

**THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
HEALTH EDUCATION SERVICES 754-321-2272
Diabetes Medication/Treatment Authorization**

Student's Name: _____ Date of Birth: _____ Date: _____
 School Name: _____ Grade _____ Homeroom _____

CONTACT INFORMATION

Parent/Guardian #1: _____ Phone Numbers: Home _____
 Work _____ Cellular/Pager _____
 Parent/Guardian #2: _____ Phone Numbers: Home _____
 Work _____ Cellular/Pager _____
 Physician/Healthcare Provider: _____ Phone Number _____
 Other Emergency Contact: Phone Number: Home _____
 Relationship: _____ Work/Cellular/Pager _____

EMERGENCY NOTIFICATION: Notify parent/guardian of the following conditions If unable to reach parent/guardian: Notify healthcare provider and emergency contact listed above

- Loss of consciousness or seizure (convulsion) immediately after Glucagon given and 911 called.
- Blood sugars in excess of _____ mg/dl
- Positive urine ketones.
- Abdominal pain, nausea/vomiting, diarrhea, fever, altered breathing, or altered level of consciousness.

BLOOD GLUCOSE MONITORING: At school: Yes No *Student has been trained by Healthcare Professional* Yes No
 To ordinarily be performed by student: Yes No *Type of Meter:* _____

Time to be performed: Before breakfast Before PE/Activity Time
 Mid-morning (before snack) After PE/Activity Time
 Before lunch Mid-afternoon
 Dismissal As needed for signs/symptoms of low/high blood glucose
 Place to be performed: Clinic/Health Room Classroom Other _____

OPTIONAL: Target Range for blood glucose: _____ mg/dl to _____ mg/dl

INSULIN INJECTIONS DURING SCHOOL: Yes No *Student has been trained by Healthcare Professional* Yes No

If yes, can student determine correct dose? Yes No Draw up correct dose? Yes No Give own injection? Yes No

Insulin Delivery: Syringe/Vial Pen Pump (If pump worn, use "Insulin Pump Medication/Treatment Plan")

Standard daily insulin at school: Yes No

Type: _____ Dose: _____ Time to be given: _____

Calculate insulin dose for carbohydrate intake: Yes No

If yes use Regular Humalog Novolog
 _____ #unit(s) per _____ grams Carbohydrate
 Add carbohydrate dose to correction dose

Correction dose of Insulin for High Blood Sugar: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, <input type="checkbox"/> Regular <input type="checkbox"/> Humalog <input type="checkbox"/> Novolog Time to be given _____	
Time to be given: _____	
Determine dose per sliding scale below:	Use formula
Blood sugar: _____ Insulin Dose: _____	Blood Glucose -
Blood sugar: _____ Insulin Dose: _____	_____ +
Blood sugar: _____ Insulin Dose: _____	_____ =
Blood sugar: _____ Insulin Dose: _____	units of insulin

OTHER ROUTINE DIABETES MEDICATIONS AT SCHOOL: Yes No

Name of Medication	Dose	Time	Route	Possible Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

EXERCISE, SPORTS, AND FIELD TRIPS:

Blood glucose monitoring and snacks as indicated.
 Easy access to sugar-free liquids, fast-acting carbohydrates, snacks, and blood glucose monitoring equipment.
 Child should not exercise if blood glucose level is below _____ mg/dl OR if _____

MANAGEMENT OF HIGH BLOOD GLUCOSE (over _____ mg/dl)

Usual signs/symptoms for this student:

- Increased thirst, urination, appetite
- Tired/drowsy
- Blurred vision
- Warm, dry, or flushed skin
- Nausea/Vomiting
- Other _____

Indicate treatment choices:

- Sugar-free fluids as tolerated
- Check urine ketones if blood glucose over _____ mg/dl
- Notify parent if urine ketones positive.
- May not need snack: **call parent**
- Frequent bathroom privileges
- See "Insulin Injections: Extra Insulin for High Blood Glucose"
- Other _____

MANAGEMENT OF LOW BLOOD GLUCOSE (below _____ mg/dl)

✓ Usual signs/symptoms for this child

- Change in personality/behavior
- Pallor
- Weak/shaky/tremulous
- Tired/drowsy/fatigued
- Dizzy/staggering walk
- Headache
- Rapid heartbeat
- Nausea/loss of appetite
- Clammy/sweating
- Blurred vision
- Inattention/confusion
- Slurred speech
- Loss of consciousness
- Seizures
- Other _____

Indicate treatment choices:

- If student is awake and able to swallow,**
 give _____ grams fast-acting carbohydrate such as:
- 4oz. Fruit juice or non-diet soda or
 - 3-4 glucose tablets or
 - Concentrated gel or tube frosting or
 - 8 oz. Milk or
 - Other _____

Retest Blood Glucose 10-15minutes after treatment

Repeat treatment until Blood Glucose over 80mg/dl

Follow treatment with snack of _____
 if more than 1 hour till next meal/snack or if going to activity (i.e. P.E. or recess)

Other _____

**If student is vomiting or unable to swallow, administer Glucose gel or Glucagon
 (See below for specific directions)**

IMPORTANT!!

If student is unconscious or having a seizure, presume the student is experiencing a low blood glucose level and:

Call 911 immediately and notify parents / guardian.

Glucagon _____ mg IM (injection) should be given by trained personnel

Glucose gel 1 tube can be administered inside cheek and massaged from outside while waiting for help to arrive, or during administration of Glucagon by any trained staff member at scene.

Student should be turned on his/her side and maintained in this "recovery" position till fully awake.

Comments _____

Physician /Healthcare Provider Signature: _____ Date: _____

Physician/Healthcare Provider Name _____ Phone Number _____

I grant the principal or his/her designee or a licensed nurse (RN/LPN) permission to assist with or perform the administration of each prescribed medication, including insulin either by injection or pump, and treatments/procedures for my child during the school day. This includes when he/she is away from school property for official school events. I have reviewed, understand and agree with the medications/treatments prescribed by the physician/healthcare provider on this form. It is my responsibility to notify the school if there is a change in the medication/treatment plan prior to its expiration date.

Parent/Guardian Signature: _____ Date: _____

LOCATION OF SUPPLIES/EQUIPMENT: To be completed by school health personnel.

Blood glucose testing equipment: _____ Insulin administration supplies: _____

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