THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
HEALTH EDUCATION SERVICES
Ph: 754-321-2272 Fax: 754-321-2743
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: _____