Zachary Community Schools
Diabetes
Physician's Orders

Date Plan Effective:

Name:			Date of Birth:
School / Grade: /			Teacher:
Parent / Guardian:			
Mother's phone	Home:	Work:	Cell:
Father's phone	Home:	Work:	Cell:
Health Care Provider:		Phone:	Fax:
Brief history of diagnosis:			
Recent hospitalizations:			
Concurrent illness or disability:			

Health Care Provider to Complete

Treatment at School:

Low Blood Sugar: less than _____ (conscious)	**Low Blood Sugar: (unconscious)**
• Call School Nurse • Give ½ cup juice, regular coke, 2-3 glucose tabs, or other fast-acting sugar source. • Recheck blood sugar in _______ minutes. • If still less than ________ give more fast-acting sugar source. • Recheck blood sugar • When blood sugar is ≥ ______, give snack with protein (peanut butter crackers or cheese & crackers). • Return student to class.	☐ Administer Glucagon (if ordered) ☐ **0.5 mg** ☐ **1.0mg** ☐ **IM** ☐**SQ** ☐ Give instant glucose (place gel between cheek & lower gum) • Turn student on side • Call 911 • Call School Nurse/Call parent • Stay with student Other: ______________________________

High Blood Sugar: more than _____.

☐ Check for ketones when blood sugar is ≥ _____

☐ Give insulin per Physician's orders (sliding scale) **OR** Insulin Pump Protocol (see attached Insulin Pump Orders)
☐ Have student slowly drink 12-16oz. of water in 4oz. increments if not nauseous or vomiting
☐ Check for ketones (if ordered):
  ✓ If ketones are positive (+), notify parents to pick up student and contact doctor for further instructions
☐ Call parent:
☐ Recheck blood sugar in _________ minutes.
☐ Other:

____

Level of Independence: (check all that apply)

- ☐ Totally independent
  - Self-treats mild hypoglycemia
  - Monitors own snacks and meals
  - Tests and interprets own ketones
- ☐ Needs assistance with diabetic care (see below)

Blood sugar testing: (check all that apply)

- ☐ Student tests independently
- ☐ Parent or PDA assists student
- ☐ Student tests with verification of number on meter by designated staff
- ☐ Student tests with verification of number on meter by designated staff to be reviewed by school nurse
- ☐ Other____

  ____

  ____

Insulin administration: (check all that apply)

- ☐ Parent or PDA assists student
- ☐ Student self-administers insulin (per sliding scale) as trained under the direction of their physician.
- ☐ Student self injects with verification of number on insulin pen by designated staff
- ☐ Student is on an insulin pump with specialized orders as indicated on HCP & on file in health office.
- ☐ Other____

Equipment and supplies provided by parent (if applicable):

- Blood sugar meter kit (includes all blood testing supplies for use at school)
- Insulin (including syringes and alcohol preps)
- Glucagon Injection
- Fast acting carbohydrate drink
- Glucose tablets and glucose gel product
- 5-6 pre-packaged snacks (crackers and cheese or peanut butter, etc.) Storage location:____

Daily school routines:

- Specific time(s) to test blood sugar: ______________________________________
- Dietary specifications:

  ☐ Carbohydrate Counting (i.e. insulin/carb ratio and total carbs/meal) (Please be specific):

  ____

  ☐ ADA Caloric Diet _____
- Regularly scheduled snacks, if applicable: AM __________ PM ___________

Extra snacks/ parties (check all that apply):

- ☐ Child will eat treat
- ☐ Teacher/staff will notify parent prior to activity
- ☐ Treat will be replaced with parent-supplied alternative
- ☐ Modify the treat as follows: ____
- ☐ Schedule extra insulin per pre-arranged plan
- ☐ Other____

  ____

  ____

Classroom Information/Accommodations:

- Unlimited access to drinking water
- Unrestricted bathroom privileges
- Send child to office with staff/buddy if possible low blood sugar
- Blood sugar testing at designated times and as needed
- Re-take tests as needed for blood sugar imbalances
- Limitations (if applicable): ____
- Other____

Students who ride the bus (check all that apply):

If a low blood sugar episode occurs 30 minutes or less prior to departure regardless if sugar returns to a normal reading, **the designated staff or School Nurse (if in the building) will:**

☐ Call parent to inform of episode
☐ Allow child to ride the bus home if blood sugar returns to normal
☐ Call parent to pick up child
☐ Other: ________________________________

Students who drive to school (high school only)

If a low blood sugar episode occurs 30 minutes or less prior to departure **student will**

☐ Self treat mild hypoglycemia and drive home
☐ Call parent to inform of episode
☐ Call parent to pick up student if blood sugar does not return to normal.
☐ Other: ________________________________

School bus driver instructions:

- Student to eat snack on bus if having signs of low blood sugar and able to swallow
- Driver to follow district plans for low blood sugar

Field Trips (all diabetes supplies are taken and care provided):

☐ Totally Independent
☐ Parent accompanies child on trip
☐ PDA accompanies child on trip
☐ School Nurse or designated school personnel accompanies child on trip and care according to high/low blood sugar school emergency plans

Scheduled after-school/extra-curricular activities (i.e. sports, school clubs):

☐ Totally Independent
☐ List activities: ____
☐ Notification of IHP details to staff in charge
☐ Parent accompanies child on above activities
☐ PDA accompanies child on above activities
☐ Other: ____

Physician's Signature ____

Print Name Here ____

Phone ______________________ Fax ______________________

Office Address ____

DIABETES MEDICAL MANAGEMENT PLAN SUPPLEMENT FOR STUDENT WEARING INSULIN PUMP
School Year ___________-_________

Student Name:_______________________________________ Date of Birth:___________ Pump Brand/Model:________________

Pump Resource Person:____________________________ Phone/Beeper ___________________(See basic diabetes plan for parent phone#)

Child-Lock On? ☐ Yes ☐ No How long has student worn an insulin pump? ______________

Blood Glucose Target Range:_________-_______________ Pump Insulin: ☐ Humalog ☐ Novolog ☐ Regular

Insulin:Carbohydrate Ratios: ____

(Student to receive carbohydrate bolus *immediately before* / _____*minutes* before eating)

Lunch/Snack Boluses Pre-programmed? ☐Yes ☐ No Times ____

Insulin Correction Formula for Blood Glucose Over Target:____

Extra pump supplies furnished by parent/guardian: ☐ infusion sets ☐ reservoirs ☐ batteries ☐ dressings/tape ☐ insulin ☐ syringes/insulin pen

STUDENT PUMP SKILLS	NEEDS HELP?	IF YES, TO BE ASSISTED BY AND COMMENTS:
1. Independently count carbohydrates	☐Yes ☐ No	
2. Give correct bolus for carbohydrates consumed.	☐ Yes ☐ No	
3. Calculate and administer correction bolus.	☐ Yes ☐ No	
4. Recognize signs/symptoms of site infection.	☐ Yes ☐ No	
5. Calculate and set a temporary basal rate.	☐ Yes ☐ No	
6. Disconnect pump if needed.	☐ Yes ☐ No	
7. Reconnect pump at infusion set.	☐Yes ☐No	
8. Prepare reservoir and tubing.	☐ Yes ☐No	
9. Insert new infusion set.	☐ Yes ☐No	
10. Give injection with syringe or pen, if needed.	☐ Yes ☐No	
11. Troubleshoot alarms and malfunctions.	☐ Yes ☐No	
12. Re-program basal profiles if needed.	☐ Yes ☐No	

MANAGEMENT OF HIGH BLOOD GLUCOSE ***Follow instructions in basic diabetes medical management plan, but in addition:***

If blood glucose over target range _______ hours after last bolus or carbohydrate intake, student should receive a correction bolus of insulin using formula; Blood glucose - ____________÷ ______________=_______ units insulin

If blood glucose over 250, check urine ketones
1. **If no ketones**, give bolus by pump and recheck in 2 hours.
2. **If ketones present or_________________**, give correction bolus as an **injection** immediately and contact parent/ health care provider

If two consecutive blood glucose readings over 250 (2 hrs or more after first bolus given)
1. Check urine ketones
2. Give correction bolus as an injection
3. Change infusion set.
4. Call parent

MANAGEMENT OF LOW BLOOD GLUCOSE *Follow instructions in Basic Diabetes Care Plan, but in addition:*

If low blood glucose recurs without explanation, notify parent/diabetes provider for potential instructions to suspend pump.

If seizure or unresponsiveness occurs:

1. Call 911 (or designate another individual to do so).
2. Treat with Glucagon (See basic Diabetes Medical Management Plan)
3. Stop insulin pump by:
   - ☐ Placing in “suspend” or stop mode (See attached copy of manufacturer’s instructions)
   - ☐ Disconnecting at pigtail or clip (Send pump with EMS to hospital.)
   - ☐ Cutting tubing
4. Notify parent
5. If pump was removed, send with EMS to hospital.

ADDITIONAL TIMES TO CONTACT PARENT

☐ Soreness or redness at infusion site
☐ Detachment of dressing/infusion set out of place
☐ Leakage of insulin
☐ Insulin injection given
☐ Other____
____

Effective Date(s) of Pump plan: ___________________________

Parent’s Signature:____ Date:_______________

School Nurse’s Signature:____ Date:_______________

Physician's Signature: ____ Date:_______________

STATE OF LOUISIANA
PHYSICIAN'S AUTHORIZATION FOR SPECIAL HEALTH CARE

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN AND PHYSICIAN

Part 1: CONTACT INFORMATION							
Student Name:	Last	First	M.I.	Sex ❑ M ❑ F	DOB:	Grade:	School Year:

I hereby request that the treatment specified below be performed on my child.
I understand that the procedure specified below may be performed by trained, unlicensed school personnel.

______________________ Parent or Legal Guardian Name (print)

______________________ Parent/Legal Guardian's Signature

________ Date

PART 2: PHYSICIAN TO COMPLETE.

PHYSICAL CONDITION FOR WHICH THE STANDARDIZED PROCEDURE IS TO BE PERFORMED:

____

____

____

NAME OF STANDARDIZED PROCEDURE: (Please complete the attached physician order form).

❑ catheterization ❑ gastrostomy care ❑ tracheostomy care ❑ suctioning

❑ oxygen ❑ blood glucose monitoring ❑ Other ______________________

PRECAUTIONS, POSSIBLE UNTOWARD REACTIONS, AND INTERVENTIONS:

____

____

____

TIME SCHEDULE AND/OR INDICATION FOR THE PROCEDURE:

____

____

____

THE PROCEDURE IS TO BE CONTINUED AS ABOVE UNTIL: ______________________ (Date)

______________________ Physician Name (print)

______________________ Physician's Signature

________ Date

______________________ Address

________ Phone

________ Fax

RETURN COMPLETED FORM TO SCHOOL NURSE AS SOON AS POSSIBLE

ZACHARY COMMUNITY SCHOOLS
DIET PRESCRIPTION FOR MEALS AT SCHOOL

Student Name ____ Age ______________

School ____ Grade/ Homeroom ______________

Parent ____ Telephone _________________

Does the student have a disability that requires a special diet? ☐ Yes ☐ No
If yes, describe the major life activities affected by the disability.____

____

____

If the student is not disabled, list the medical condition that requires special nutritional or feeding needs.

____

____

____

Diet Prescription (Check all that apply):

☐ Food Allergy
☐ Diabetes
☐ Hypoglycemic
☐ Increased Calorie ___________ (# of Calories)
☐ Reduced Calorie ___________(# of Calories)
☐ Texture Modification:
  ☐ Chopped ☐ Ground ☐ Pureed ☐ Liquefied
☐ PKU
☐ Tube Feeding
  ☐ Liquefied Meal ☐ Formula
☐ Other ____

Food Groups to Omit: ☐ Meat and Meat Alternatives ☐ Milk and Milk Products

☐ Bread and Cereal Products ☐ Fruits and Vegetables

Specific Foods to Omit____

Specific Foods to Substitute ____

I certify that the above named student needs special school meals prepared as described above because of the student's disability or chronic medical condition.

____ Office Telephone _______________

Physician's Signature

Fax ______________

ZACHARY COMMUNITY SCHOOLS
4700 Main Street • Zachary, LA 70791 • 225-658-4969 • Fax: 658-5261 •
www.zacharyschools.org

SELF-MONITORING OF BLOOD GLUCOSE

____ has been adequately instructed by you or your staff and demonstrated competence in self-monitoring blood glucose to the degree that he/she may perform this task at school provided the school nurse has determined it is safe and appropriate for him/her in this particular setting.

The physician and family are aware that ____ will be providing self-care. ____ will be performing his/her own blood glucose monitoring and observed by a trained unlicensed school employee. In an emergency, the school nurse or a trained unlicensed school employee will perform blood glucose monitoring. Ketones will be checked by the student and results observed by the school nurse or trained unlicensed employee.

____ ____________________________
Physician's Signature Date

ZACHARY COMMUNITY SCHOOLS

4700 Main Street ● Zachary, LA 70791 ● 225-658-4969 ● Fax: 658-5261 ●
www.zacharyschools.org

SELF-ADMINISTRATION OF INSULIN
AND
BLOOD GLUCOSE MONITORING

____ has been adequately instructed by you or your staff and demonstrated competence in self-administration of (type of insulin) __________________________________ to the degree that she/he may perform this task at school provided the school nurse has determined it is safe and appropriate for her/him in this particular setting.

____ has been trained and is deemed competent by you or your staff in performing accu-checks, obtaining ketone results from urine, drawing up the appropriate amount of insulin as ordered, in performing proper technique in self-injection of insulin, and proper documentation of results. She/He is responsible for her/his own care and will be able to repeat the blood sugar monitoring per doctor's orders.

The physician and family are aware that ____ will be providing self-care. ____ will be performing her/his own blood glucose monitoring and observed by a trained unlicensed school employee. In an emergency, the school nurse or a trained unlicensed school employee will perform blood glucose monitoring. Ketones will be checked by the student and results observed by the school nurse or trained unlicensed employee.

____	____________________________
Physician's Signature	Date