FREDERICK COUNTY PUBLIC SCHOOLS/FREDERICK COUNTY HEALTH DEPARTMENT

# MEDICAL AUTHORIZATION FORM FOR DIABETIC MANAGEMENT

**This order is valid only for the Current School Year_____(Including summer session)**

| Student: | Date of Birth: |
|---|---|
| School: | Grade: |

## BLOOD GLUCOSE (BG) MONITORING

| | |
|---|---|
| Target for blood glucose at school: _____ | Check Glucose: □Before snacks □Before meals<br>□ ____ hours after lunch □ ____ hours after a correction dose<br>□ As needed for symptoms of hypo/hyperglycemia □ With signs and symptoms of illness<br>□ Other times: |
| **Hypoglycemia** = blood glucose less than: _____ | □ Self treatment for mild lows. □ Suspend pump for severe hypoglycemia for _____min.<br>□Give _____ grams of fast-acting carbohydrate according to care plan. Recheck BG in 10-15 mins.<br>□ Repeat treatment if BG less than _____mg/dl<br>□ Provide extra protein & carbohydrate snack after treating low if next meal/snack greater than_____minutes away. |
| **If student is unconscious, seizing or unable to swallow, call 911 and notify parent.** | □ **Glucagon injection (1 mg in 1 cc) _____mg, subcutaneously (SQ) or intramuscular (IM)**<br>□ **OK to use glucose gel inside cheek, even if unconscious, seizing.**<br>□ **Other:** |
| **Hyperglycemia** = blood glucose greater than: _____ | □ Check urine ketones, follow emergency care plan, and administer insulin as per orders.<br>□ Encourage sugar free fluids, at least _____ounces per_____.<br>□ For pumps, insulin may be given by syringe or pen if needed and follow insulin orders below.<br>□ If student complains of nausea, vomiting or abdominal pain; follow urine ketones and insulin orders below.<br>□ Other _____ |

## INSULIN ORDERS

**(Complete Only if Insulin is Needed at School)**

**Insulin Administration Via:**

□ Syringe and vial □ Insulin pen □ Insulin pump: Type of pump_____Basal rates_____

□ Other:

*Give Insulin As Indicated Below:*

Name of Insulin: _____

□ Routine lunchtime dose: _____ □ Routine breakfast dose: _____

□ Per sliding scale as follows:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Blood Glucose** | | **To** | | **Give** | | **Units** | **Additional/Alternative Calculations** |
| **Blood Glucose** | | **To** | | **Give** | | **Units** | |
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□ Calculated insulin dose (add carbohydrate coverage and correction dose for total insulin dose):
Carbohydrate Coverage: Insulin to carbohydrate ratio Give _____# unit(s) insulin per _____gms carbohydrates
□ Correction: Give _____# unit(s) insulin per _____mg/dl of glucose above _____mg/dl
Subtract_____# unit(s) for every _____mg/dl of glucose below_____mg/dl
□ 1-2 units insulin may be added/subtracted at parent/student discretion

**Other times insulin may be given:**

□ Routine Snack: □ Dose:_____ □ Calculated on sliding scale above
□ Ketones: If ketones are _____ give _____ unit(s)
□ Hyperglycemia: □ If blood glucose is greater than _____ give _____ units of insulin
**OR** □ Use sliding scale above **OR** □ Use correction formula above

## MISCELLANEOUS INSTRUCTIONS

**Meal Plan**
☐ AM snack, time: _____ ☐PM snack, time: _____ ☐ Avoid snack if blood glucose greater than _____mg/dl.
☐Lunch: _____ ☐ Extra food allowed ☐Parent's discretion ☐ Student's discretion

**Exercise (check and/or complete all that apply)**
Fast-acting carbohydrate source must be available before, during and after all exercise.
☐ With student ☐With Teacher
If most recent blood glucose is less than _____, exercise can occur when blood glucose is corrected and above _____.
☐Eat _____ grams of carbohydrate ☐Before ☐Every 30 minutes during ☐After vigorous exercise
Avoid exercise when blood glucose is greater than _____ or ketones are _____.

**Bus Transportation**
☐Blood glucose monitoring not required prior to boarding bus ☐Check blood glucose 15 minutes prior to boarding bus
☐Allow student to eat on bus if having symptoms of low blood glucose
☐Provide care as follows:_____

**Health Care Provider Assessment / Student's Independent Self-Care**
Student can self-perform the following procedures (school nurse and parent must verify competency):
☐Blood glucose monitoring ☐Measuring insulin ☐Injecting insulin ☐Determining insulin dose
☐Independently operating insulin pump ☐Other:_____

**Disaster Plan (if needed for lockdown, 24 hr shelter in place)**
☐Additional insulin orders as follows:_____
☐Administer long acting insulin as follows: _____
☐Other: _____

**Other Instructions:**

## HEALTH CARE PROVIDER AUTHORIZATION

Health Care Provider's Name/Title: (Type or Print)

| Telephone: | Fax: | Use for Health Care Provider's Address Stamp |
|---|---|---|
| Address: | | |
| Health Care Provider's Signature: | Date: | |

## *PARENT/GUARDIAN AUTHORIZATION*

I request designated staff to administer the medication/treatment as prescribed by the health care provider above. I certify that I have legal authority to consent to the administration of medication/treatment at school.

| Parent/Guardian Signature: | Date: |
|---|---|
| Parent/Guardian Phone: | Work Phone: |
| Order reviewed and signed by school registered nurse: | Date: |