

AUTHORIZATION FOR DIABETES MANAGEMENT FOR SCHOOL YEAR 2010-2011

Student's Name (Last, First, Middle)	Birth Date	Medicaid #	Grade/Homeroom Teacher	Parent Emergency Phone #
--------------------------------------	------------	------------	------------------------	--------------------------

PART I. STUDENT'S SELF-CARE ASSESSMENT (Provider to complete initially; school nurse will update as needed).

Student's Competency:	Self-Care	Assisted Care	Dependent Care
1. Performs blood glucose monitoring			
2. Determines insulin dosage			
3. Administers insulin			

PART II. TREATMENT PLAN (To Be Completed By Physician).

Diagnosis: Diabetes Mellitus ___ Type 1 ___ Type 2	Procedure: Blood Glucose Monitoring by finger stick Check blood glucose before meals and as needed
---	--

Action Plan for Glucose Levels:

60 mg/dl or below:	Immediately give an emergency snack with simple sugars (e.g. 4 glucose tablets, 1 tube of glucose gel, or 1/3 can of regular soda). Note: Anytime the student becomes unconscious, uncooperative, combative, or cannot take the emergency snack, give Glucagon STAT, call 911 and then call parent. Observe the student for hypoglycemic symptoms (altered mental status, shakiness, sweating or weakness). DO NOT LEAVE THE STUDENT ALONE! Recheck blood glucose in 15 minutes. •If symptoms persist after 15 minutes , give a second emergency snack with simple sugars. •If no symptoms are present after 15 minutes , escort student to front of the line for meal. If it is not mealtime, give a regular snack before allowing the student to return to class.
61-80 mg/dl	Observe the student for symptoms (altered mental status, shakiness, sweating or weakness). •If symptoms are present, immediately give an emergency snack with simple sugars (e.g. 4 glucose tablets, 1 tube of glucose gel, or 1/3 can of regular soda). Recheck blood glucose in 15 minutes. •If no symptoms are present, escort the student to front of the line for meal. If it is not mealtime, give a regular snack before allowing the student to return to class.
81-300 mg/dl	The student should follow his normal routine.
Above 300 w/ Neg - Sm. Ketones	If the student has an insulin dose correction order, then give insulin if it has been 3 hours or greater since the last dose of insulin was given. The student should return to class. Recheck blood glucose and ketones at the next scheduled time or in 3 hours whichever is first. Do not withhold meal or snack if scheduled at this time. Encourage water or other sugar free fluids.
Above 300 w/ Mod - Lg. Ketones	Notify parent. Refer to Authorization for Administration of Medications (Part III) for short acting insulin orders for moderate or large ketones. The student should return to class. Restrict physical activity. Recheck blood glucose and ketones at the next scheduled time or in 3 hours whichever is first. Do not withhold meal or snack if scheduled at this time. Encourage water or other sugar free fluids. Recheck blood glucose and ketones prior to student leaving school. Notify parent if ketones are still present.

PART III. AUTHORIZATION FOR ADMINISTRATION OF MEDICATIONS FOR DIABETES MELLITUS

1. Short Acting Insulin:

Humalog or Novolog/Regular (circle one) **Dosage:** _____
Administration Time: At meals, for special occasion snacks and as needed for correction/Action Plan.
 Note any untoward side effects: Hypoglycemia (Low blood glucose)

For moderate or large ketones:

Give correction factor + _____ units if it has been more than 3 hours since last correction.

2. Insulin Adjustments:

Insulin to Carbohydrate Ratio: From 1 unit of Humalog/Novolog insulin for every _____ grams of carbohydrate to 1 unit for every _____ grams of carbohydrate eaten.

Correction Factor: From 1 unit of Humalog/Novolog insulin for every _____ mg/dl up to 1 unit for every _____ mg/dl above or below blood glucose target of 120 mg/dl.

3. Glucagon:

Dosage: 1 mg. subq.
Time: **STAT** as needed for severe hypoglycemia
Call 911 then parent
 Note any untoward side effects: Nausea, vomiting and elevated blood sugar.

Print Physician/Provider Name	Physician/Provider Address	Phone
-------------------------------	----------------------------	-------

Physician/Provider Signature: _____

Date: _____

PART IV. PARENTAL PERMISSION (To Be Completed By Parent/Guardian). Form is void if this section is incomplete.

I hereby request Escambia County school personnel, or its agents, to assist in Diabetes Management & administration of medications as listed above for my child as prescribed by the doctor. I understand that there is no liability on the part of the school district, its personnel, or agents, including school district and county health department personnel, for civil damages as a result of assisting with these procedures when the person acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances. I hereby authorize the exchange of medical information regarding my child's treatment plan between the physician and school health personnel of this school district and county health department.

If my child is covered by Medicaid and receives health services under an IEP, I consent for the school district to bill Medicaid for these services. I consent for the school district to release and exchange my child's confidential student information to agencies of the State of Florida and to bill Medicaid for these services each time a billable service is provided. This will allow the county public school to receive Medicaid funding for services it provides for my child while in school.

Parent/Guardian Signature: _____ Date: _____