



Diabetes Management and Treatment Plan

Physician/Parent Authorization for Diabetes Care

Student: _____ Date of Birth: _____ Grade: _____

School: _____ Nurse: _____ Fax Number: _____

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. Yes No

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 nurse on campus.

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/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 gel 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 ketenes 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

1) Does this student have physician permission to provide self-care? Yes No

2) This student has been provided instruction/supervision in recognizing signs/symptoms of hypoglycemia and can do self-glucose monitoring and his/her own insulin injections/insulin pump care, including using universal precautions and proper disposal of sharps. Yes No

3) This student requires the supervision of a designated adult. Yes No

4) This student requires the assistance of a designated adult. Yes No

6. SIGNATURES

Physician's Signature _____ Date _____

Clinic/Office _____ Phone _____ Fax _____

TO BE COMPLETED BY THE PARENT(S)/GUARDIAN(S)

I (We) the undersigned, the parent(s)/guardian(s) of _____ request that the above Diabetes Management and Treatment Plan be implemented for my (our) child. Delivery of this form to the school nurse constitutes my participation in developing the plan, and my consent to implement this plan. I will notify the school immediately if there are any changes in my child's health, treatment plan, physicians, 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.

I authorize an Unlicensed Diabetic Care Assistant (UDCA) to provide diabetes management and care services to my child at school. I understand that an UDCA is immune from liability for civil damages under section 22.0511 of the Texas Education Code.

I DO NOT authorize an UDCA to provide diabetes management and care services to my child at school.

SIGNATURE _____ DATE _____ PHONE _____