mg/dl OR [ ] BG < _____

Give **[ ]** 15 gm or **[ ]** _____ gm fast-acting glucose
[ ] recheck in 15 minutes **or** [ ] recheck in _____minutes.

If hypoglycemic after specified time, treat with same does of glucose and recheck at same interval until normal.
[ ] Notify Parent if not improved after 3 treatments.
[ ] Provide extra protein and carb snack after treating lows if next meal not scheduled for **[ ] 1 hr [ ] 2 hr.**

[ ] Suspend pump when low, restart when BG > _____

Call parent if symptoms of hypoglycemia but BG normal.

Severe hypoglycemia *(seizure, unconscious, combative, unable to swallow)*: Call 911 – ensure open airway

[ ] OK to use glucose gel inside cheek ONLY IF CONSCIOUS

[ ] Use glucagon injection IM if unconscious or seizing
[ ] 0.5 mg **[ ]** 1 mg

HYPERGLYCEMIA:

Signs of hyperglycemia include frequency of urination and excessive thirst. (Deep rapid respirations combined with a fruity odor the breath, and positive urinary ketones are signs of ketoacidosis. This is an emergency – notify parent).

Hyperglycemia:

BG > _____mg/dl: Check Ketones in [ ] blood [ ] urine
Encourage fluids.
If student is ill or vomiting, call parent to pick up.
For confusion, labored breathing, or unconscious – call 911.
[ ] BG > _____WITH Ketones moderate or large: call parent to pick up child.
[ ] BG > _____WITH Ketones negative or small, child may remain in school if not ill or vomiting.

For BOTH ABOVE initiate insulin per sliding scale ONLY IF more than two hours have passed since last insulin dose and encourage sugar-free liquids.
DO NOT give insulin more frequently than every 2 hours.

[ ] If student has pump:
Immediately troubleshoot pump, infusion set, and site.
Use pump for initial correction does.
Recheck BG in ONE HOUR to ensure adequate insulin delivery.

Illness: If student is ill, check ketones and blood glucose.

If ketones are _____ or larger, provide fluids and call parents to pick up.

If ketones and BG are within range, follow standard procedure for ill students and notify parent.

Bus Transportation:

[ ] Blood glucose test not required prior to boarding bus

[ ] Test blood glucose 10-15 minutes prior to boarding bus and treat hypoglycemia appropriately

[ ] Notify parent if BG > _____mg/dl prior to boarding bus

******Recommend caution if giving insulin prior to transportation**

1200 Fifth Street
Floresville, Texas 78114
www.fisd.us
(830) 393-5300
Fax: (830) 393-5399

INSULIN ORDERS:

Brand Name of Insulin: _____

Insulin administration via:

[ ] Syringe **[ ]** Pump **[ ]** Pen **[ ]** Other: _____

Routine administration times:

[ ] Breakfast **[ ]** AM Snack **[ ]** Lunch **[ ] Other: _____**

[ ] Food Bolus insulin dose:

[ ] Insulin to carb ration: _____units per _____grams Carbs

[ ] Fixed Insulin Dose:

[ ] Breakfast dose _____ units

[ ] AM Snack dose_____ units

[ ] Lunch dose _____units

[ ] Other dose _____ units

Correction Dose:

Give _____unit(s) for every _____above _____mg/dl

Blood glucose from _____ to _____ = _____ Units

Blood glucose from _____ to _____ = _____ Units

Blood glucose from _____ to _____ = _____ Units

Blood glucose from _____ to _____ = _____ Units

Blood glucose from _____ to _____ = _____ Units

Blood glucose from _____ to _____ = _____ Units

Blood glucose from _____ to _____ = _____ Units

Blood glucose from _____ to _____ = _____ Units

Blood glucose from _____ to _____ = _____ Units

Blood glucose from _____ to _____ = _____ Units

Blood glucose from _____ to _____ = _____ Units

[ ] OK to add food/bolus units to correction dose

Meal Plan:

Meal/snack will be considered mandatory unless otherwise specified. Timing of snacks will be per school/daycare schedule unless otherwise indicated.

[ ] AM Snack
[ ] at student discretion **[ ]** special time _____
[ ] Lunch
[ ] at student discretion **[ ]** special time _____
[ ] After-noon Snack
[ ] at student discretion **[ ]** special time _____
[ ] After-school Snack
[ ] at student discretion **[ ]** special time _____

Content of snack will be specified by:
[ ] Parent **[ ]** Student
[ ] Health Care Provider **[ ] NO** snack needed

[ ] **PUMP**
[ ] Basal and Bolus setting programmed
[ ] Food / Bolus insulin dose per pump setting:
[ ] _____ units insulin per _____grams carbs
[ ] Varied preprogrammed Carb ratio per pump/time
[ ] Correction Dose ("sensitivity")
[ ] Give _____unit(s) for every _____above _____mg/dl
[ ] Varied preprogrammed correction per pump / time
[ ] May administer insulin per pump recommendation for BG >____
DO NOT give insulin more frequently than every 2 hours

EXERCISE:

Liquid / solid carb sources must be available.
Follow Hypoglycemia, illness, and hyperglycemia protocols when relevant,
[ ] Eat _____ extra grams of carbs with vigorous exercise.
[ ] Before Exercise
[ ] Every 30 minutes during exercise
[ ] After exercise
[ ] Other
[ ] Student may disconnect pump for up to _____ hrs
[ ] Student may decrease basal rate at their discretion.

OTHER NEEDS:

_____

_____

FOR DIABETIC SELF-CARE ONLY

Does this student have physician permission to provide self-care? _____ YES _____ NO

This student has been provided instruction / supervision and is capable of doing glucose self-care for glucose monitoring and his/her own insulin injections/insulin pump care, including using universal precautions and proper disposal of sharps? _____YES _____NO

The student may perform safe glucose monitoring and/or insulin injections / pump care in the **[ ]** clinic; **[ ]** classroom; **[ ]** cafeteria.

Physician Name: _____

Physician Signature: _____Date: _____

Clinic Facility: _____Phone:_____ Fax: _____

To be completed by parent: We (I) the parent/guardian(s) of _____ request that the above medication and procedures be administered to my (our) child. I will notify the school immediately if the health status of my child changes, I change physicians or emergency contacts, or the procedure is canceled or changes in any way. Information concerning my child's diabetes health management may be share with/obtained from the diabetes healthcare providers. I understand that the above diabetic care plan will be initiated and carried out by a nurse or a trained school district employee who is not a licensed nurse.

Signature _____ Relationship _____ Date _____

Phone (Home) _____Cell_____Work_____