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

a. Loss of consciousness or seizure (convulsion) immediately after Glucagon given and 911 called.
b. Blood sugars in excess of _____mg/dl
c. Positive urine ketones.
d. Abdominal pain, nausea/vomiting, diarrhea, fever, altered breathing, slurred speech, 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
__ Mid-morning (before snack)
__ Before lunch
__ Dismissal
__ Before PE/Activity Time
__ After PE/Activity Time
__ Mid-afternoon
__ 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: __ Yes
No

If yes, __Regular __ Humalog ___Novolog ___Other
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:_____	_____ =

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**_____

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:_____

Fast-acting carbohydrate:_____ Snack Foods: _____

_____

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:** _____