Lubbock Independent School District

Diabetes Management &Treatment Plan

*** Physician/Parent Authorization for Diabetes Care**

(Must be completed at beginning of the school year or at the time of enrollment/diagnosis)

EFFECTIVE PLAN DATE: ___________STUDENT: _____________________________________ DOB: _____________

CAMPUS: _________________ TEACHER: _____________________________ GRADE/ROOM: __________________

A. TO BE COMPLETED BY PHYSICIAN:

BLOOD GLUCOSE MONITORING

Target range for blood glucose at school: ________________mg/dl to ___________________mg/dl.

Times for testing (check all that apply for this student):

____no glucose testing at school ____for suspected hypoglycemia ____for suspected hyperglycemia
____before am snack ____before lunch ____2 hours after lunch
____before exercise ____after exercise ____other-please explain ____________

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 **OR** 6 ounces of regular soda **OR** 4 ounces of juice **OR** 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.

2. **If blood glucose is BELOW _________ and the 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.

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

4. **If blood glucose is OVER_____________:**
   A. 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 orders.
   B. Student checks urine ketones.
      <u>If Ketones are negative or small</u>
      - Encourage water until ketones are negative.

      <u>If Ketones are moderate or large:</u>
      - 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

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

Insulin/Medication Administration

Brand Name and Type: ___________________________ ☐ administered at home only ☐ administered at home and at school

Administration Times: (check all that apply and specify time)
____AM (breakfast) ____AM Snack ____Lunch ____PM Snack ____Other Times __________

Insulin Administered Via: ____Syringe and Vial ____Insulin Pump **(please attach pump guidelines)** ____Insulin Pen
____Other: __________

Lubbock Independent School District

Insulin Dose Determined By: (check all that apply)

Food/Bolus Dose:

____Standard Lunchtime Dose: _______________

____Insulin to Carbohydrate Ratio: __________# unit(s) insulin per ________________grams Carbohydrate

____Correction Calculation (complete only those that apply):
- Give _________ unit(s) for every _____________mg/dl above _________ mg/dl
- Decrease correction by _______% unit(s) if PE or increased activity is anticipated after correction dose, or last dose was given less than 2 hours before

OR

____Written insulin sliding scale as follows: (Complete the following or attach sliding scale orders)
- ______ blood glucose from ______ to ______ = ______ unit(s)
- ______ blood glucose from ______ to ______ = ______ unit(s)
- ______ blood glucose from ______ to ______ = ______ unit(s)
- ______ blood glucose from ______ to ______ = ______ unit(s)
- ______ blood glucose from ______ to ______ = ______ unit(s)

____Add carbohydrate calculation insulin dose and correction calculation for total insulin dose/bolus

Meal Plan

Meals and Snacks Eaten at School: (check all that apply and specify time) **A source of glucose should always be readily available**

	Time	Food Content/Amount:		
____Breakfast	_______	___________________________	☐ Mandatory	☐ At student's discretion
____AM Snack	_______	___________________________	☐ Mandatory	☐ At student's discretion
____Lunch	_______	___________________________	☐ Mandatory	☐ At student's discretion
____PM Snack	_______	___________________________	☐ Mandatory	☐ At student's discretion

Other times to give snacks and content/amount: ____

Foods to avoid, if any:____

Exercise and Sports (check all that apply)

____A snack such as ____________________________should be readily available at the site of exercise or sports
____No exercise if most recent blood glucose is < 70 (or _____________ mg/dl)
____Eat _____ grams Carbs for vigorous exercise: ____ before _____ every 30 minutes _____after
____No exercise when blood glucose is > ____________ mg/dl or ketones are present

Restrictions on activity, if any: ____

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

I authorize the Diabetes Management and Treatment Plan as specified above for this student:

Physician Printed Name: ______________________________________ Signature: ______________________________

Date: _____________________ Office Phone: ____________________________FAX: ____________________________

B. To Be Completed By The Parent:

I request that the above Diabetes Management and Treatment Plan be implemented for 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 cancelled or changes in any way. Information concerning my child's diabetes health management may be shared with/obtained from the physician indicated above.

Printed Name: ____________________________Signature: ________________________Relationship: _______________

Date _______________ Phone:(Hm) ______________________(Wk) ______________________(Cell) _______________