Clayton Public Schools

Diabetes Action Plan/Medication Consent Form

School Nurse #: **856-881-8701 x 2241** School Fax #: **856-474-2285**

Student's Name:_____Grade:_____Date of Birth:_____

Effective Date:_____School Year:_____

Parent/Guardian fills out information in this block by filling in all blanks

STUDENTS EMERGENCY CONTACT INFORMATION

Parent/Guardian #1:_____Cell #:_____ Home #:_____ Work #:_____

Parent/Guardian #2:_____Cell #:_____Home #:_____Work #:_____

Emergency Contact #3:_____Cell #:_____ Home #_____ Relationship:_____

Insurance Carrier:_____Preferred Hospital:_____

Healthcare Provider fills out this information by filling in all blanks & check boxes that apply to student

STUDENT'S COMPETENCE WITH PROCEDURES/AUTHORIZATION TO SELF-CARRY DIABETIC SUPPLIES TO PROVIDE SELF-CARE DURING SCHOOL/SCHOOL ACTIVITIES

- ☐ Blood glucose monitoring
- ☐ Determining insulin dose
- ☐ Measuring insulin
- ☐ Injecting insulin
- ☐ Operates insulin pump
- ☐ Carry supplies for BG monitoring
- ☐ Carry supplies for insulin administration
- ☐ Monitor BG in classroom
- ☐ Self-treatment for mild low blood sugar
- ☐ Determine own snack/meal content
- ☐ Must be supervised by nurse
- ☐ Needs some assistance

EMERGENCY NOTIFICATION (the school will notify parent/guardian of the following conditions):

- ☐ Loss of consciousness or seizure/convulsion immediately after calling 911 & administering Glucagon
- ☐ Blood glucose > _____mg/dl
- ☐ Positive urine ketones
- ☐ Abdominal pain, nausea/vomiting, fever, diarrhea, altered breathing, altered level of consciousness

- ☐ Name Insulin used for BASAL administration at home:_____Units:_____
- ☐ Name Insulin used for HYPERGLYCEMIA and MEAL COVERAGE/SNACKS while at school:_____
- ☐ Blood Glugose TARGET Range:_____mg/dl to _____mg/dl)
- ☐ Insulin Delivery System: ☐ Syringe ☐ Pen ☐ Pump (HCP will provide supplemental instructions/orders for students with pump).

MANAGEMENT OF HYPERGLYCEMIA (>_____mg/dl)

- ☐ Sugar-free fluids/frequent bathroom privileges
- ☐ If BG is > _____, and it's been_____hours since last dose, give ☐ HALF ☐ FULL correction formula noted above.
- ☐ If BG is > _____, and it's been____hours since last dose, give FULL correction formula stated above.
- ☐ If BG is > _____, check for ketones.
- ☐ Notify parent/guardian if ketones are present.
- ☐ Note and document changes in status.
- ☐ Child should be allowed to stay in school unless vomiting and/or moderate or large ketones are present.

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MEAL COVERAGE

Step #1:

- ☐ SLIDING SCALE/Insulin Carbohydrate Ratio (I:C) Insulin Lunch units:_____Carbs Lunch gm:_____
  OR
- ☐ BG from _____to _____ = _____ units
  BG from _____to _____ = _____ units
  BG from _____to _____ = _____ units

Step #2:

CORRECTION of HYPERGLYCEMIA/Correction Formula (CF) to be used for high blood glucose before meals:

Present BG:_____ – (minus) Target BG _____/(divided by) Insulin Carbohydrate Ratio (I:C)= Total Insulin Coverage_____

Step #3:

Add Step #1 + Step #2 together, then round after calculated.

CORRECTION OF HYPOGLYCEMIA

Mild: Blood Glucose < _____

- ☐ Never leave student alone
- ☐ Give ____gms glucose; recheck in 15 minutes
- ☐ If BG < ____, re-treat & re-check in 15 min. x 3
- ☐ Notify parent/guardian if not resolved
- ☐ Provide snack with carbohydrate, fat, protein after treating if meal not scheduled > ____hour

SEVERE: Loss of consciousness or seizure

- ☐ Call 911, open airway, turn to side
- ☐ Glucagon injection ☐ 0.25 mg ☐ 0.50 mg ☐1.0 mg
- ☐ Baqsimi 3mg one notrilNotify parent/guardian
- ☐ Gvoke full dosage sq

EXERCISE

Child should NOT exercise if blood glucose levels are below_____mg/dl or above_____mg/dl and urine contains moderate or large ketones.

- ☐ Check blood sugar right before PE to determine need for additional snack.
- ☐ If BG is less than target range, eat_____grams carbohydrate before exercise.

Signatures: *I understand that all treatments and procedures may be performed by the student and/or unlicensed personnel within the school or by EMS in the event of loss of consciousness or seizure. I also understand that the school is not responsible for damage, loss of supplies/equipment, or expenses utilized in these treatments and procedures. I give permission for school personnel to contact my child's healthcare provider for guidance and recommendations. I give pernmission for school personnel to contact my emergency contact if I cannot be reached. I understand that I am responsible for providing all diabetic supplies to the school for my child, including snacks throughout the school year, as needed. Suppose my child does not have the required diabetic supplies in school. In that case, I understand that I could be called to pick my child up until the necessary supplies have been provided to the school. I have reviewed this information form and agree with the indicated information and requirements to care for my child while in school. This form will assist the school in developing a health plan and providing appropriate care for my child.*

Parent/Guardian Signature:_____Date:_____

School Nurse Signature:_____Date:_____

My signature provides authorization for the above orders. I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.

- ☐ If changes are indicated, I will provide new written, authorized orders (may be faxed).
- ☐ Dose/treatment changes may be relayed through parent.

Healthcare Provider STAMP here:

Health Care Provider Signature:_____ Date:_____

Address:_____Phone #:_____Fax #:_____ *Updated 2/9/22, CPS, Slr*