THE SCHOOL DISTRICT OF MARTIN COUNTY, FLORIDA

PHYSICIAN AUTHORIZATION FOR DIABETES CARE AND MEDICATION ADMINISTRATION

Name of Student:_____ **Birthdate:** _____

Diagnosis: _____DIABETES_____ **Any known allergies (food or drugs):**_____

MEALS/SNACKS	**Time/Location**	**Food Content and Amount**	**MEALS/SNACKS**	**Time/Location**	**Food Content and Amount**
[ ] Breakfast	_____	_____	[ ] Before PE/activity	_____	_____
[ ] Mid-morning	_____	_____	[ ] After PE/activity	_____	_____
[ ] Lunch	_____	_____			
[ ] Mid-afternoon	_____	_____			

(Parent/guardian to provide and restock needed snacks) [ ] ABOVE AS PER PARENT **

BLOOD GLUCOSE MONITORING: At school: [ ] Yes [ ] No To ordinarily be performed by student: [ ] Yes [ ] No
With supervision: [ ] Yes [ ] No [ ] Before lunch only

Time to be performed: [ ] Arrival at school [ ] Mid-afternoon [ ] Prior to dismissal
[ ] Mid-morning: before snack [ ] Before PE/activity time
[ ] Before lunch [ ] After PE/activity time [ ] As needed for signs/symptoms of low/high blood glucose

Place to be performed: [ ] Clinic/Health Room [ ] Classroom [ ] Other_____

INSULIN INJECTIONS DURING SCHOOL: [ ] Yes [ ] No [ ] Parent/Guardian elects to give insulin needed at school
If yes, can student: Determine correct dose? [ ] Yes [ ] No Draw up correct dose? [ ] Yes [ ] No
Give own injection? [ ] Yes [ ] No Needs supervision? [ ] Yes [ ] No

Insulin Delivery: [ ] Syringe/vial [ ] Pen [ ] Pump

Standard daily insulin at school: [ ] Yes [ ] No

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

Carbohydrate Ratio:
[ ] Calculate insulin dose for carbohydrate intake
Use: [ ] Regular [ ] Humalog [ ] Novolog

[ ] Give _____unit(s) per _____grams of Carbohydrate
[ ] at lunch [ ] with snacks

[ ] Add carbohydrate dose to correction dose
Carbohydrate bolus: [ ] before OR [ ] after food.

*__***Correction Dose of Insulin for High Blood Glucose:***__ [ ] Yes [ ] No
If yes: [ ] Regular [ ] Humalog [ ] Novolog

Time to be given: [ ] before lunch [ ] Other_____

Range for correction factor: If blood sugar greater than_____
**Only give correction bolus if >_____hours from last bolus.

[ ] *Determine dose per sliding scale below:*
Blood sugar:_____ Insulin Dose:_____
Blood sugar:_____ Insulin Dose:_____
Blood sugar:_____ Insulin Dose:_____
Blood sugar:_____ Insulin Dose:_____
Blood sugar:_____ Insulin Dose:_____

[ ] *Use formula:*
(Blood glucose – _____ ÷ _____ = # of units

INSULIN PUMP MANAGEMENT **Pump brand/model**_____ **How long on pump?**_____

[ ] **INDEPENDENT**
This student has been trained to independently perform routine pump management and troubleshoot problems, including but not limited to: With Supervision?

- Giving boluses of insulin for both correction of blood glucose above target range and for food consumption. [ ] Yes [ ] No
- Changing of insulin infusion sets using universal precautions. [ ] Yes [ ] No
- Switching to injections, should there be a pump malfunction. [ ] Yes [ ] No

[ ] **NON-INDEPENDENT** (Child Lock On?) [ ] Yes [ ] No
Because of young age or other factors, this student cannot independently evaluate pump function nor independently change infusion sets. Notify parent for pump/infusion set/infusion site malfunction.

- Insulin for meals and snacks will be given and verified as follows:_____

** *(Parent/guardian will provide extra supplies to include infusion sets, reservoirs, batteries, pump insulin, syringes.)*

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 above.
Easy access to sugar-free liquids, fast-acting carbohydrates, snacks, and blood glucose monitoring equipment.
Child should not exercise if, SYMPTOMATIC; **OR** if_____ mg/dl; **OR** if KETONES ARE MODERATE TO LARGE

_____MD Initials

Student Name:_____
DOB:_____

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/abdominal pain
[ ] Rapid shallow breathing
[ ] Weakness/muscle aches
[ ] Other _____ALL OF THE ABOVE_____

Indicate treatment choices:
[ ] Sugar-free fluids as tolerated
[ ] Check urine ketones if blood glucose over _____mg/dl
[ ] Notify parent if urine ketones: MODERATE TO LARGE
[ ] May not need snack: ***call parent***
[ ] See **"Insulin Injections: Extra Insulin for High Blood Glucose**
[ ] Frequent bathroom privileges
[ ] Stay with student and document changes in status
[ ] Delay exercise IF KETONES ARE MODERATE TO LARGE
[ ] Other_____

MANAGEMENT OF LOW BLOOD GLUCOSE (below _____mg/dl)
Usual signs/symptoms for this student:
[ ] Change in personal behavior/confusion
[ ] Pallor/clammy/sweating
[ ] Weak/shaky/tremulous
[ ] Tired/drowsy/fatigued
[ ] Dizzy/staggering walk
[ ] Headache
[ ] Rapid heartbeat
[ ] Nausea/loss of appetite
[ ] Blurred vision or slurred speech
[ ] Loss of consciousness/seizures
[ ] Other _____ALL OF THE ABOVE____

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
[ ] 8oz. skim milk or
[ ] Other __AS PER PARENT_____
Then:
Retest blood glucose 10-15 minutes after treatment.
Repeat treatment until blood glucose over 70 mg/dl
Follow treatment with snack of COMPLEX CARBOHYDRATE unless going to lunch within 10-15 minutes.
[ ] Other: NOTIFY parents if after two treatments BG remains less than 70.

NOTIFY PARENTS OF THE FOLLOWING CONDITIONS:
a. Loss of consciousness or seizure (convulsion) immediately after 911 called and Glucagon given
b. Blood sugars in excess of _____ mg/dl and Positive urine ketones(MODERATE OR LARGE)
c. Abdominal pain, nausea/vomiting, diarrhea, fever, altered breathing, or altered level of consciousness.

IMPORTANT!!

If student is unconscious or having a seizure, ***C*all 911 immediately, administer Glucagon as ordered below, Notify Parent**

[ ] Glucagon ½ mg or 1mg (circle desired dose) should be given by trained personnel. SC or IM
[ ] Glucose gel or cake icing 1 tube can be administered inside cheek and massaged from outside while awaiting or during administration of Glucagon by staff member at scene.
[ ] Glucagon/Glucose gel could be used if student has documented low blood sugar and is vomiting and unable to swallow.
[ ] If has insulin pump – suspend or disconnect pump. (send pump to hospital with parent/EMS)

***Student should be turned on his/her side until fully awake and alert.*

Physician Authorization for Student with Diabetes

- Student proficient in technique [ ] Yes [ ] No to self-administer the prescribed medication/treatment (insulin, glucose testing meters only) if the school nurse determines it is safe and appropriate.
- The parent knows of this request and has agreed to provide all the supplies needed for the above medication(s).
- Should the student manifest any of the above symptoms that may be caused by the medication, I understand that the parent will be contacted and the school health directives relating to emergency care will be followed.

_____	_____	_____
Physician's Name (Print)	*Physician's Signature*	*Date*
_____	_____	_____
License Number	*Telephone Number*	*Fax Number*

Student Name:_____
DOB:_____

Parent/Guardian Permission

I understand that:

- Medication orders are valid for this school year only and need to be renewed at the beginning of each school year.
- Medication orders will become part of my child's school health record.
- Medication must be in original container and labeled to match physician's order for school use including field trips.
- I have the responsibility for providing medication(s) and supplies as needed.
- I give permission to the school nurse to share information with appropriate school staff relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.
- I give permission to the school nurse to contact the above health care provider for information relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.
- I may retrieve the medication(s) from the school at any time; however the medication(s) will be destroyed if it is not picked up within one week following termination of the order or two days beyond the close of school.

I hereby give permission for my child (named above) to receive medication during school hours administered by the nurse or trained principal designee. I understand the School District and School Health Program undertake no responsibility for the administration of the medication. This medication has been prescribed by a licensed physician. I hereby release the School District and its agent and employees as well as the School Health Program from any and all liability that may result from my child taking the medication(s).

_____ _____ _____
Parent/Guardian's Name (print) *Parent/Guardian's Signature* *Date*

_____ _____ _____ _____
Home Phone *Work Number* *Cellular Number* *Pager Number*

_____ _____
Emergency Contact Name *Relationship*

_____ _____ _____ _____
Home Phone *Work Number* *Cellular Number* *Pager Number*

Principal_____ Date_____

School Nurse_____ Date_____

Trained Principal Designee_____ Date_____

This document follows the guiding principles outlined by the American Diabetes Association

Diabetes Medical Management Plan/Florida Governor's Diabetes Advisory Council