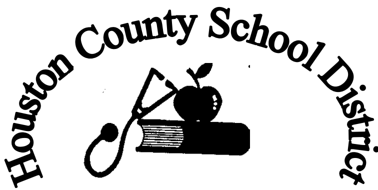

Student Information and Consent for Diabetic Care

Student's Name: ________________________ Student's ID#:__________ Date of Birth: _________School Year:_____

Effective Date: ________School Name: ____________________________ Grade: ________ Homeroom: ___________

CONTACT INFORMATION:

Parent/Guardian #1: ___________________________Cell: ______________________Work: ______________________

Parent/Guardian #2: ___________________________Cell: ______________________Work: ______________________

Diabetes Care Provider: _______________________________________ Phone #: ____________________________

Other Emergency Contact: _____________________________________ Relationship: ________________________

Phone Numbers: Cell: __________________________________ Work:_______________________________________

EMERGENCY NOTIFICATION: Notify parents of the following conditions:

a. Blood sugar less than ______________mg/dl and / or loss of consciousness or seizure.
b. Blood sugars in excess of _______________ mg/dl and / or positive urine ketones.
c. Abdominal pain, nausea/vomiting, altered level of consciousness.

LOCATION OF SUPPLIES/EQUIPMENT: *Parent to provide and restock snacks and low blood sugar supplies box.*

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

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

☐ My child may perform all diabetic care independently. **OR**

☐ My child may perform the following independently (check below as appropriate):

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

Confidential Diabetic Information Release: I understand that all treatments and procedures may be performed by 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: __________________

HEALTH CARE PROVIDER AUTHORIZATION FOR SCHOOL MANAGEMENT OF DIABETES

STUDENT: ____ DOB: ________________ DATE: ______________

BLOOD GLUCOSE MONITORING: (Target range: ________ mg/dl to ____________ mg/dl.)

☐ None required at this time.	☐ Before PE/activity time	☐ 2 Hrs after correction
☐ Before meals	☐ After PE/activity time	☐ PRN for suspected low/high BG
☐ Midmorning	☐ Mid-afternoon	☐ Before Dismissal

INSULIN ADMINISTRATION: Dose changes determined by: ☐ Student ☐ Parent ☐ Strict Sliding Scale

Insulin delivery system: ☐ Syringe ☐ Pen ☐ Pump (Use supplemental form for Student Wearing Insulin Pump)

Insulin Type: ___________________ CHO Insulin Ratio: ________ units per ______________ gms. CHO

☐ Correction Bolus Dose: ***(Check only those which apply)***

- ☐ Use the following formula: BG - ________ / _________
- ☐ Sliding Scale:
  - BG from _______ to ______ = ______ u
  - BG from _______ to ______ = ______ u
  - BG from _______ to ______ = ______ u
  - BG from _______ to ______ = ______ u
  - BG from _______ to ______ = ______ u

- ☐ Decrease correction dose by _____ units or _____% if PE/activity is anticipated < 1 hr after correction dose.
- ☐ Decrease correction dose by _____ units if given following a low blood glucose level.
- ☐ Add CHO bolus to correction bolus for total insulin dose

MANAGEMENT OF LOW BLOOD GLUCOSE: (below ____________ mg/dl)

MILD: BG < ___________

- ☐ Never leave student alone
- ☐ Give 15 gms glucose; recheck in 15 min.
- ☐ If BG < 70, retreat and recheck q 15 min x 3
- ☐ Notify parent if not resolved.
- ☐ Provide snack with CHO, fat, protein after treating and meal not scheduled > 1 hr

SEVERE: Loss of consciousness or seizure

- ☐ Call *911*. Open airway. Turn to side.
- ☐ Glucagon injection ______ mg IM/SQ if unconscious
- ☐ Notify parent.
  (Be prepared for seizure activity)

MANAGEMENT OF HIGH BLOOD GLUCOSE: (Above ____________ mg/dl)

- ☐ Sugar-free fluids/frequent bathroom privileges
- ☐ If BG is greater than _______ , initiate insulin orders
- ☐ If BG is greater than ________, check for ketones. Notify parent if ketones are present.
- ☐ May not need snack.
- ☐ Note and document changes in status.
- ☐ Notify parent per “Emergency Notification” Section.

EXERCISE:
Child should NOT exercise if blood glucose levels are below ____________ mg/dl or above _____________ mg/dl + ketones.
☐ Eat _________ gms. CHO for vigorous exercise ☐ Before ☐ During ☐ After exercise.
☐ Student may disconnect insulin pump for _______ hr. or decrease basal rate by ___________.

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

- ☐ **If changes are indicated, I will provide new written authorized orders (may be faxed).**
- ☐ **Dose/treatment changes may be relayed through parent. (Frequent dose changes may need new orders.)**

Dr. Signature: ____ Date: _______________________

SUPPLEMENTAL INFORMATION FOR STUDENT WEARING AN INSULIN PUMP AT SCHOOL

Student's Name: ______________________________Student ID#: _______ Date of Birth: _________ Pump Brand/Model:_________________
Pump Resource Person: ____________________________ Phone/ Beeper _______________ (See diabetes care plan for parent phone #)
Blood Glucose Target Range: _______________ Pump Insulin: Humalog ☐ Regular ☐
Insulin Correction Factor for Blood Glucose Over Target: _______________________________________
Insulin Carbohydrate Ratios: ____
(Student to receive insulin bolus for carbohydrate intake immediately before / ______ minutes before eating. Circle appropriate interval)
Location of Extra Pump Supplies ____

☐ ***INDEPENDENT MANAGEMENT***

This student has been trained to independently perform routine pump management and to troubleshoot problems including but not limited to:

- Giving boluses of insulin for both correction of blood glucose above target range and for food consumption.
- Changing of insulin infusion sets using universal precautions.
- Switching to injections should there be a pump malfunction.
  Parents will provide extra supplies to include infusion sets, reservoirs, batteries, pump insulin and syringes.

☐ ***NON-INDEPENDENT MANAGEMENT (Child Lock On? Yes ☐ No☐)***

Because of young age or other factors, this student cannot independently evaluate pump function nor independently change infusion sets.

- Insulin for meals and snacks will be given and verified as follows: _______________________
  ____
- Insulin for correction of blood glucose over ________ will be give and verified as follows:
  ____

PARENT NOTIFICATION: (*Refer to basic diabetes care plan and check ✓ all others that apply. Contact the Parent in event of:*

☐ Pump alarms / malfunctions
☐ Corrective measures do not return blood glucose to target range within ___ hrs.
☐ Soreness or redness at site
☐ Student has to change site
☐ Detachment of dressing / infusion set our of place
☐ Leakage of insulin
☐ Student must give insulin injection
☐ Other: ____

MANAGEMENT OF HIGH / VERY HIGH BLOOD GLUCOSE: Refer to previous sections and to basic Diabetes Care Plan

MANAGEMENT OF LOW BLOOD GLUCOSE: *Follow instructions in basic Diabetes Care Plan, but in addition:*

If low blood glucose recurs without explanation, notify parent / diabetes provider for potential instructions to suspend pump.

If seizure or unresponsiveness occurs:

1. Give Glucagon and / or glucose gel (See basic Diabetes Health Plan)
2. CALL ***911***
3. Notify Parent
4. Stop insulin pump by:
   - ☐ Placing in "Suspend" or stop mode
   - ☐ Disconnecting at pigtail or clip
   - ☐ Cutting tubing
5. If pump was removed, send with EMS to hospital.

My signature provides authorization for the above orders. This authorization is valid for one year.

- ☐ **If changes are indicated, I will provide new written authorized orders (may be faxed).**
- ☐ **Dose/treatment changes may be relayed through parent. (Frequent dose changes may need new orders.)**

Dr. Signature: ____ Date: ________________________
Address: ____

☐ **I request that the school nurse provide me with a copy of the School Health Action Plan for this student.**