THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
COORDINATED STUDENT HEALTH SERVICES
Phone 754-321-1575 Fax 754-321-1692

Diabetes Medication/Treatment Authorization Form

Student's Name: _____ Date of Birth: _____ Date: _____

School Name: _____ Grade_____ Homeroom _____

CONTACT INFORMATION

Parent/Guardian #1: _____ Phone Number_____

Parent/Guardian #2: _____ Phone Number_____

Emergency Contact:_____Relationship:_____Phone Number: _____

Physician/Healthcare Providers;_____ Phone Number_____ Fax Number _____

Date of Diagnosis: _____ **Diabetes** ☐ Type 1 ☐ Type 2

BLOOD GLUCOSE MONITORING: At school: ☐ Yes ☐ No Type of Meter: _____

Student has been trained by Healthcare Professional ☐ Yes ☐ No Needs supervision: ☐ Yes ☐ No Independent ☐

Time to be performed:
☐ Before breakfast ☐ Before PE/Activity Time
☐ Mid-morning (before snack) ☐ After PE/Activity Time
☐ Before lunch ☐ Mid-afternoon
☐ Dismissal ☐ Dinner
☐ As needed for signs/symptoms of low/high blood glucose

Place to be performed: ☐ Clinic/Health Room ☐ Classroom ☐ Other **Bus, Field Trips and Day Trips**

CONTINUOUS BLOOD GLUCOSE MONITOR (CGM) ☐ Yes ☐ No Brand/model_____

Alarms set for ☐ High_____☐ Low_____ ☐ Ok to use CGM result for insulin coverage

☐ Recheck CGM result if blood sugar is greater than_____ or less than_____ *Note: **Only confirm CGM results with finger stick if ordered by healthcare provider.*

Target range for blood glucose (if applicable) _____mg/dL to _____mg/dL ☐ N/A

INSULIN ADMINISTRATION DURING SCHOOL: ☐ Yes ☐ No

Student has been trained by Healthcare Professional ☐ Yes ☐ No Needs supervision: ☐ Yes ☐ No Independent ☐ Yes ☐ No

Insulin Delivery: ☐ Syringe/Vial ☐ Pen ☐ Pump (If pump worn, use "Student With Insulin Pump" section")

☐ InPen (student may self-carry) Ok to use InPen for insulin coverage ☐ Yes ☐ No

Standard daily insulin at school: ☐ Yes ☐ No Type:_____ Dose:_____ Time to be given:_____

Mealtime: Insulin/Carbohydrate Ratio + Blood Glucose Correction OR Sliding Scale = Total Insulin dose

Insulin/Carbohydrate Ratio Insulin: ☐ Humalog ☐ Novolog ☐ Apidra ☐ Fiasp ☐ Admelog ☐ Other _____

☐ Breakfast _____ # unit(s) per _____grams of carbohydrates

☐ Lunch_____#unit(s) per _____ grams of carbohydrates

☐ Snacks_____#unit(s) per _____ grams of carbohydrates

☐ Dinner_____ #unit(s) per _____grams of carbohydrates

Ex: 1. **I/CR** is 1 unit of Insulin per 15 grams of carbs. Total meal carbs are 60 grams. 60 ÷ 15= **4 units of Insulin**

2. **Blood Glucose Correction** Ex: 200 - 150 ÷ 50 =1 **unit**

3. ** **Total Insulin Dose is 5 units for the meal** **

Blood Glucose Correction: Blood Glucose Minus_____ Divided By_____ Equals # Unit (s) Of Insulin

Correction dose of Insulin for High Blood Glucose: (*OUTSIDE OF MEALTIMES***)** ■ Yes ☐ No

BLOOD GLUCOSE MINUS _____ DIVIDED BY _____ EQUALS # UNIT(S) OF INSULIN

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OR

Sliding Scale

Blood sugar: _____to_____ Insulin Dose: _____

Blood sugar: _____to_____ Insulin Dose: _____

Blood sugar: _____to_____ Insulin Dose: _____

Blood sugar: _____to_____ Insulin Dose: _____

Insulin correction dose for blood glucose greater than _____mg/dl and at least _____ hours since last insulin dose.

****If a blood sugar correction is administered _____ hour(s) prior to lunch only administer insulin to cover carbohydrates****

If the insulin dose is 0.5 should insulin dose be rounded: ☐Up OR ☐ Down to the nearest whole number?

Example: Insulin calculated dose is 4.5 units should trained personnel round down to 4 or up to 5?

STUDENT WITH INSULIN PUMP

Brand/Model of pump:_____ Type of infusion set:_____

Type of insulin in pump: _____ Basal rates during school: _____

Student to receive insulin bolus for carbohydrate intake _____ prior to mealtime

Student's self-care pump skills:	Independent?	Student's self-care pump skills:	Independent?
Count carbohydrates	☐ Yes ☐ No	Disconnect pump	☐ Yes ☐ No
Bolus correct amount for carbohydrates consumed	☐ Yes ☐ No	Reconnect pump to infusion set	☐ Yes ☐ No
Calculate and administer correction bolus	☐ Yes ☐ No	Prepare reservoir and tubing	☐ Yes ☐ No
Calculate and set a temporary basal rate	☐ Yes ☐ No	Insert infusion set	☐ Yes ☐ No
Change batteries	☐ Yes ☐ No	Troubleshooting alarms and malfunctions	☐ Yes ☐ No

*****For pump failure please refer to insulin administration orders and call parents*****

Comments/Special Instructions:

_____

Please fax log to Dr. _____at Fax:_____at the end of each ☐ weekly ☐monthly**.**

Thank You!

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COORDINATED STUDENT HEALTH SERVICES
Phone 754-321-1575 Fax 754-321-1692
Diabetes Medication/Treatment Revision Form

☐ Dose change ☐Overnight field trips

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

School Name:_____ School Number:_____ School Fax:_____

Parent(s) Name and Contact Information:_____

INSULIN ADMINISTRATION DURING SCHOOL: ☐ Yes ☐ No

Student has been trained by Healthcare Professional ☐ Yes ☐ No Needs supervision: ☐ Yes ☐ No Independent ☐

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

☐ InPen Ok to use InPen for insulin coverage ☐ Yes ☐ No

Standard daily long-acting insulin: ☐ Yes ☐ No Type:_____ Dose:_____ Time to be given:_____

Insulin/Carbohydrate Ratio + Blood Glucose Correction OR sliding scale = Total Insulin dose

Insulin/Carbohydrate ratio: Insulin: ☐ Humalog ☐ Novolog ☐ Apidra ☐ Other _____

☐ Breakfast _____# unit(s) per _____ grams of carbohydrates

☐ Lunch_____#unit(s) per _____ grams of carbohydrates

☐ Snacks_____#unit(s) per _____ grams of carbohydrates

☐ Dinner_____#unit(s) per _____ grams of carbohydrates

Blood Glucose Correction:

BLOOD GLUCOSE MINUS _____ DIVIDED BY _____ EQUALS # UNIT(S) OF INSULIN **OR**

Sliding Scale

Blood sugar: _____ **Insulin Dose:** _____

Blood sugar: _____ **Insulin Dose:** _____

Blood sugar: _____ **Insulin Dose:** _____

Blood sugar: _____ **Insulin Dose:** _____

Correction dose of Insulin for High Blood Glucose: ☐ Yes ☐ No (*****OUTSIDE OF MEAL TIMES*****)

Blood Glucose Correction

BLOOD GLUCOSE MINUS _____ DIVIDED BY _____ EQUALS # UNIT(S) OF INSULIN

Insulin correction dose for blood glucose greater than _____mg/dl and at least _____ hours since last insulin dose.

PHYSICIAN AUTHORIZATION:

_____ _____ _____

Physician's Name (PLEASE PRINT / STAMP) **Signature** **Date**

Address: **Telephone:** **Fax:**

Parent Name: **Parent Signature**: Date

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DIABETES EMERGENCY CARE PLAN

LOW BLOOD SUGAR (HYPOGLYCEMIA)

IF STUDENT EXHIBITS ANY OF THE FOLLOWING:	DO THESE:
Change in personality, behavior Pallor Weak, shaky or dizzy including staggering walk Tired, drowsy or fatigue Headache Rapid heart rate Nausea, vomiting or loss of appetite Clammy or sweating Blurred vision Inattention or confusion Slurred speech Loss of consciousness/seizures	**Check blood glucose level** **If blood glucose level below 70** • Give 15 grams of carbohydrates such as 3-4 glucose tablets, 4 ounces of juice or glucose gel • Recheck blood glucose 15 minutes after treatment • Repeat above treatment if blood glucose has not increased by 15 points • If blood glucose is not above **70 mg** after second treatment **NOTIFY PARENT AND CALL 911 IF STUDENT IS SYMPTOMATIC** • Follow treatment with snack of 15-20 grams of complex carbohydrates **IF** more than 1 hour till next meal/snack or if going to an activity (i.e. P.E. or recess) • Child should not exercise if blood glucose level is **BELOW 70mg/dL**
IF CHILD IS UNCONSCIOUS OR HAVING A SEIZURE	**CALL 911 IMMEDIATELY AND NOTIFY PARENT/GUARDIAN** Glucagon administration by trained personnel only (if ordered and provided by parent): Route: ☐ SQ ☐ IM ☐ Intranasal Dose: ☐ 1/2 mg ☐ 1mg ☐ 3mg **OR** Glucose gel 1 tube may be administered inside cheek and massaged from outside while waiting for help to arrive or during administration of Glucagon **Student should be turned on his/her side and maintained in the "recovery" position until fully awake.**

HIGH BLOOD SUGAR (HYPERGYLCEMIA)

IF STUDENT EXHIBITS ANY OF THE FOLLOWING:	DO THESE:
Increased thirst, urination, appetite **Tired/drowsy** **Blurred vision** **Warm, dry, or flushed skin** **Nausea/Vomiting**	**If blood glucose is between 250 mg/dL and 300mg/dl** • **Drink 8-16 ounces of water as tolerated** • **Administer insulin as ordered** • **Check ketones if ordered** • **Blood sugar should be repeated after 30-60 minutes to ensure downward trend** • **If student Is asymptomatic, contact parent (as requested) and continue to monitor as per healthcare provider orders.** **If blood glucose is above 300 mg/dL ALSO:** • **Check urine ketones (If ketones are present, CALL PARENT IMMEDIATELY)** • **Administer insulin as ordered** • **If student exhibits nausea, vomiting, stomachache, lethargy, or any other abnormal symptoms contact parent/healthcare provider Immediately.** • **If student is asymptomatic and NO ketones are present student may return to class** • **Continue to monitor as per healthcare providers orders**

A copy of this plan will be kept in the school office and copies will be given to the school administrative staff. Teachers will be notified if a student has a plan on file in the office. The following staff members have been trained to deal with an emergency, and initiate the appropriate procedures as described above. See attached sheet for additional names:

1. _____ 2. _____

3._____ 4. _____

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PHYSICIAN AUTHORIZATION:

Student Name :_____ **School Name:**_____

_____ _____ _____

Physician's Name (PLEASE PRINT/STAMP) **Signature** **Date**

Address:_____ **Telephone:**_____

Fax:_____

PARENT/ GUARDIAN PERMISSION: I understand that:

- This *Diabetes Medication/Treatment Authorization Form* is valid for one full year from the date signed by the healthcare provider.
- Any changes in the medication, dosage, or frequency of treatment will require a signed *Diabetes Medication/Treatment Revision Form* to be completed by healthcare provider
- Medications/equipment must be in original container and labeled to match healthcare provider order for use in school
- The parent/guardian is responsible for providing medication(s) and supplies as needed
- The parent will utilize the posted lunch menu to guide meal planning and carbohydrate counting with student

I grant the licensed nurse or health support technician 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 their 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 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:**_____

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