UCSF Pediatric Diabetes Program (415) 353-7337
Management of Diabetes at School and School Events

Student: _____ **DOB** _____ **School Fax:** _____

1. Blood Glucose Checking:

- ☐ Before meals
- ☐ Before snacks
- ☐ For suspected hypoglycemia
- ☐ Before exercise
- ☐ Before getting on bus
- ☐ Blood glucose checking by staff
- ☐ Provide assistance/supervision with blood glucose checking
- ☐ Should be allowed to test in classroom
- ☐ By student at his/her discretion
- ☐ Nurses office for routine checks
- ☐ Student allowed to carry fast-acting carbs and checking supplies at all times

2. Routine Care of Hypoglycemia (BG < 70)

********** *see decision tree (back of form)* **********

- ☐ Self treatment of mild lows
- ☐ Needs assistance for all lows

3. Care of Severe Hypoglycemia

(unconscious, combative, or unable to swallow)

- *see decision tree (back of form)*
- administer glucagon **1st** by intramuscular injection ☐ 0.3mg ☐ 0.5mg
- then **call 911**
- notify guardian

4. Care of Hyperglycemia (BG > 300)

********** *see decision tree (back of form)* **********

- ☐ Ketones checked by staff
- ☐ Ketones checked by student with staff verification

5. Food

- ☐ No restriction
- ☐ Extra snack allowed before/during exercise:
  - If BG < ____ treat hypoglycemia first
  - If BG is ____ to ____ give _____ grams of carbs *without insulin coverage*
  - If BG is _____ to 299, _____
  - If BG ≥300, check for ketones, if + ketones no Exercise & follow decision tree
- ☐ Lunch to be eaten between ____ am & ____ pm and consist of ____ to ____ grams of carbs

6. Insulin at School: ☐ Yes ☐ No

Type: ☐ Humalog/Novolog ☐ Other:_____

☐ Before snacks ☐ Before lunch

☐ Before all carbohydrates *unless treating or preventing hypoglycemia*

--- for storage & expiration of medications, see package insert ----

7. Dose Prepared By:

- ☐ *Student independently*
- ☐ Guardian
- ☐ As designated by guardian
- ☐ Staff
- ☐ Student with staff verification

Equipment Used:

- ☐ Syringe and vial
- ☐ Insulin pump (syringe & vial for pump failure)
- ☐ Insulin pen
- ☐ Student should be allowed to carry his/her insulin pen at all times and independently decide how much insulin is needed and when it is needed

8. Insulin dose administered by:

- ☐ *Student independently*
- ☐ Guardian
- ☐ As designated by guardian
- ☐ Staff
- ☐ Student with staff verification

9. Insulin dose:

- ☐ Use bolus wizard or pump calculator to determine
- ☐ Standard lunch time dose _____ units
- ☐ Insulin to carb ratio: _____ unit(s) for every _____ grams
- ☐ Add sliding scale dose to the insulin to carb ratio dose
- ☐ Sliding scale to correct high blood sugar at

☐ Snack ☐ Lunch ☐_____

Blood Glucose	**Dose** (units)
Less than 100	
101-125	
126-150	
151-175	
176-200	
201-225	
226-250	
251-275	
276-300	
301-325	
326-350	
351-375	
376-400	
More than 400	

☐ Call guardian for any insulin injection dosing questions and/or pump failure. Guardian is **authorized** to make necessary changes or adjustments to this diabetes medical management plan.

10. During a disaster situation, use the current insulin plan (provided by the family after each clinic visit) BUT decrease the long-acting insulin dose by 10%.

11. Student needs an individualized 504 plan.

12. Student to be allowed to call home any time.

13. Please fax school logs to 415-476-8214 every _____week(s)

14. Other: _____

Guardian Consent for Diabetes Management in School

I, the undersigned, request that the following specialized physical health care services for the management of diabetes in school be administered to my child in accordance with Education Code Section 49423.

I will: 1. Provide the necessary supplies and equipment.
2. Notify the school staff and healthcare provider if there is a change in my child's health status.
3. Notify the school staff immediately and provide new school form/insulin plan for any regimen changes.

I authorize the school nurse and/or school staff to communicate with the healthcare provider or their representative when necessary.

Guardian Signature: _____ **Date:** _____

Healthcare Provider Signature: _____ **Date:** _____

Revised 6/2010