SimiValleySchools
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

(Autorización del Médico para el Cuidado de la Diabetes en la Escuela/Plan de Cuidado a ser llenada por el médico)

DEMOGRAPHICS

Date(Fecha): ____________ (valid for the current school year/vigencia de un año) School (Escuela): ______________ ❒ Type 1 ❒ Type 2
Student Name(Nombre del alumno): _________________________DOB(FDN):________________ Date of (Fecha de)Diagnosis:_____
Condiciones médicas/medicamentos actuales que puedan afectar el cuidado de la diabetes:
❒ Food Allergies(Alergias a alimentos) ❒Celiac Disease (Celiaquía) ❒Medications (Medicamentos)
Parent/Legal Guardian/Padre/Tutor: ______________________ Casa: ____________Cell: ______________Of:______________
Parent/Legal Guardian/Padre/Tutor: ______________________ Casa: ____________Cell: ______________Of:______________
Avisar si sucede lo siguiente (Notify for the following situations): ❒ Madre ❒ Padre ❒ Tutor ❒ Otro: ____(# en orden de avisar primero)
❒ 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

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____________________

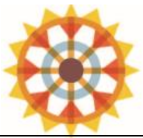
Insulin/Carb Ratio:	Correction Factor:	Calculating Correction Dose:
1u:_____grams	1 u:___mg/dL > ____ (Target BG)	Actual – Target ÷ CF = # of units of insulin (BG) (BG)

❒ 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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MILD – MODERATE HYPOGLYCEMIA

Student's Usual Symptoms include: ____

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 ❒ **<u>Give only</u>** 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. • If BG is <_____ mg, or if symptoms persist/recur, repeat Steps 2 & 3 • If BG still < ____mg/dL after 3rd check, parent will be contacted to pick student up *(as per district policy)* • If symptoms subside and BG is >_____mg, resume usual activity. ❒ 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 **<u>unopened</u>** 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. Doy permiso a la enfermera escolar y al personal capacitado a proporcionar el cuidado arriba mencionado. La enfermera puede contactar al equipo de diabetes, cuando sea necesario, y divulgar la información contenida en este documento a todos el personal y a otros adultos, a cargo del cuidado de mi hijo(a), en la escuela o eventos patrocinados por la escuela para mantener a mi hijo(a) sano y a salvo. **Student's Parent/Guardian** ___________________________________**Date**: _________________
(Firma del Padre/Tutor) (Fecha)

875 E. Cochran Street ▪ Simi Valley, CA 93065 ▪ Telephone: 805-306-4500 Ext. 4302 ▪ Fax: 805-520-6586 ▪ sean.goldman@simivalleyusd.org