Information For School Management of Diabetes Mellitus

School Year: _____

Student's Name:_____ Date of Birth:_____ Effective Date:_____

School Name:_____ Grade:_____ Homeroom:_____

CONTACT INFORMATION:

Parent/Guardian #1:_____ Home Phone:_____ Work:_____ Cell:____

Parent/Guardian #2:_____ Home Phone:_____ Work:_____ Cell:____

Diabetes Care Provider:_____ Phone:_____

Other emergency contact:_____ Relationship:_____

Phone Numbers: Home:_____ Work:_____ Cell/Pager:_____

Insurance Carrier:_____ Preferred Hospital:_____

EMERGENCY NOTIFICATION: Notify parents of the following conditions:

a. Loss of consciousness or seizure (convulsion) immediately after calling 911 and administering Glucagon.
b. Blood sugars in excess of 300 mg/dl with ketones present.
c. Positive urine ketones.
d. Abdominal pain, nausea/vomiting, fever, diarrhea, altered breathing, altered level of consciousness.

STUDENT'S COMPETENCE WITH PROCEDURES: (Must be verified by parent and school nurse)

- ☐ Blood glucose monitoring
- ☐ Determining insulin dose
- ☐ Measuring insulin
- ☐ Injecting insulin
- ☐ Independently operates insulin pump
- ☐ Carry supplies for BG monitoring
- ☐ Carry supplies for insulin administration
- ☐ Monitor BG in classroom
- ☐ Self-treatment for mild low blood sugar
- ☐ Determine own snack/meal content

MEAL PLAN	Time	Location	CHO Content		Time	Location	CHO Content
☐ Bkft.				☐ Mid-PM			
☐ Mid-AM				☐ Before PE			
☐ Lunch				☐ After PE			

Meal/Snack will be considered mandatory. Times of meals/snacks will be at routine school times unless alteration is indicated. School nurse will contact diabetes care provider for adjustment in meal times. Content of meal/snack will be determined by:

☐ student ☐ parent ☐ school nurse ☐ diabetes provider

Please provide school cafeteria with a copy of this meal plan in order to fulfill ESDA requirements.
Parent to provide and restock snacks and low blood sugar supplies box.

Location of supplies/equipment: (To be completed by school personnel)

Blood glucose equipment ☐ Clinic/health room ☐ With Student

Insulin Administration supplies ☐ Clinic/health room ☐ With Student

Glucagon emergency kit:_____ **Glucose gel:**_____ **Ketone testing supplies**_____

Fast Acting carbohydrate: ☐ Clinic/health room ☐ With Student **Snacks**: ☐ Clinic/health room ☐ With Student

Signatures: I understand that all treatments and procedures may be performed by the student and/or the student and/or unlicensed personnel within the school or by EMS in the event of loss of consciousness or seizure. I also understand that the school is not responsible for damage, loss of equipment, or expenses utilized in these treatments and procedures. I give permission for school personnel to contact my child's diabetes provider for guidance and recommendations. I have reviewed this information form and agree with the indicated information. This form will assist the school in developing a health plan and in providing appropriate care for my child.

Parent Signature:_____ Date:_____

School Nurse Signatures:_____ Date:_____

*Refer to 504 coordinator if appropriate

DIABETES MEDICAL MANAGEMENT PLAN
School Year:

Student's Name: _____ Date of Birth: _____

Parent/Guardian: _____ Phone at Home: _____ Work: _____ Cell/Pager: _____

Parent/Guardian: _____ Phone at Home: _____ Work: _____ Cell/Pager: _____

Other emergency contact: _____ Phone #: _____ Relationship: _____

Insurance Carrier: _____ Preferred Hospital: _____

BLOOD GLUCOSE (BG) MONITORING: (Treat BG below _____ mg/dl or above _____mg/dl as outlined below.)

☑ Before meals ☑ as needed for suspected low/high BG ☐ 2 hours after correction
☐ Midmorning ☐ Mid-afternoon ☐ Before dismissal

INSULIN ADMINISTRATION:

Insulin delivery system: ❑ Syringe or ❑ Pen or ❑ Pump **Insulin type:** ❑Humalog or ❑Novolog or ❑Apidra

MEAL INSULIN: (Best if given right **before eating**. For small children, can give within 15-30 minutes of the first bite of food-or right after meal)

☐ Insulin to Carbohydrate Ratio:
Breakfast: **1** unit per _____ grams carbohydrate
Lunch: **1** unit per _____ grams carbohydrate

☐ Fixed Dose per meal:
Breakfast: Give ___ units/Eat ____ grams of carbohydrate
Lunch: Give ___ units/Eat ____ grams of carbohydrate

CORRECTION INSULIN: (For high blood sugar. Add before *MEAL INSULIN to CORRECTION INSULIN* for *TOTAL INSULIN* dose.)

☐ Use the following correction formula
For pre-meal blood sugar over _____

(BG - ____) ÷ ____ = extra units insulin to provide

☐ Sliding Scale:
BG from ____ to ____ = _____ units
BG from ____ to ____ = _____ units
BG from ____ to ____ = _____ units
BG from ____ to ____ = _____ units
> ____ = _____ units

SNACK: ☐ A snack will be provided each day at: _____
Carbohydrate coverage only for snack (**No BG check required**):

☐ No coverage for snack
☐ 1 unit per _____ grams of carb
☐ Fixed snack dose: Give ___ units/Eat ____ grams of carb

PARENTAL AUTHORIZATION to Adjust Insulin Dose:

☐ YES ☐ NO Parents/guardians are authorized to increase or decrease insulin-to-carb ratio within the following range:
1 unit per prescribed grams of carbohydrate, +/-_____grams of carbohydrate

☐ YES ☐ NO Parents/guardians are authorized to increase or decrease correction dose with the following range: +/-_____units of insulin

☐ YES ☐ NO Parents/guardians are authorized to increase or decrease fixed insulin dose with the following range: +/-_____units of insulin

MANAGEMENT OF LOW BLOOD GLUCOSE:

MILD low sugar: Alert and cooperative student (BG below _____)
☑ Never leave student alone
☑ Give 15 grams glucose; recheck in 15 minutes
☑ If BG remains below 70, retreat and recheck in 15 minutes
☑ Notify parent if not resolved
☐ If no meal is scheduled in the next hour, provide an additional snack with carbohydrate, fat, protein.

SEVERE low sugar: Loss of consciousness or seizure
☑ Call 911. Open airway. Turn to side.
☑ Glucagon injection IM/SubQ ❑ _____ ☑ 0.50mg
☑ Notify parent.
☑ For students using insulin pump, stop pump by placing in "suspend" or stop mode, disconnecting at pigtail or clip, and/or removing an attached pump. If pump was removed, send with EMS to hospital.

MANAGEMENT OF HIGH BLOOD GLUCOSE: (above _____mg/dl)
☐ Sugar-free fluids/frequent bathroom privileges.
☐ If BG is greater than 300 and it's been 2 hours since last dose, give ❑ **HALF** ❑ **FULL** correction formula noted above.
☐ If BG is greater than 300 and it's been 4 hours since last dose, give **FULL** correction formula noted above.
☐ If BG is greater than _____, check for ketones. Notify parent if ketones are present.
☐ Child should be allowed to stay in school unless vomiting with moderate or large ketones present.

MANAGEMENT DURING PHYSICAL ACTIVITY:
Student shall have easy access to fast-acting carbohydrates, snacks, and blood glucose monitoring equipment during activities. Child should NOT exercise if blood glucose levels are below _____ mg/dl or above 300 mg/dl and urine contains moderate or large ketones.

☐ Check blood sugar right before physical education to determine need for additional snack.
☐ If BG is less than _____ mg/dl, eat 15-45 grams carbohydrate before, depending on intensity and length of exercise.
☐ Student may disconnect insulin pump for 1 hour or decrease basal rate by _____.
☐ For new activities: Check blood sugar before and after exercise only until a pattern for management is established.
☐ A snack is required prior to participation in physical education.

SIGNATURE of AUTHORIZED PRESCRIBER (MD, NP, PA): _____ Date: _____

Student's Name: _____ Date of Birth: _____

NOTIFY PARENT of the following conditions: (If unable to reach parent, call diabetes provider office.)

a. Loss of consciousness or seizure (convulsion) immediately after calling 911 and administering glucagon.
b. Blood sugars in excess of 300 mg/dl, when ketones present.
c. Abdominal pain, nausea/vomiting, fever, diarrhea, altered breathing, altered level of consciousness.

SPECIAL MANAGEMENT OF INSULIN PUMP:

☐ Contact Parent in event of: • Pump alarms or malfunctions • Detachment of dressing / infusion set out of place • Leakage of insulin
• Student must give insulin injection • Student has to change site • Soreness or redness at site
• Corrective measures do not return blood glucose to target range within _____ hrs.

☐ Parents will provide extra supplies including infusion sets, reservoirs, batteries, pump insulin, and syringes.

This student requires assistance by the School Nurse or Trained Diabetes Personnel with the following aspects of diabetes management:

- ☐ Monitor and record blood glucose levels
- ☑ Respond to elevated or low blood glucose levels
- ☑ Administer glucagon when required
- ☐ Calculate and give insulin injections
- ☐ Administer oral medication
- ☐ Monitor blood or urine ketones
- ☐ Follow instructions regarding meals and snacks
- ☐ Follow instructions as related to physical activity
- ☐ Respond to CGM alarms by checking blood glucose with glucose meter. Treat using Management plan on page 1.
- ☐ Insulin pump management: administer insulin, inspect infusion site, contact parent for problems
- ☐ Provide other specified assistance:

_____

This student may independently perform the following aspects of diabetes management:

Monitor blood glucose:
- ❑ in the classroom
- ❑ in the designated clinic office
- ❑ in any area of school and at any school related event

- ❑ Monitor urine or blood ketones
- ❑ Calculate and give own injections
- ❑ Calculate and give own injections with supervision
- ❑ Treat hypoglycemia (low blood sugar)
- ❑ Treat hyperglycemia (elevated blood sugar)
- ❑ Carry supplies for blood glucose monitoring
- ❑ Carry supplies for insulin administration
- ❑ Determine own snack/meal content
- ❑ Manage insulin pump
- ❑ Replace insulin pump infusion set
- ❑ Manage CGM

LOCATION OF SUPPLIES/EQUIPMENT: (Parent will provide and restock all supplies, snacks and low blood sugar treatment supplies.)
This section will be completed by school personnel and parent:

	Clinic room	With student		Clinic room	With student
Blood glucose equipment	❑	❑	Glucagon kit	❑	❑
Insulin administration supplies	❑	❑	Glucose gel	❑	❑
Ketone supplies	❑	❑	Juice /low blood glucose snacks	❑	❑

My signature provides authorization for the above Diabetes Mellitus Medical Management Plan.
I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.

SIGNATURE of AUTHORIZED PRESCRIBER: _____ DATE: _____
Authorized Prescriber: MD, NP, PA

Name of Authorized Prescriber:

Address:

Phone:

SIGNATURES

I, (Parent/Guardian) _____ understand that all treatments and procedures may be performed by the student and/or Trained Diabetes Personnel within the school, or by EMS in the event of loss of consciousness or seizure. I also understand that the school is not responsible for damage, loss of equipment, or expenses utilized in these treatments and procedures. I give permission for school personnel to contact my child's diabetes provider for guidance and recommendations. I have reviewed this information form and agree with the indicated information. This document serves as the Diabetes Medical Management Plan as specified by Georgia state law.

PARENT/GAURDIAN SIGNATURE: _____ DATE: _____

SCHOOL NURSE SIGNATURE: _____ DATE: _____

Request for Administration of Medication

If medications can be given at home or after school hours, please do so. However, if medication administration is absolutely necessary to be given during school hours, this form must be completed.
Permission is hereby granted to the local school principal or his/her designee to supervise my child in taking the following prescribed medication.

I hereby release and discharge the Forsyth County Board of Education and its employees and officials from any and all liability in case of accident or any other mishap in supervising said medication due to any side effects, illness, or other injury which might occur to my child through supervising said medication. I hereby release aforementioned officials from any liability because of any injury or damage which might occur.

I give the above-mentioned personnel permission to contact my child's health care provider and/or pharmacy to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required.

I understand that:

- All medications, herbals, and supplement must be approved by the U.S. Food and Drug Administration and appear in the U.S. Pharmacopeia.
- Medications must be in the original container.
- Parent/Guardian must provide specific instructions (including drugs and related equipment) to the principal or his/her designee.
- It will be the responsibility of the parent/guardian to inform the school of any changes in pertinent data. New medications will not be given unless a new form is completed.
- All medication will be taken directly to the office by the parent or guardian. Students may not have medication in their possession, except with a physician's request or a physician's order on a Forsyth County care plan.
- Students who violate these rules will be in violation of the Alcohol/Illegal Drug Use Policy (JCDAC).
- A daily record shall be kept on each medication administered. This record will include student's name, date, medication administered, time, and signature of school personnel who supervised.
- MEDICATIONS MUST BE PICKED UP BY PARENT/GUARDIAN. Any medication not picked up from the school by the end of the last school day of the year will be considered abandoned. Abandoned medication will be properly discarded in accordance with local, state, and federal laws/rules by the school nurse and an administrator.

Name of Student: _____ **Date of Birth:** _____

School: _____ **Grade:** _____ **Teacher:** _____

Medication: _____ **Date of Prescription:** _____

Physician's Name: _____ **Physician's Phone:** _____

Dosage & Time of Administration: _____

Allergies: _____ **Stop Medication on:** _____

Statement of Parent or Guardian

I hereby give my permission for my child to receive this medication at school.

_____

Parent/Guardian Name (Print) Parent/Guardian Signature Date

_____

Home Phone Work Phone Cell phone

To be completed by Physician for long-term medications (more than two weeks):
"Physician" as defined in Article 2 of the Medical Practice Act of Georgia

Condition/Illness Requiring Medication: _____

Possible Side Effects of Medication: _____

Other Medication Student is Taking: _____

Physician's Signature: _____ **Date:** _____

Parent/Guardian Picked Up Medication: _____ **Date**: _____

Parent Signature: _____ **Nurse**: _____ **Date**: _____

Administration of Medication Information

The administration of medication to students during the school day presents an increased concern and awareness of the need to have written procedures.

Medication may be dispensed to students with the assistance of school personnel whenever physicians find it necessary to prescribe medication to be taken during school hours. School personnel will cooperate with parents in this regard by providing a place for the medication to be stored; however, the major responsibility for a child taking medication at school rests entirely with the child's parents.

A nurse is not always available to assist in the administration of the medication. The student may be assisted by an adult designated by the principal.

Prescription and non-prescription medication will be given to students by school personnel only when the following guidelines are observed:

***All medication MUST be in its original container and MUST be brought to school by the parent or guardian**. Medications brought in baggies or other unmarked containers will not be given. Prescription medication must be in the pharmacy container labeled with the child's name, date, name of medication, name of the prescribing physician, time(s) the medication is to be given and name of the pharmacy filling the prescription. We request that you ask the pharmacist to give you two labeled prescription bottles so that you have one bottle at home and one at school.

*A "Request for Administration of Medication" form (see back) must be completed by the parent/guardian (and physician if the medication needs to be given for longer than two weeks - such as (Ritalin) and sent to school along with the medication.

***Do not send medication to school which needs to be given daily or two/three times a day unless the physician specifically states a time during the school day which it is to be given.** An antibiotic which is to be given three times daily can be given before the child leaves for school, when he/she gets home, and at bedtime.

*School personnel cannot give medication that contains aspirin to students under 18 years old due to the correlation with Reyes Syndrome. Examples are Pepto Bismol, Excedrin Migraine, Goody's Powder.

The safety and well-being of your child is our concern. With your understanding and cooperation, we can eliminate much of the unnecessary medications that are brought to school and ensure that our students who do need to take medication at school will receive it appropriately. If you have any questions regarding medications, please call your child's school or you may call the school nurse.

Authorization For Students to Carry a Prescription Inhaler, Epinephrine Auto Injector, Insulin, and Diabetic Supplies, or Other Approved Medication

_____needs to carry the following prescription labeled inhaler, epinephrine auto injector, insulin, and diabetic supplies, and/or

_____prescription medication with him/her. The above-named student has been instructed in the proper use of the medication and fully understands how to administer this medication.

It is preferable that a second prescription inhaler, epinephrine auto injector, additional insulin, and diabetic supplies or other prescribed medication be kept in the school in case the first is lost or left at home.

Name of Medication: _____

Practice Name | Address | Telephone Number

Examiner's Name (Please Print) | Credentials

Examiner's Signature | Date

I have been instructed in the proper use of my prescription labeled medication and fully understand how it is administered. I will not allow another student to use my medication under any circumstances. I also understand that should another student use my prescription, the privilege of carrying my medication may be altered. I also accept responsibility for notifying the school nurse each time I take my medication.

Student's Signature *Date*

I hereby request that the above-named student, over whom I have legal guardianship, be allowed to carry, and use this prescribed medication at school:

- I accept legal responsibility should the medication be lost, given to, or taken by another person other than the above-named student.
- I understand that if this should happen, the privilege of carrying the medication may be altered.
- I release Forsyth County School System and its employees of any legal responsibility when the above- named student administers his/her own medication.

Parent/Guardian Name (Please Print) | Parent/Guardian Signature | Date