Atlanta Independent School District

Diabetes Management and Treatment Plan

PHYSICIAN/PARENT AUTHORIZATION FOR DIABETIC CARE

STUDENT: _____ **DATE OF BIRTH:** _____

TO BE COMPLETED BY PHYSICIAN:

Please respond to the following questions based on your records and knowledge of the student.

1. PROCEDURES (Parent must provide supplies for all procedures)

☐ Test blood glucose before lunch and as needed for signs/symptoms of hypoglycemia.

☐ Test urine ketones when blood glucose is hyperglycemic, and/or when student is ill.

☐ This student has an insulin pump. (ATTACH PUMP GUIDELINES)

2. MEDICATIONS

Assistance Required (indicate one)

☐ Student **does not need assistance** with preparation and administration of insulin injections.
☐ Student **needs assistance** with preparation and administration of insulin injections.

Rapid Action Insulin, specify kind:_____, given subcutaneously prior to lunchtime (within 30 minutes prior to lunch) based on the following guidelines:

☐ Fixed dose: _____ units plus insulin correction scale; *OR*

☐ Insulin to Carbohydrate Ratio; 1 unit insulin per _____ grams of carbohydrate plus insulin correction scale

☐ **Insulin Correction Scale**

Blood glucose below _____=no additional insulin
Blood glucose from _____ to _____= _____unit(s) insulin
Blood glucose from _____ to _____= _____unit(s) insulin
Blood glucose from _____ to _____= _____unit(s) insulin
Blood glucose from _____ to _____= _____unit(s) insulin

Notify parent if blood glucose is over _____

☐ Other, specify, _____

☐ Parent **may** adjust pre-lunch insulin dosage by up to 10% every 4 or 5 days as indicated by glucose trends.

Oral diabetes medication: _____ Dose _____ Time _____

☐ Student is to eat lunch following pre-lunch blood test and required medication.

☐ Parent will communicate changes to school nurse.

3. Meal Plan

Breakfast _____grams at _____ (time)
Mid AM snack _____grams at _____(time)
Lunch _____grams at _____ (time)
Mid PM snack _____grams at _____(time)

4. Precautions

A. Hypoglycemia: Signs of hypoglycemia include trembling, sweating, shaking, pale, weak, dizzy, sleepy, lethargic, confusion, coma, or seizures

B. Hyperglycemia: Signs include frequency of urination, excessive thirst and positive urinary ketones.

5. Guidelines for Responding to Blood Glucose Test Results

If glucose is BELOW _____:

A. Give the child 15 grams of carbohydrate (but NO CHOCOLATE), i.e.:
    a. 4 ounces of juice
    b. 1 cup of milk
    c. 4 ounces of regular soda
    d. 4 hard candies
    e. 4 glucose tabs
B. Allow the 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 and repeat A and B.

If blood glucose is BELOW _____ and the child is unconscious or having a seizure:

A. Call 911 [or 9-911]
B. Rub a small amount of glucose gel (or cake frosting) on student's gums and oral mucosa.
C. If available, inject Glucagon _____mg SQ
D. Notify parent

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

If blood glucose is OVER _____;

A. If within 30 minutes prior to lunch, the nurse or unlicensed diabetes care assistant is to be called if student unable to administer correction dose of insulin per student's sliding scale orders.
B. Student checks urine ketones
    a. IF ketones are negative or small encourage student to drink water until ketones are negative
    b. If ketones are moderate or large
        i. Student must remain in clinic for monitoring
        ii. Notify parent for pick up
        iii. Give 8-16 ounces of water every hour
        iv. 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 glucose is above _____ and/or ketones are present.
D. If student develops nausea/vomiting, rapid breathing, and/or fruity odor to the breath, call 911, the nurse and the parent.

FOR DIABETIC SELF-CARE ONLY

____ This student has physician permission to provide self-care.

____ 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

____ This student requires the **supervision** of a designated adult

____ This student requires the **assistance** of a designated adult

Physician Signature **Clinic/facility**

Phone **Fax**

Diabetes Nurse Educator Name Phone Fax

Clinical Dietitian Name Phone Fax

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. Deliver 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 (Home) Phone (Work)