Cedar Hill Independent School District

Annual Health Service Prescription

Physician/Parent Authorization for Diabetic Care

*This form is to be renewed annually. Prescribed in-school medication or procedures may be administered by a school nurse or a non-health professional designee of the principal.

Student: _____ Birth Date: _____

TO BE COMPLETED BY PHYSICIAN:
Please respond to the following questions based on your records and knowledge of the student.
Procedures: (parent to provide supplies for procedures):
Test blood glucose before lunch and PRN for signs/symptoms of hypoglycemia.
Test urine ketones when blood glucose is hyperglycemic, and/or when child is ill.

Medication: (Child may ____ may not ____ prepare/administer insulin injection).
Humulin Regular/Humalog insulin given SQ prior to lunchtime (within 15 minutes prior to lunch) based on the following guidelines:

Pre-lunch dosage: (Fixed) _____ or (Carb to insulin ratio) _____units
Humalog *plus the following sliding scale insulin as indicated by blood glucose level*

Blood glucose below _____ = no additional insulin

Blood glucose from _____ to _____=____ unit(s) Regular/Humalog insulin SQ

Blood glucose from _____ to _____=____ unit(s) Regular/Humalog insulin SQ

Blood glucose from _____ to _____=____ unit(s) Regular/Humalog insulin SQ

Blood glucose over _____=____ unit(s) Regular/Humalog insulin SQ

(Notify parent if blood glucose is over _____.)

Precautions:
Hypoglycemia: Signs of hypoglycemia include trembling, sweating, shaking, pale, weak, dizzy, sleepy, lethargic, confusion, coma, or seizures. See treatment chart on following page.
Hyperglycemia: Signs include frequency of urination and excessive thirst. See treatment chart on the following page. (*Note: Deep rapid respirations combined with a fruity odor to the breath, and positive urinary ketones are signs of ketoacidosis.* ***This is an emergency.*** *Notify parent.)*

Meal Plan: The *Constant Carbohydrate Diet* emphasizes consistency in the number of grams of carbohydrate eaten from day to day at each meal or snack. Proteins and fats are "free foods" in that they have minimal effect on the blood glucose level. The child and parent can choose the carbohydrate product that they wish to use for meals or snacks. The parent will update the meal plan when changed.
Breakfast _____ grams at _____(time).
Mid AM snack _____grams at _____(time).
Lunch _____grams at _____(time).
Mid PM snack _____grams at _____ (time).

Does this student have an insulin pump? Yes ___ No ___. If yes, please attach student's pump guidelines.

FOR DIABETIC SELF-CARE ONLY
Does this student have physician permission to provide self-care? Yes_____ No_____
This student has been provided instruction/supervision and is capable of doing self-glucose monitoring and giving his/her own insulin injections/insulin pump care, including using universal precautions, handwashing and proper disposal of sharps? Yes_____ No_____
The student may perform safe glucose monitoring and/or insulin injections/pump care in the ☐ clinic; ☐ classroom; ☐ cafeteria.
Does this student need the supervision of a designated adult? Yes_____ No _____

Physician portion continued on following page

GUIDELINES FOR RESPONDING TO BLOOD GLUCOSE TEST RESULTS

1. **If glucose is BELOW _____:** (hypoglycemia or low blood sugar)
   - A. Give child 15 grams' carbohydrate (CHO). i.e.:
     - 6 lifesavers
     - 6 ounces of regular soda
     - 4 ounces of juice
     - 3 – 4 glucose tabs
   - B. Allow child to rest for _____ minutes, and retest glucose.
   - C. If symptoms persist (or blood glucose remains below _____), repeat CHO. * If it is within 30 minutes prior to lunch, monitor in clinic until lunch then proceed with pre-lunch dosage.
2. **If blood glucose is BELOW _____ and the child is unconscious or seizing:**
   - A. Call emergency medical services 911.
   - B. Rub a small amount of glucose gel (or cake frosting) on child's gums and oral mucosa. If available, inject Glucagon _____mg. SQ.
   - C. Notify parent.

3. **If blood glucose if FROM _____ to _____: Follow usual meal plan and activities (**unless otherwise directed by sliding scale for insulin administration.)

4. **If blood glucose is OVER _____:**
   - A. If within 30 minutes prior to lunch, nurse to be called to assess student and assist if student is unable to administer correction dose of insulin per student's sliding scale orders, if so ordered.
   - B. Student checks urine ketones.

     <u>If Ketones are negative or small</u>
     - Encourage 8-10 oz. of water every hour until ketones are negative.

     <u>If Ketones are moderate or large:</u>
     - Student should remain in clinic for monitoring.
     - Give 1-2 (8 -10 oz.) glasses of water every _____ mins. for the first hour and then every hour until clear.
     - Notify parent of medical condition and possible pick up depending on symptoms.
     - If student remains at school, retest glucose and ketones every 2-3 hours or until ketones are negative.
   - C. Student not to participate in PE or other forms of exercise if blood sugar is above _____ and ketones are present.
   - D. If student develops nausea/vomiting, rapid breathing, and/or fruity odor to the breath, call 911, the nurse and the parents/guardians.

Physician signature _____ Date _____

Clinic/facility _____Phone_____ Fax_____

Diabetes Nurse Educator: Name _____ Phone _____

Clinical Dietitian: Name _____ Phone _____

TO BE COMPLETED BY THE PARENT:

We (I) the undersigned, the parents/guardians of _____ request that the above medication and procedures be administered to our (my) child. I will notify the school immediately if the health status of my child changes, I change physicians or emergency contact information, or the procedure is canceled or changes in any way. Information concerning my child's diabetes health management may be shared with/obtained from the diabetes health care providers.

Signature_____ Relationship _____

Date _____ Phone (Hm)_____ Cell _____ (Wk)_____