

Student \_\_\_\_\_ DOB \_\_\_\_\_ Authorization is for one year - beginning date \_\_\_\_\_  
MRN \_\_\_\_\_

**Blood Glucose (BG) Checking**

for suspected hypoglycemia

**Before:**

Breakfast  AM snack  Lunch  PM snack

before PE  before after school activities

before boarding bus: if BG is <100 give 15 grams carbohydrate (no insulin bolus)

other \_\_\_\_\_

**Student allowed to check blood glucose:**

independently, can carry glucometer and check as needed

with supervision

student cannot self-check

**Continuous Glucose Monitoring (CGM)/Sensor: Must check blood glucose with glucometer for all treatment decisions.**

**Routine Care of Hypoglycemia (blood glucose < \_\_\_\_\_ )**

- See Diabetes Flow Chart
- Never leave student alone if low is suspected

self-treatment of mild lows

needs assistance for all lows

**Care of Severe Hypoglycemia** (unconscious, seizure, or unable to swallow)

- Administer glucagon by intramuscular injection
  - 0.5mg
  - 1mg
- Lay student on side to prevent aspiration
- Call 911**
- Notify parent/guardian

**Care of Hyperglycemia (blood glucose >300)**

- See Diabetes Flow Chart for instructions injections vs insulin pump
- Check urine or blood ketones
- Ketones check by school staff or by student with staff verification

**Diet**

carb counting

extra food allowed at:
 

- parent's discretion  student's discretion

gluten-free

other: \_\_\_\_\_

**Other**

**Insulin at School**  Yes  No

Injection by syringe/vial or pen  Insulin pump

**Type: (Bolus/Rapid-Acting)** Humalog, Novolog or Apidra

**Injection Insulin Plan** - use current insulin plan for doses (guardian to provide updated plan if doses change)

**Insulin for carbohydrate**

Breakfast  AM snack  Lunch  PM snack

Other \_\_\_\_\_

with all carbohydrates unless treating or preventing low blood glucose

**Insulin correction for high blood glucose** (corrections should not be given within three hours of the last rapid-acting insulin dose)

Breakfast  Lunch  Other \_\_\_\_\_

**Type: (Basal/Long-Acting)** Lantus or Levemir

Breakfast  Lunch  Other \_\_\_\_\_

**Pump Insulin Plan** – use bolus wizard or pump calculator for dosing carb intake and correcting high blood glucose. Guardian to provide Insulin Pump Plan once a year for use in the event of a disaster and/or pump, tubing or infusion set malfunction.

guardian can adjust pump settings

student can change pump infusion set as needed

Other \_\_\_\_\_

**Pump Malfunction Plan: if pump, tubing or infusion set malfunctions**

- Call Guardian
- If unable to reach Guardian, call Diabetes Educator urgent line: 510-428-3654 #5

**Student allowed to prepare insulin dose**

independently

with supervision

student cannot self-prepare

**Student allowed to administer insulin**

independently, can carry insulin/administer as needed

with supervision

student cannot self-administer

**P.E. Guidelines**

- Carbohydrate food/beverage must be available before, during and after exercise (to treat and or prevent low BG)
- 15 grams carbohydrate (no insulin bolus) for 30 minutes or more vigorous activity/exercise- e.g. running laps, etc.

**Field trips and after school activities**

- Arrange for appropriate monitoring and access to supplies
- Overnight camps: guardian to contact Diabetes Team for revised insulin plan

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**DISASTER PREPAREDNESS PLAN**

Diabetes management goals:

1. Prevent severe lows
2. Prevent diabetic ketoacidosis

Bolus/Rapid-Acting Insulin: Humalog, Novolog or Aprida; Basal/Long-Acting Insulin: Lantus or Levemir

Insulin by injection

1. use **Insulin Plan Rapid Acting Insulin** for carbohydrate coverage
2. use **Rapid Acting Insulin** correction dose with meals: give \_\_\_\_\_ unit(s) for every \_\_\_\_\_ above \_\_\_\_\_ mg/dl  
 use **Insulin Plan** to determine **Basal Insulin**: give 80% of Lantus or Levemir dose at:  breakfast and/or  dinnertime
3. Other \_\_\_\_\_

Insulin by pump

1. Continue using pump for carbohydrate coverage and to correct high blood glucose  
 Untethered pump: Inject Lantus or Levemir daily: give \_\_\_\_\_ units at  breakfast and/or  dinnertime
2. If pump fails refer to the **Pump Malfunction Plan** in the **Insulin Pump Plan** and use the following:
  - a. **Rapid Acting Insulin** by injection for carbohydrate coverage
  - b. **Rapid Acting Insulin** correction dose with meals: give \_\_\_\_\_ units(s) for every \_\_\_\_\_ above \_\_\_\_\_ mg/dl

**Note: If Basal Insulin is unavailable give above correction dose every 3 hours to provide basal coverage (or)**

- c. **Basal Insulin**: give 80% of Lantus or Levemir dose at time of pump malfunction, repeat every 24 hours

**PHYSICIAN AUTHORIZATION FOR DIABETES MANAGEMENT INSCHOOL  
AUTHORIZATION IS FOR ONE YEAR**

My signature below provides authorization for the written orders specified above. I understand that procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse or other health care professional.

Electronically signed by \_\_\_\_\_ Date \_\_\_\_\_

UCSF Benioff Children's Hospital Oakland, Department of Endocrinology, 747 52<sup>nd</sup> St, Oakland, CA 94609

FAX (510) 450-5614

Phone (510) 428-3654

**PARENT/GUARDIAN CONSENT FOR DIABETES MANAGEMENT INSCHOOL**

I, the undersigned, request that the following specialized physical health care services for the management of diabetes in school be administered to my child in accordance to the Education Code 49423.

**As guardian I will:**

1. Provide the necessary supplies and equipment: rapid-acting insulin, basal insulin, syringes/pen needles, and/or pump supplies with extra batteries, blood glucose meter/test strips, Glucagon kit, fast-acting carbohydrate source, snacks and ketone strips.
2. Notify the school immediately and provide new **Insulin Plan** for any change in the diabetes plan.
3. Notify the school if there is a change in student's health status or attending physician.

I authorize the school personnel to communicate with the diabetes medical team when necessary.

Guardian Signature \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

**SCHOOL USE ONLY**

Management Plan Reviewed by \_\_\_\_\_ Date \_\_\_\_\_  
(School Nurse/Personnel name/title)