SAYRE SCHOOL
MAKE·YOUR·MARK

Diabetes Action Form

2022-2023 School Year

Parents must complete and submit this Diabetes Action Plan annually in order to authorize Sayre School personnel to treat a student's diabetes at school if necessary.

Student Information:
Name: _____ DOB: _____ Grade: _____

Parent/Guardian names and cell phone numbers: _____

_____

TO BE COMPLETED BY THE STUDENT'S HEALTH CARE PROVIDER:

Blood glucose monitoring needs to be performed during school hours:

☐ before meals ☐ two hours after meal ☐ before snack ☐ Other: _____

Is student capable of:
- Performing their own blood glucose checks? ☐ Yes ☐ No
- Giving their own injections? ☐ Yes ☐ No
- Calculating carbs and determining correct amount of insulin? ☐ Yes ☐ No
- Dialing correct dose of insulin? ☐ Yes ☐ No
- Effectively troubleshooting problems with pump? ☐ Yes ☐ No ☐ N/A

Target blood sugar range: _____ to _____

☐ If checked, use Dexcom readings to dose insulin. If signs/symptoms do not match Dexcom reading, perform finger stick blood sugar test.
Student's glucometer should be kept: ☐ in the nurse's office ☐ with student

Insulin:
Type of insulin to be administered at school: _____

Meals and snacks: ____ units for every ____ grams of carbohydrates eaten

Correction dose: ☐ No ☐ Yes (please select one option below):
☐ ___ units for every ___ md/dl points above ___ mg/dl
☐ ___ bolus per pump recommendations

Physician's Signature: _____ Date: _____

The above medication order is valid for one year from the date signed by the physician.

Please continue on next page.

TO BE COMPLETED BY THE STUDENT'S HEALTH CARE PROVIDER:

Treating hypoglycemia:

Typical symptoms for student when their blood sugar is low:

☐ Hungry	☐ Tired/Sleepy	☐ Tearful/Crying	☐ Dizzy
☐ Shaky	☐ Irritable	☐ Unable to Concentrate	
☐ Pale	☐ Personality Change	☐ Combative	☐ Blurry Vision
☐ Weakness	☐ Moist skin/sweating	☐ Confusion	☐ Other: _____

If student exhibits symptoms, check blood glucose. If blood sugar is _____ mg/dl or less or if signs of low blood sugar are present, treat with _____ grams of fast-acting sugar (glucose tabs, juice or snack). Recheck blood glucose in 15 minutes; treat again until blood glucose is greater than _____.

Indications for use of glucagon:
Unconsciousness, drowsy, inability to swallow by mouth or severe hypoglycemia (blood glucose below_____).

Action to be taken:
I order the administration of glucagon (brand used: _____) for treatment of severe hypoglycemia. Please administer glucagon _____ mg (please circle route) sq, im, intranasal

Call 911 and notify parent/guardian

Other instructions: _____

Physician's Signature: _____ Date: _____

The above medication order is valid for one year from the date signed by the physician.

Please continue on next page.

TO BE COMPLETED BY THE STUDENT'S HEALTH CARE PROVIDER:

Treating hyperglycemia:

Typical symptoms for student when their blood sugar is high:

☐ Excessive Thirst ☐ Nausea ☐ Frequent Urination ☐ Warm/Dry/Flushed Skin

☐ Fatigue/Drowsy ☐ Headache ☐ Abdominal Discomfort ☐ Blurry Vision

☐ Nausea/Vomiting ☐ Personality Changes ☐ Other: _____

If student exhibits any of the symptoms listed above, check student's blood glucose

If blood glucose is higher than _____ mg/dl and it has been greater than _____minutes from last insulin dose:

- Give insulin per sliding scale/bolus per pump recommendations
- Provide 8-16 ounces of water per hour
- Recheck blood glucose in two hours and treat with sliding scale insulin as ordered
- When having symptoms of nausea/vomiting, student will be released from school to parent/guardian

Please provide any other specific instructions here or provide separate documentation:

_____

_____

_____

_____

Physician's Name: _____ Phone: _____

Physician's Signature: _____ Date: _____

The above medication order is valid for one year from the date signed by the physician.

MEDICATION GUIDELINES

The administration of medication to students shall be done only in exceptional circumstances where the student's health may be jeopardized without the medication.

Whenever possible, administration of medication should be done at home. Medication prescribed three times per day can be given before school, afterschool, and at bedtime. If a new medication is started, the first dose must be given at home, unless it is a rescue medication.

The school will adhere to the following guidelines as it pertains to medication:

- Administration of prescription medication by school personnel must only be done according to the written order of a licensed prescriber and written authorization of parent / guardian and Licensed School Nurse, regardless of the student's age.
    - Mixed dosages in a single container will not be accepted for administration at school.
    - If a half tablet is required for a correct dosage, it is the parent's / guardian's responsibility to provide pre-cut tablets for administration at school.
    - Altered forms of medication will not be accepted or administered at school.
    - Narcotics / medical cannabis will not be administered at school.
    - Aspirin-containing products will not be administered at school.
    - Only FDA approved treatments will be provided at school. (No essential oils)

- All medication (prescription and non-prescription) must be brought to and from school by a parent / guardian in its original container. The following information must be on the prescribed container label:
    - Student's full name
    - Name and dosage of medication
    - Time and directions for administration at school
    - Physician / licensed prescriber's name
    - Date (must be current)

- New consent from a licensed health care provider and parent / guardian signatures must be received each school year.

- A new medication consent form is required when the medication dosage or time of administration is changed.

- When a long-term daily medication is stopped, a written physician / licensed prescriber's order is requested.

- Medication will be kept in a locked cabinet in the Nurse's Office unless authorized by the Licensed School Nurse, and must not be carried by the student.

PARENT/GUARDIAN AUTHORIZATION

- I request the medication(s) listed on page one be given to my child during regular school hours as ordered by the physician/licensed prescriber. (Note: This does not pertain to after-school activities.)
- I give permission for the medication to be given by designated personnel.
- For prescription medication, I will provide the above-mentioned medication in the pharmacy labeled container.
- I authorize the Licensed School Nurse or designee to exchange information with my child's healthcare provider concerning any questions that arise with regard to the listed medication, medical condition, or side effects of this medication.
- I authorize the Licensed School Nurse or designee to communicate with appropriate school personnel regarding this medication for my child.
- I release Sayre School and school personnel from any liability in relation to the administration of this medication.
- I have read and understand the Medication Guidelines included in this form.

Parent Name: _____

Parent Signature: _____ Date: _____