MANAGEMENT PLAN FOR STUDENTS WITH DIABETES
Parent Consent and Physician Authorization

POWAY UNIFIED SCHOOL DISTRICT HEALTH SERVICES
15250 Avenue of Science, San Diego, CA 92128

Dear Parent/Guardian and Physician of _____

California Education Code, Section: 49423.5 allows specialized health care services such as a Diabetes Management Plan to be performed by trained designated school staff under indirect supervision of a Credentialed School Nurse.

Diabetic management at school is provided only after the parent and physician complete specific instructions for the current school year.

1. Please complete and sign the attached Diabetic Management Plan and return to the Health Technician at your child's school.
2. Standardized procedures for diabetic management: blood glucose testing, treatment procedures for high and low blood glucose levels, emergency treatment for moderate and severe low blood glucose levels, are available on the PUSD Health Services website at www.powayusd.com\Depts\LSS\Health.
3. Diabetic management for your child/patient will begin ***after*** completed paperwork has been received. All supplies are provided by the parent/guardian. Please notify the Resource Nurse of change in student health and/or change to physician's orders.
4. Parents may instruct their child in insulin dosage changes provided the child is self-administering insulin. If a licensed nurse is administering insulin, physician orders are required.
5. Use of CGM at School: Students may wear CGM devices at school. School staff are not required to continually monitor CGM readings. Parents are responsible for entering calibrations. Students and/or staff will respond to audible alarms which are set by parents based on Physician recommendations.
6. Parent may provide a three-day supply of food/insulin to be kept at school in case of emergency/disaster. Please complete Parent and Physician Authorization for insulin dose during disaster, including parent and physician signature.
7. If you feel your child requires additional assistance during the school day that is not covered in this Diabetic Management Plan, please refer to the Annual Notification of Parents'/Students' Rights. A copy can be found on the PUSD website ***or*** at your child's school site.

Thank you for your assistance. Please call a Resource Nurse at Health Services if you have questions.

I request that this Specialized Physical Health Care service for Management of Diabetes be administered to my child and authorization be given to the Resource Nurse to communicate with the physician when necessary. I also understand that if my child requires nursing support with insulin administration, a PUSD or contracted agency nurse will be available.

PARENT/GUARDIAN SIGNATURE_____ Date _____

Expiration date:
Glucagon:

Physician Authorization

For Management of Diabetes at School and School Sponsored Events

Name:	DOB:	School:	Grade:
Mother	Home#	Work#	Alt.#
Father	Home#	Work#	Alt.#

PHYSICIAN'S WRITTEN AUTHORIZATION: PLEASE CHECK ALL THAT APPLY

1. Blood Glucose testing:
☐Before Meals ☐ As needed
☐By student independently ☐Needs Assistance/Monitoring
☐Adult verifies results

2. Continuous Glucose Monitor:
☐Yes ☐No
Brand/Model:_____
Alarm set for:
Low:_____ High:_____

3. Snacks:
☐None ☐Before exercise
☐Morning ☐After exercise
☐Afternoon ☐Independent
☐Needs verification

4. Treat low blood sugar below as follows:
☐Standardized algorithm attached
☐Modified

5. Emergency care of severe hypoglycemia (low blood sugar)
Glucose gel per standardized procedure:
☐Conscious ☐Unconscious
Glucagon Injection per procedure **when unconscious**:
☐0.5 mg. ☐1 mg.

6. Treat high blood sugar above as follows:
☐Standardized algorithm attached
☐Modified
☐Check Ketones if blood sugar greater than _____

7. If Insulin needed at school:
Type of Insulin: _____
Insulin delivery by:
☐Insulin pen ☐Insulin pump
☐Insulin and syringes ☐Inhaler
☐Pre-filled syringes (labeled per dose)
Give Insulin at:
☐Lunch ☐As needed
Written sliding scale as follows:
Blood Glucose from _____to_____=_____Units
Blood Glucose from _____to_____=_____Units
Blood Glucose from _____to_____=_____Units
Blood Glucose from _____to_____=_____Units

Carbohydrate Counting:
☐Yes ☐No
_____# units per _____gms carb

Number of SQ Insulin Units Determined by:
☐Student ☐Licensed nurse
☐Parent ☐Parent Designee*

SQ Insulin Dose Prepared and Administered by:
☐Student ☐Parent/Parent Designee*
☐Licensed nurse: PUSD nurse/Agency nurse
☐Student with staff verification of dose (insulin pen, pump, or pre-filled syringe labeled with dose)
☐Parent may verbally decrease # of units of insulin

The Health Technician must be Notified Two Weeks Before the Field Trip/Other Activity to plan for Qualified Personnel to Provide Procedure

7. Field Trip:
All diabetic supplies are taken and care is provided according to this Diabetic Plan (a copy is taken on trip). Student will have Blood Glucose checked ***before*** departing campus. If 70 or less, care will be provided per Procedure For Mild to Moderate Low Blood Glucose; parent will be called if not resolved.

8. Classroom/School party, food will be handled as follows:
☐Student will eat the treat
☐Replace with parent supplied alternative
☐Put in baggie and take home

9. Physical Education/Exercise:
☐None if Blood Glucose test results are:
below _____mg/dl
or
above _____mb/dl

* A parent designee is authorized by the parent and is not an employee of the school district.

My Signature below provides authorization for the above written orders. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization.

It is my professional opinion that this student be allowed to carry and administer such medications by himself/herself. _____ (PHYSICIAN INITIALS)

PHYSICIAN SIGNATURE_____ DATE _____

PHONE #_____ FAX # _____

Student's Name:
School:
Parent/Guardian Phone:

Blood Glucose Testing

Algorithms for Blood Glucose Testing Results

***Desired Blood Glucose range may vary from student to student.**

Check Blood Glucose

Below: _____	From: _____ To: _____	Above:_____

Check Ketones (if ordered)

1. Give fast acting sugar source*. 2. Observe for 10 minutes 3. Retest blood glucose, if less than _____* repeat sugar source. If over _____ give carbohydrate and protein snack (e.g. crackers and cheese) or if within one hour to next meal feed early. 4. Notify Parent and Resource Nurse if two or more episodes in one week. **If Student Becomes Unconscious or is Unable to Swallow:** 1. Call 911. 2. Turn student on side to ensure open airway. 3. Give glucose gel and Glucagon if ordered. 4. Notify parent and Resource Nurse. **5. If unconscious and having a seizure, administer glucagon only, if ordered.**	1. If student feels OK, may resume school activities. 2. If the student does not feel OK, retest blood glucose immediately. • If glucose< _____, then follow instructions on left. • If glucose> _____, then contact parent for instructions.	**Student Feels OK – Ketones Neg. – Sm.** 1. Give 1-2 glasses of water every hour. 2. Give insulin/exercise if ordered per Diabetic Plan. 3. Notify parent if small ketones are present. 4. Notify parent and Resource Nurse if two or more episodes occur in one week.	**Student Does Not feel OK – Ketones Mod. – Large** 1. Consult immediately with Resource Nurse and notify parent to pick up child. 2. Provide –2 glasses of water every hour until parent/guardian arrives. **If at any time student vomits, is confused, and/or has labored breathing or coma CALL 911**

***Fast Acting Sugar**	
• 15 gm. glucose tablets • 15 gm. glucose gel • 1/3 c. sugared soda • ___c. orange juice	• ___c. apple juice • ___c. grape juice • ___ tube cake mate gel • 3 tsp. Sugar (in water)

To Physician:

Please make desired modifications to the standard procedure above and insert numbers of personal algorithms for this child in the boxes provided.

Please list any additional needs or special considerations for this child.

_____

_____

_____

_____**PHYSICIAN INITIALS**_____

Parent Consent and Physician Authorization for Self Administered Insulin Dose during a Disaster (Optional)

Student: _____ DOB: _____ Date: _____

RECOMMENDATIONS

- If insulin is available but there is a limited food supply then decrease their usual dose of NPH, Lente or Ultralente by 20% - 30% for breakfast and evening (dinner or bedtime). Regular or Humalog should not be given*. If the food supply meets the needs of the student's regular meal plan, decrease the NPH, Lente or Ultralente for breakfast and evening (dinner or bedtime) by 10% and decrease the Regular or Humalog before breakfast and before breakfast and before evening meal by 25%.
- Rationale: hypoglycemia will be less likely to occur with these lower insulin does and mild hyperglycemia for one to three days in acceptable.

Insulin Brand Name and Type(s): _____

	Time of Day	Units of NPH, Lente, or Ultralente ↓20-30%	↓10%	Units of Regular or Humalog Omit	↓25%	Dose Administered via:
Breakfast						Prefilled Syringe:
Lunch						Insulin Pen:
Dinner						Syringe:
Bedtime						Insulin Pump:

OR use the sliding scales below:

Breakfast
Blood Glucose from _____to_____=_____units of _____insulin (type)
Blood Glucose from _____to_____=_____units of _____insulin (type)
Blood Glucose from _____to_____=_____units of _____insulin (type)
Blood Glucose from _____to_____=_____units of _____insulin (type)

Lunch
Blood Glucose from _____to_____=_____units of _____insulin (type)
Blood Glucose from _____to_____=_____units of _____insulin (type)
Blood Glucose from _____to_____=_____units of _____insulin (type)
Blood Glucose from _____to_____=_____units of _____insulin (type)

Dinner
Blood Glucose from _____to_____=_____units of _____insulin (type)
Blood Glucose from _____to_____=_____units of _____insulin (type)
Blood Glucose from _____to_____=_____units of _____insulin (type)
Blood Glucose from _____to_____=_____units of _____insulin (type)

Bedtime
Blood Glucose from _____to_____=_____units of _____insulin (type)
Blood Glucose from _____to_____=_____units of _____insulin (type)
Blood Glucose from _____to_____=_____units of _____insulin (type)
Blood Glucose from _____to_____=_____units of _____insulin (type)

3 Day Disaster Diabetes Supplies

☐ Vial of insulin: 6 syringes
☐ Insulin pen with cartridge and needles
☐ Blood glucose testing kit (testing strips lancing devise w/lancets)
☐ Glucose gel product and glucose tablets
☐ Glucagon kit
☐ Food supply (include daily meal plan) stored as follows:
_____
☐ Ketone strips/plastic cup

School will include a copy of the Diabetes Management Plan with the Disaster Supplies. Stored as follows:
_____
Other Supplies (Specify):
_____
_____

PHYSICIAN AUTHORIZATION

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state law governing school health services. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization (may be faxed).

Physician Signature: _____ Date: _____

Address: _____City _____ Zip: _____
(use office stamp)

Phone Number: _____ Fax Number: _____

PARENT OR GUARDIAN CONSENT

We/I, the undersigned, the parent(s)/guardian of the above named student, request that the above defined insulin dose be given during a disaster for our/my child in accordance with State laws and regulations.

Parent/Guardian Signature: _____ Date: _____

Specialized Healthcare Plan
For Management of Diabetes at School
Completed by Parent and Student
Pump Skills Checklist

This form is to be completed by parent and student when Insulin Pump is used at school. Competency must be in accordance with standard procedures.

Student	**DOB**	**School**	**Grade**
Student will be able to:		**Requires Supervision**	**Independently Performs**
1. Appropriately count carbohydrates **If supervision is required, parents are to provide calculations**			
2. Calculate appropriate correction dose based on physician's orders			
3. Calculate total dose based on physician's orders for carbohydrate consumption and correction dose. Refer to Physician Authorization Page; item 6.			
4. Program appropriate bolus **If supervision is required, parents can program a bolus delay. Health Technician can only verify programmed # of Insulin units on display panel. Licensed nurse must supervise if more assistance is required for bolus insulin dosing.**			
5. Adjust temporary rate for exercise **If supervision is required, a temporary basal rate is not recommended at school. Adjustment for exercise will be made by pre-set basal profile at home or with provision of extra carbohydrates with instruction.**			
6. Disconnect and reconnects tubing **If supervision is required, tubing will NOT be disconnected at school.**			
7. Insert new infusion set **If supervision is required, parents are responsible for proper insertion.**			
8. Use Universal Precaution for site insertion			
9. Fill reservoir and primes tubing **If supervision is required, parents are responsible for filling and priming.**			
10. Trouble shoot alarms appropriately **Child to report any alarm to teacher/school staff.**			
11. Appropriately identify high and low blood glucose levels			
12. Pump model #			
13. Pump serial #			

Parent Signature _____ Date _____