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 ☐ ____ hours after lunch ☐ ____ hours after a correction dose ☐ As needed for symptoms of hypo/hyperglycemia ☐ With signs and symptoms of illness ☐ Other times:
Hypoglycemia = blood glucose less than: _________________	☐ Self treatment for mild lows. ☐ Suspend pump for severe hypoglycemia for __________min. ☐Give _______ grams of fast-acting carbohydrate according to care plan. Recheck BG in 10-15 mins. ☐ Repeat treatment if BG less than _________mg/dl ☐ 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)** ☐ **OK to use glucose gel inside cheek, even if unconscious, seizing.** ☐ **Other:**
Hyperglycemia = blood glucose greater than: _________________	☐ Check urine ketones, follow emergency care plan, and administer insulin as per orders. ☐ Encourage sugar free fluids, at least ________________ounces per_______________. ☐ For pumps, insulin may be given by syringe or pen if needed and follow insulin orders below. ☐ If student complains of nausea, vomiting or abdominal pain; follow urine ketones and insulin orders below. ☐ 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	
Blood Glucose		To		Give		Units	
Blood Glucose		To		Give		Units	
Blood Glucose		To		Give		Units	
Blood Glucose		To		Give		Units	
Blood Glucose		To		Give		Units	
Blood Glucose		To		Give		Units	
Blood Glucose		To		Give		Units	

☐ 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:

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