Schertz-Cibolo-Universal City Independent School District
1060 Elbel Rd. • Schertz, TX 78154
Telephone (210) 619-4211 • Facsimile (210) 619-4220

Diabetes Management and Treatment Plan
Physician/Parent Authorization for Diabetes Care

Student**:** _____ Date of Birth: _____ Grade:_____

School: _____ School Nurse: _____ Fax: _____

TO BE COMPLETED BY PHYSICIAN:

1. PROCEDURES: Parent will provide all supplies for procedures

A. Blood Glucose Monitoring

Usual times to check blood glucose _____

Target range for blood glucose is ☐ 70-150 ☐ 70-180 ☐ Other _____

Times to do extra blood glucose checks (*check all that apply*)

☐ before exercise
☐ after exercise
☐ when student exhibits symptoms of hyperglycemia
☐ when student exhibits symptoms of hypoglycemia
☐ other (explain): _____

Can student perform own blood glucose checks? ☐ Yes ☐ No

Exceptions: _____

Type of blood glucose meter student uses: _____

B. Test urine ketones when student is hyperglycemic and/or when student is ill. ☐ Yes ☐ No

2. MEDICATION:

A. Insulin

Usual Lunchtime Dose: To be given subcutaneously within 30 minutes prior to lunchtime

1) Base dose of Humalog®/Novolog®/Regular insulin (circle type of rapid/short-acting insulin used): _____ units plus Insulin Correction Scale; **OR**
2) Flexible dosing using _____ units of insulin per _____ grams of carbohydrate plus Insulin Correction Scale
3) Other insulin at lunch (circle type of intermediate insulin used):
-Intermediate/NPH®/Lente® _____ units **OR**
-Basal/Lantus®/Ultralente® _____ units

B. Oral diabetes medication

- Medication: _____ Dose: _____Time: _____

C. Insulin Correction

1. Parent authorization should be obtained before administering a correction dose for high blood glucose levels. ☐ Yes ☐ No

2. Insulin correction scale

_____ units if blood glucose is _____ to _____ mg/dl

_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl

3. Can this student give their own injections? ☐ Yes ☐ No
4. Can this student determine the correct amount of insulin? ☐ Yes ☐ No
5. Can this student draw the correct dose of insulin using the proper technique? ☐ Yes ☐ No

D. Parent/family has been instructed in diabetes self-management.
Parent/family is authorized _____ / is not authorized _____ to adjust pre- lunch insulin dose by up to 10% every 4-5 days as indicated by blood glucose trends.
Parent will communicate changes to campus nurse.

3. Meals and Snacks Eaten at School

A. Is student able to calculate carbohydrates and insulin correction independently? ☐ Yes ☐ No

B.

Meal/Snack	**Time**	**Carbohydrates**
Breakfast	_____	_____
Mid-morning snack	_____	_____
Lunch	_____	_____
Mid-afternoon snack/ After school snack	_____	_____

C. Other times to give snacks: _____
-Content and amount: _____

4. GUIDELINES FOR RESPONDING TO BLOOD GLUCOSE TEST RESULTS

A. Hypoglycemia: Low blood sugar
Signs include pale skin, trembling/shaking, sweating, weakness, dizziness, lethargy, confusion, sleepiness, seizures, and coma.

If blood glucose is BELOW _____ mg/dl and student is alert and oriented:

1.) Give student 15 grams of carbohydrates (6 lifesavers, 4 ounces of orange juice, 6 ounces of regular soda, 3-4 glucose tabs). **DO NOT GIVE ANYTHING BY MOUTH IF STUDENT IS UNABLE TO SWALLOW.**
2.) Observe student for 10-15 minutes and retest glucose.
3.) If glucose is above _____mg/dl, student may proceed with scheduled meal, class, or snack.
4.) If signs persist or if blood glucose remains below _____mg/dl, repeat steps 1 and 2.
5.) If signs continue to persist, notify parent/family and keep student in clinic.

If blood glucose is BELOW _____mg/dl and the student is unconscious or seizing:

1.) Call EMS immediately
2.) Rub small amount of glucose get (or cake frosting) on child's gums and oral mucosa.
3.) If available, inject Glucagon _____mg. SQ.
4.) Notify parent/family.

B. **Hyperglycemia:** High blood sugar

Signs include increased frequency of urination, excessive thirst, headache, difficulty concentrating, and positive urinary ketones.

If blood glucose is OVER _____mg/dl.

1.) If within 30 minutes prior to lunch, administer correction dose of insulin per student's Insulin Correction Scale.

2.) Check urine for ketones when blood glucose is above _____mg/dl.

If ketones are negative or small:

- Encourage water until ketones are negative.

If ketones are moderate or large:

- Student should remain in clinic for monitoring
- Contact parent/family
- Student should drink 1-2 glasses of water every hour while waiting for parent
- If student remains at school, retest glucose and ketones every 2 hours or until ketones are negative.

3.) Student should not participate in PE or other exercise if blood glucose is above 250mg/dl and ketones are present.

4.) If student develops nausea/vomiting, rapid breathing, and/or fruity odor to the breath, call 911 and the parents

5. FOR DIABETIC SELF-CARE ONLY

- Does this student have physician permission to provide self-care? ☐ Yes ☐ No
- This student has been provided instruction/supervision in recognizing signs/symptoms of hypoglycemia and is capable of doing self-glucose monitoring and his/her own insulin injections/insulin pump care, including using universal precautions and proper disposal of sharps? ☐ Yes ☐ No
- This student requires the **supervision** of a designated adult ☐ Yes ☐ No
- This student requires the **assistance** of a designated adult ☐ Yes ☐ No

6. SIGNATURES

Physician signature _____ Date _____

Clinic/Office _____ Phone _____ Fax _____

Nurse or Certified Diabetes Educator: Name _____ Phone _____

Clinical Dietician: Name _____ Phone _____

TO BE COMPLETED BY THE PARENT:

We (I) the undersigned, the parents/guardians of _____ request that the above Diabetes Management and Treatment Plan be implemented for our (my) child. Delivery of this form to the school nurse constitutes my participation in developing the plan, and is my consent to implement this plan. I will notify the school immediately if there are any changes in my child's health, treatment plan, physician's or emergency contact information. Information concerning my child's diabetes management may be shared with/obtained from the diabetes health care providers and school staff who may need to know.

Signature _____Relationship _____

Date _____ Phone (Hm) _____ (Wk) _____

FOR DIABETIC SELF-CARE ONLY

Does this student have physician permission to provide self-care? YES _____ NO _____

This student has been provided instruction/supervision in recognizing signs/symptoms of hypoglycemia and is capable of doing self-glucose monitoring and his/her own insulin injections/insulin pump care, including using universal precautions and proper disposal of sharps? YES _____ NO _____

This student requires the **supervision** of a designated adult _____
This student requires the **assistance** of a designated adult _____

GUIDELINES FOR RESPONDING TO BLOOD GLUCOSE TEST RESULTS

1. If glucose is BELOW _____: (hypoglycemia or low blood sugar)

A. Give child 15 grams carbohydrate, i.e.:

6 lifesavers	6 ounces of regular soda
4 ounces of juice	3 – 4 glucose tabs

B. Allow child to rest for 10 – 15 minutes, and retest glucose.
C. If glucose is above _____, allow student to proceed with scheduled meal, class or snack.
D. If symptoms persist (or blood glucose remains below _____), repeat A and B.
E. If symptoms still persist, notify parent and keep child in clinic.

20. **If blood glucose is BELOW _____ and child is unconscious or seizing:**

A. Call emergency medical services.
B. Rub a small amount of glucose gel (or cake frosting) on child's gums and oral mucosa.
C. If available, inject Glucagon _____ mg. SQ.
D. Notify parent.

21. **If blood glucose is FROM _____ to _____:** Follow usual meal plan and activities (unless otherwise directed by insulin correction scale for insulin administration)

22. **If blood glucose is OVER** _____:

B. If within 30 minutes prior to lunch, nurse or unlicensed diabetes care assistant to be called if student unable to administer correction dose of insulin per student's sliding scale order.
B. Student checks urine ketones.

If Ketones are negative or small:

- Encourage water until ketones are negative.

If Ketones are moderate or large:

- Student should remain in clinic for monitoring.
- Notify parent for pick up.
- Give 1-2 glasses of water every hour.
- If student remains at school, retest glucose and ketones every 2-3 hours or until ketones are negative.

B. Student not to participate in PE or other forms of exercise if blood sugar is above 250 and ketones are present.
B. If student develops nausea/vomiting, rapid breathing, and /or fruity odor to the breath, call 911, the nurse and the parents.

Physician signature _____ Date _____

Clinic/facility _____ Phone _____ Fax _____

Nurse or Certified Diabetes Educator: Name _____Phone _____

Clinical Dietician: Name _____Phone_____

TO BE COMPLETED BY THE PARENT:

We (I) the undersigned, the parents/guardians of _____ request that the above Diabetes Management and Treatment Plan be implemented for our (my) child. Delivery of this form to the school nurse constitutes my participation in developing this Plan, and is my consent to implement this Plan. I will notify the school immediately if the health status of my child changes, if I change physicians or emergency contact information, or if the procedure is canceled or changes in any way. Information concerning my child's diabetes health management may be shared with/obtained from the diabetes health care providers.

Signature _____Relationship_____

Date _____Phone (Hm)_____(Wk)_____