

**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: <input type="checkbox"/> Before snacks <input type="checkbox"/> Before meals <input type="checkbox"/> ____ hours after lunch <input type="checkbox"/> ____ hours after a correction dose <input type="checkbox"/> As needed for symptoms of hypo/hyperglycemia <input type="checkbox"/> With signs and symptoms of illness <input type="checkbox"/> Other times: _____
Hypoglycemia = blood glucose less than: _____	<input type="checkbox"/> Self treatment for mild lows. <input type="checkbox"/> Suspend pump for severe hypoglycemia for _____ min. <input type="checkbox"/> Give _____ grams of fast-acting carbohydrate according to care plan. Recheck BG in 10-15 mins. <input type="checkbox"/> Repeat treatment if BG less than _____ mg/dl <input type="checkbox"/> 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.	<input type="checkbox"/> Glucagon injection (1 mg in 1 cc) _____ mg, subcutaneously (SQ) or intramuscular (IM) <input type="checkbox"/> OK to use glucose gel inside cheek, even if unconscious, seizing. <input type="checkbox"/> Other: _____
Hyperglycemia = blood glucose greater than: _____	<input type="checkbox"/> Check urine ketones, follow emergency care plan, and administer insulin as per orders. <input type="checkbox"/> Encourage sugar free fluids, at least _____ ounces per _____. <input type="checkbox"/> For pumps, insulin may be given by syringe or pen if needed and follow insulin orders below. <input type="checkbox"/> If student complains of nausea, vomiting or abdominal pain; follow urine ketones and insulin orders below. <input type="checkbox"/> 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: