Santa Rosa District Schools

Berryhill Administrative Complex
6751 Berryhill Street
Milton, Florida 32570

Phone (850) 983-5052
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Sherry Smith
Director of Student Services

July 19, 2013

MEMO:
TO: School Board Members
Superintendent Tim Wyrosdick
RE: Authorization for Diabetes Management and Authorization for Diabetes Management with Insulin Pump Forms

Attached you will find updated Authorization for Diabetes Management and Authorization for Diabetes Management with Insulin Pump forms which are contained in the School Health Policy and Procedure Manual. These forms are developed by the Nemours Pediatric Endocrinology Department. Nemours has recently updated these forms on Part II and IV.

The new language added is as follows:

Part II: Students may _____or may not_____ carry diabetes supplies or medication.
Part IV: I assume all risks and liability in respect to my child's use of diabetes management supplies, insulin, and/or glucagon including any related injection device when authorizing my child to carry and/or self administer prescribed supplies and/or medication.

If you approve, these newly updated forms will replace the current forms in our School Health Policy and Procedure Manual.

Should you have further questions, please call me at 983-5052.

Sincerely,

Sherry Smith

Sherry Smith
Director of Student Services
Santa Rosa County School District
BAC Complex – 6751 Berryhill Road
Milton, Fl 32570
850-983-5052

SANTA ROSA COUNTY SCHOOL DISTRICT AUTHORIZATION FOR DIABETES MANAGEMENT

Student's Name:	Birth Date:	Medicaid #:	Grade:	Parent Emergency Phone #:

Part I Student's Self-Care Assessment: (Provider to complete initially; school nurse will update as needed).

Student's Competency:	Self-Care	Assisted Care	Dependent Care
Performs glucose monitoring			
Determines insulin dosage			
Administers insulin			

Part II Treatment Plan: (To be completed by Physician)

Diagnosis: Diabetes Mellitus, Type I ___ Type II ___. Procedure: Blood Glucose Monitoring by finger stick. Check blood glucose before meals and as needed. Students may ___ or may not ___ carry diabetes supplies or medication.

Action Plan for Glucose Levels:

60 mg/dl or below	Immediately give an emergency snack with simple sugars (e.g. 4 glucose tablets, 1 tube of glucose gel, or 1/3 can of regular soda). **Note: Anytime the student becomes unconscious, uncooperative, combative, or cannot take the emergency snack, give glucagon STAT, call 911 and then call the parent.** Observe the student for hypoglycemic symptoms (altered mental status, shakiness, sweating or weakness). **DO NOT LEAVE THE STUDENT ALONE!** Recheck blood glucose in 15 minutes. • **If symptoms persist after 15 minutes**, give a second emergency snack with simple sugars. • **If no symptoms are present after 15 minutes,** escort the student to front of the line for meal. If it is not mealtime, give a regular snack before allowing the student to return to class.
61-80 mg/dl	Observe the student for symptoms (altered mental status, shakiness, sweating or weakness). • If **symptoms** are present, immediately give an emergency snack with simple sugars (e.g. 4 glucose tablets, 1 tube of glucose gel, or 1/3 can of regular soda). Recheck blood glucose in 15 minutes. • If **no symptoms** are present, escort the student to front of the line for meal. If it is not mealtime, give a regular snack before allowing the student to return to class.
81-300 mg/dl	The student should follow his normal routine.
Above 300 w/ Neg - Sm Ketones	If the student has an insulin dose correction order, then give insulin if it has been 3 hours or greater since the last dose of insulin was given. The student should return to class. Recheck blood glucose and ketones at the next scheduled time or in 3 hours whichever is first. Do not withhold meal or snack if scheduled at this time. Encourage water or other sugar free fluids.
Above 300 w/ Mod - Lg Ketones	**Notify parent**. Refer to Authorization for Administration of Medication (Part III) for short acting insulin orders for moderate or large ketones. The student should return to class. Restrict physical activity. Recheck blood glucose and ketones at the next scheduled time or in 3 hours whichever is first. Do not withhold meal or snack if scheduled at this time. Encourage water or other sugar free fluids. Recheck blood glucose and ketones prior to student leaving school. Notify parent if ketones are still present.

Part III Authorization for Administration of Medications:

1. **Short Acting Insulin: Humalog/Novolog/Regular (circle one) Dosage: _____.**
   Administration Time: At meals, for special occasion snacks and as needed for Correction/Action Plan.
   Note any untoward side effects: Hypoglycemia (Low blood glucose)
   For moderate or large ketones: Give correction factor + ___ units if it has been more than 3 hours since last insulin dose.
2. **Insulin Adjustments:**
   Insulin to carbohydrate ratio: From 1 unit of Humalog/Novolog insulin for every ___ grams of carbohydrate to 1 unit for every ___ grams of carbohydrate eaten.
   Correction factor: From 1 unit of Humalog/Novolog insulin for every ___ mg/dl up to 1 unit for every ___ mg/dl above or below blood glucose target of 120 mg/dl.
3. **Glucagon: Dosage:** ___ mg Subcutaneous
   Time: STAT as needed for severe hypoglycemia.
   Call 911 then parent
   Note any untoward side effects: Nausea, vomiting, and elevated blood sugar.

Print Physician's/Provider's Name:	Physician/Provider Address:	Phone:
Physician's/Provider's Signature:	Date:	

Part IV PARENTAL PERMISSION (To Be Completed By Parent/Guardian) Form is void if this section is incomplete

I hereby request Santa Rosa County school personnel, or its agents, to assist in Diabetes Management & administration of medications as listed above for my child as prescribed by the doctor. I understand that there is no liability on the part of the school district, its personnel, or agents, including school district and county health department personnel, for civil damages as a result of assisting with these procedures when the person acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances. I hereby authorize the exchange of medical information regarding my child's treatment plan between the physician and school health personnel of this school district and county health department. I assume all risks and liability in respect to my child's use of diabetes management supplies, insulin, and/or glucagon including any related injection device when authorizing my child to carry and/or self administer prescribed supplies and/or medication. If my child is covered by Medicaid and receives health services under an IEP, I consent for the school district to bill Medicaid for these services. I consent for the school district to release and exchange my child's confidential student information to agencies of the State of Florida and to bill Medicaid for these services each time a billable service is provided. This will allow the county public school to receive Medicaid Funding for services it provides for my child while in school.

Parent/Guardian Signature: Date:

SANTA ROSA COUNTY SCHOOL DISTRICT AUTHORIZATION FOR DIABETES MANAGEMENT with INSULIN PUMP

Student's Name:	Birth Date:	Medicaid #:	Grade:	Parent Emergency Phone #:

Part I Student's Self-Care Assessment: (Provider to complete initially; school nurse will update as needed).

Student's Competency:	Self-Care	Assisted Care	Dependent Care
Performs glucose monitoring			
Determines insulin dosage			
Administers insulin			

Part II Treatment Plan: (To be completed by Physician)
Diagnosis: Diabetes Mellitus, Type I ___ Type II ___. Procedure: Blood Glucose Monitoring by finger stick. Check blood glucose before meals and as needed. Student may ___ or may not ___ carry diabetes supplies or medication.

Action Plan for Glucose Levels:

60 mg/dl or below	Immediately give an emergency snack with simple sugars (e.g. 4 glucose tablets, 1 tube of glucose gel, or 1/3 can of regular soda). **Note: Anytime the student becomes unconscious, uncooperative, combative, or cannot take the emergency snack, give Glucagon STAT.** If you have given Glucagon, **disconnect insulin pump, call 911 and then call the parent.** Observe the student for hypoglycemic symptoms (altered mental status, shakiness, sweating or weakness). **DO NOT LEAVE THE STUDENT ALONE!** Recheck blood glucose in 15 minutes. • **If symptoms persist after 15 minutes**, give a second emergency snack with simple sugars. • **If no symptoms are present after 15 minutes**, escort the student to front of the line for meal. If it is not mealtime, give a regular snack before allowing the student to return to class.
61-80 mg/dl	**Observe the student for symptoms** (altered mental status, shakiness, sweating or weakness). • If symptoms are present, immediately give an emergency snack with simple sugars (e.g. 4 glucose tablets, 1 tube of glucose gel, or 1/3 can of regular soda). Recheck blood glucose in 15 minutes. • If no symptoms are present, escort the student to front of the line for meal. If it is not mealtime, give a regular snack before allowing the student to return to class.
81-300 mg/dl	The student should follow his normal routine.
Above 300 w/ Neg - Sm Ketones	If the student has an insulin dose correction order, then give insulin if it has been 3 hours or greater since the last dose of insulin was given. The student should return to class. Recheck blood glucose and ketones at the next scheduled time or in 3 hours whichever is first. Do not withhold meal or snack if scheduled at this time. Encourage water or other sugar free fluids.
Above 300 w/ Mod - Lg Ketones	**Notify parent.** Refer to Authorization for Administration of Medication for Diabetes (Part III) for short acting insulin orders for moderate or large ketones. Student is to take insulin (correction and/or meal bolus) by insulin pen. The student should return to class. Restrict physical activity. Recheck glucose and ketones at the next scheduled time or in 3 hours, whichever is first. Do not withhold meal or snack if scheduled at this time. Encourage water or other sugar free fluids. Student is to take meal bolus by Insulin pen. Recheck blood glucose and ketones prior to student leaving school. Notify parent if ketones are still present. Self-care students should change infusion site.
Loss of infusion site or pump malfunction	**Notify parent.** Self-care students with supplies may reinsert infusion site. Recheck blood glucose in 3 hours or next scheduled time, whichever occurs first. Student is to take correction by insulin pen every 3 hours if pump is malfunctioning or student is unable to reinsert infusion site.

Part III Authorization for Administration of Medications:

1. **Short Acting Insulin: Humalog/Novolog/Regular (circle one) Dosage: ____________.**
   Administration Time: At meals, for special occasion snacks and as needed for Correction/Action Plan.
   Note any untoward side effects: Hypoglycemia (Low blood glucose)
   For moderate or large ketones: Give correction factor + ___ units if it has been more than 3 hours since last insulin bolus.
2. **Insulin Adjustments:**
   Insulin to carbohydrate ratio: From 1 unit of Humalog/Novolog insulin for every ___ grams of carbohydrate to 1 unit for every ___ grams of carbohydrate eaten.
   Correction factor: From 1 unit of Humalog/Novolog insulin for every ___ mg/dl up to 1 unit for every ___ mg/dl above or below blood glucose target of 120 mg/dl.
3. **Glucagon: Dosage:** ___ mg Subcutaneous
   Time: STAT as needed for severe hypoglycemia.
   Call 911 then parent
   Note any untoward side effects: Nausea, vomiting, and elevated blood sugar.

Print Physician's/Provider's Name:	Physician/Provider Address:	Phone:
Physician/Provider Signature:	Date:	

Part IV. PARENTAL [illegible] (To Be Completed By Parent/Guardian) [illegible]

I hereby request Santa Rosa County school personnel, or its agents, to assist in Diabetes Management & administration of medications as listed above for my child as prescribed by the doctor. I understand that there is no liability on the part of the school district, its personnel, or agents, including school district and county health department personnel, for civil damages as a result of assisting with these procedures when the person acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances. I hereby authorize the exchange of medical information regarding my child's treatment plan between the physician and school health personnel of this school district and county health department. I assume all risks and liability in respect to my child's use of diabetes management supplies, insulin, and/or glucagon including any related injection device when authorizing my child to carry and/or self administer prescribed supplies and/or medication. If my child is covered by Medicaid and receives health services under an IEP, I consent for the school district to bill Medicaid for these services. I consent for the school district to release and exchange my child's confidential student information to agencies of the State of Florida and to bill Medicaid for these services each time a billable service is provided. This will allow the county public school to receive Medicaid Funding for services it provides for my child while in school.

Parent/Guardian Signature: Date: