Nixa Schools Health Services

Diabetes Medical Management and Treatment Plan

This page should be completed by parent/guardian:

Student Name_____Grade_____Teacher/Homeroom_____School_____

Date of Birth_____Age/Date Diagnosed_____

Transportation to/from school ☐ Bus ☐ Car ☐ Drives ☐ Walk ☐ Daycare ☐ Other_____

Parent/Guardian Name_____Home_____Cell_____Work_____

Parent/Guardian Name_____Home_____Cell_____Work_____

Emergency Contact (if parent can't be reached) _____Phone_____

Primary Physician Name_____Phone_____Preferred Hospital_____

Endocrinologist (if different than above)_____Phone_____

Emergency Items to be Left at School

☐ Glucose tablets ☐ Fast-acting Glucose ☐ Glucagon Kit ☐ Ketone Strips

☐ Meter ☐ Meter Supplies ☐ Pump Supplies ☐ Snacks

Permission to Check Blood Glucose Level

Permission is given for blood glucose testing by the school nurse or designee, using equipment provided by the parent/guardian. It is understood when the school nurse or designee is not available for blood glucose testing, the parent/guardian and/or 911 will be notified depending on the state of the crisis.

☐ Nurse or designee to perform blood glucose testing OR supervise procedure performed by student

☐ Student is independent and may test blood glucose levels without supervision

☐ Student is independent and may administer insulin without supervision

The responsibility of physician ordered student self-monitoring blood glucose and/or self-administration of insulin during school hours shall be determined by the school nurse following assessment of skill and knowledge level. Demonstration by student of specific responsibilities include, but are not limited to, correct use of blood glucose meter, understanding of symptoms and treatment of high and low blood sugar levels, knowledge of self-administration of insulin including time(s) and disposal of supplies, and management of pump. The student will agree to seek assistance from the school nurse as needed.

I hereby give authorization to release/receive information regarding _____(student's name) between Dr._____(physician/clinic) and _____School including specific and confidential data to assist in the delivery of health care services to my child while at school.

Parent/Guardian Signature_____Date_____

Student demonstrates responsibility to be independent in self-administration of insulin and blood glucose testing and agrees to follow district policies in relation to self-administration of medicine. ☐ Yes ☐ No

Student Signature_____School Nurse Signature_____Date_____

Authorized Diabetes Management Orders (Page 1)

This page should be completed by the medical provider.

Student Name_____Date of Birth_____

HYPOGLYCEMIA (LOW BLOOD SUGAR)

Recommended treatment for low blood sugar (<_____)
Symptoms:_____

1. Give 15 grams of **fast acting** carbohydrate (1/2 cup fruit juice or 3-4 glucose tablets); Retest in 10-15 minutes. If below 70, repeat this step.
2. If meal time is greater than an hour away, then protein and some additional carbohydrates can be added (i.e. crackers and cheese)
3. GLUCAGON: Glucagon is reserved for low glucose levels associated with loss of consciousness or convulsions. If weight < 20 kg, administer 0.5 mg IM. If weight > 20 kg, administer 1.0 mg IM. (Student Weight_____)
   Call 911 following injection.

Additional comments_____

HYPERGLYCEMIA (HIGH BLOOD SUGAR)

Recommended treatment for high blood sugar (>_____)

Symptoms:_____

1. Correction formula: Current blood sugar minus _____, then divided by _____
   a. Use when blood sugar is above _____. Correction insulin doses must be spaced 2 hours apart.
2. Check for ketones if blood glucose > 250. If moderate to large ketones, notify parent/guardian.
3. Provide water or sugar-free beverage

Additional comments_____

****Students are allowed water and snacks in the classroom to stabilize blood sugar levels. Students are also allowed restroom breaks as needed. Students utilizing a Continuous Glucose Monitoring Device will be allowed cell phone access in the classroom as needed for the purpose of monitoring blood sugar levels at school. ****

Authorized Prescriber's Instructions

Targeted Blood Glucose Range _____to_____

Test blood glucose level as needed and:

☐ __ hours after eating ☐ before meals/snacks ☐ before going home

Meal/Snack Insulin Dosing: Give _____units of INSULIN (Novalog/Humalog/Apidra) for every _____grams of carbs for meals/snacks with _____hours between doses.

Correction Formula Dosing: Current blood sugar minus _____, then divided by _____
Use when blood sugar is above _____. Correction insulin doses must be spaced 2 hours apart.

Additional Comments/Insructions:_____

Authorized Diabetes Management Orders (Page 2)

This page should be completed by the medical provider.

Student Name_____Date of Birth_____

Pump Users

Type of Pump_____Insulin/Carb Ratio (Bolus)_____

Correction Factor_____Basal Rate(s)_____

Additional Comments/Instructions:

_____

_____

_____

It is the opinion of this medical provider that at this time:

- ☐ Student requires supervision with diabetic care (testing and/or insulin administration)
- ☐ Student is independent and may test blood glucose without supervision.
- ☐ Student is independent and may administer insulin without supervision.

Authorized Prescriber Signature_____Date_____

Prescriber Name (printed)_____Phone_____Fax_____

Prescriber Address_____

School Nurse Signature_____Date_____

School_____Address_____

*****ALL changes in insulin doses administered during the school day require written instruction from the authorized prescriber. *****

Administrative Note: The reader is encouraged to review policies and/or procedures for related information in this administrative area.