



Schertz-Cibolo-Universal City Independent School District
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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 (Most insulin expires within 30 days**)**

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):

-Basal/Lantus®//Levemir® _____ units

-Other type of insulin _____ / _____ 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 15-20 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 the student is unconscious or seizing:

- 1.) If available, inject Glucagon _____ mg. SQ
- 2.) Call EMS immediately
- 3.) 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
 - Give correction injection every 3 hours if needed
 - 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) _____