Simi Valley Schools
SIMI VALLEY UNIFIED SCHOOL DISTRICT

School Year:_____
Grade: _____
Teacher: _____
P.E Days.: M / T / W / Th / F
Times: _____

# Physician's Authorization for Diabetes Care at School/Management Plan

**DEMOGRAPHICS**

Date: _____ (valid for the current school year) School: _____ ❒ Type 1 ❒ Type 2
Student Name: _____ DOB:_____ Date of Diagnosis:_____
Medical Conditions/Current Medications that may affect diabetes care: ❒ Food Allergies ❒Celiac Disease ❒Medications
Parent/Legal Guardian: _____ Hm:_____Cell:_____Wk:_____
Parent/ Legal Guardian: _____Hm:_____Cell:_____Wk_____
Notify for the following situations: ❒ Mother ❒ Father ❒ Guardian ❒ Other: _____ (# in order of who to contact 1st)
❒ BG < _____ ❒ BG >_____ ❒ Ketones: ≥ _____ ❒ Other: _____

**COMPETENCY**

**Independent self-management (Ind):** Student is capable of performing tasks without adult supervision or assistance
**Self-management with supervision (Supv):** Designated trained adult personnel will observe and assist with tasks identified
**Total care (Total):** Designated trained adult personnel to perform ALL aspects of the tasks identified

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|---|---|---|---|---|---|
| Blood glucose testing | ❑ Ind | ❑ Supv ❑ Total | Give insulin by insulin pen | ❑ Ind | ❑ Supv ❑ Total |
| Carbohydrate counting | ❑ Ind | ❑ Supv ❑ Total | Give insulin by insulin pump | ❑ Ind | ❑ Supv ❑ Total |
| Give insulin by injection | ❑ Ind | ❑ Supv ❑ Total | Ketone testing | ❑ Ind | ❑ Supv ❑ Total |
| Hypoglycemia* | ❑ Ind | | Hyperglycemia* | ❑ Ind | |

**NOTE:** *If cognitively impaired or BG <____ or >_____, checks & treatment should be ❑ Supv ❑ Total

**BLOOD GLUCOSE MONITORING**

Target Range: ❒ 70-150 ❒ 70-180 ❒ Other:_____
Check BG: ❒ Mid-morning/before snack ❒ Before lunch ❒ Before P.E. or exercise
Additional: ❒ As needed, for signs/symptoms of LOW or HIGH blood glucose or illness ❒ After P.E. or exercise
❒ 2 hours after correction ❒ Before getting on bus ❒ Other:_____
Brand/Model of Glucometer::_____❒ Continuous Glucose Monitor (CGM) Type: _____# mo./yrs? _____
Alarms for: ❒ HIGH =_____ ❒ LOW=_____ Remote Monitoring: (Type) _____❒ Cell phone ❒ Wi-Fi Access

❒ **Finger stick** before administering any insulin ❒ **CGM** (Dexcom only) may be used to give corrections/boluses
❒ Treatment parameters, depending on sensor trend, and any additional instructions are attached
****Student/Parent is responsible for calibration of sensor to maintain best accuracy****

**INSULIN ADMINISTRATION**

Device (Choose all that may apply): ❒ Pen ❒ Syringe ❒ Pump: Manufacturer:_____ Model:_____

Insulin bolus/correction for: ❒ Mid-morning/snack time ❒ Lunchtime ❒ Other_____

Insulin/Carb Ratio:
1u:_____grams

Correction Factor:
1 u:___mg/dL > ____ (Target BG)

Calculating Correction Dose:
Actual – Target ÷ CF = # of units of insulin
(BG) (BG)

❒ Contact parent before administering any insulin or carbohydrates, if BG >_____
❒ Parents are trained and authorized to adjust the insulin dosage ❒ Parameters: +/-_____units or % (circle one)

**PUMPS**

❒ Follow attached pump settings, in the event of a disaster, lockdown, or pump failure
❒ Parents are trained and authorized to adjust pump settings/dosing ❒ Parameters: +/-_____units or % (circle one)

****Parent must notify school of changes to pump settings, for emergency purposes****

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*Student's Usual Symptoms include:* _____

**MILD – MODERATE HYPOGLYCEMIA**

| | |
|---|---|
| **Step 1** | Always treat symptoms, assuming BG is low, if unable to test blood glucose level. |
| **Step 2** | Give 15 grams of **readily available** fast acting carbohydrate ❒ **Give only** what parent provides (if medically indicated) i.e. *4 oz. apple or orange juice, 4 oz. soda (regular not diet), 3- 4 glucose tablets, 6 Lifesaver candies (circle with hole), 15 grams of glucose gel, 1 tablespoon sugar or honey, with or without 4 oz. of water*. |
| **Step 3** | Monitor and re-check in ____ minutes.<br>• If BG is <_____ mg, or if symptoms persist/recur, repeat Steps 2 & 3<br>• If BG still < ____mg/dL after 3rd check, parent will be contacted to pick student up *(as per district policy)*<br>• If symptoms subside and BG is >_____mg, resume usual activity.<br>❒ If symptoms subside and BG is >____ mg **and** lunch, or snack, is **> 1 hour away**, give ____grams of complex carbohydrates: **(E.g.- *cheese & crackers, peanut butter & crackers, granola/protein bar - parent will provide)*** |
| **Step 4** | Notify parent/guardian and school nurse, as soon as reasonably possible. |

**SEVERE HYPO**

**Symptoms:** *to swallow, begins losing consciousness, or seizure*

| | |
|---|---|
| **Step 1** | Administer Glucagon – DOSE: ❑ 0.5 mg IM ❑ 1 mg IM |
| **Step 2** | **Call 911**. Keep student on side. Ensure open airway. |
| **Step 3** | Notify parent/guardian, school nurse, as soon as, reasonably possible. Contact doctor, if unable to reach parent. |

**HYPERGLYCEMIA**

*Student's Usual Symptoms include:* _____

Administer insulin per protocol ❒ **No <** _____ hours, after previous insulin dose.
❒ **According** to pump recommendations

Check urine/blood for ketones ❒ blood glucose > _____
❒blood glucose is **>**____for __ consecutive readings_____ hrs apart (for insulin pump users)

**EXERCISE**

❒ Test before exercise ❒ Test after exercise ❒ Snack before exercise: _____grams when BG < _____

Student should **NOT** exercise if, BG is < _____, or > _____, or has urine/blood ketones.

**DISASTER**

❒ Follow orders contained in this authorization or ❒ See attached

***Medications/Supplies:*** *Must have extra **unopened** emergency supply of insulin (short and long acting). Extra pump supplies & inserters are, also, strongly recommended.*

**SIGNATURES**

**Physician Name:** _____ **Phone:** _____
**Address:** _____ **Fax:** _____
**Signature** _____ **Date:** _____

I give permission to the school nurse and trained personnel and staff to provide care, as outlined above. The school nurse may contact the Diabetes Team, when needed, and release information contained in this document to all staff members and other adults, who have custodial care of my child, at school or school sponsored events to maintain my child's health and safety.

**Student's Parent/Guardian** _____ **Date**: _____

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