

Hillsborough County Public Schools
Tampa, Florida

School Health Services ♦ 1202 E. Palm Ave. ♦ Tampa, FL ♦ 33605 ♦ 813-273-7020

Authorization for Administration of Medication and Management of Diabetes In the School Setting

INSTRUCTIONS:

1. When the information on this form is completed and signed by the Physician and Parent, it will serve as the Physician Orders in the school setting.
2. If the Physician's Office has a comparable form it will be acceptable and can serve as the Physicians Orders.
3. The School Nurse will review the information.
4. Attach Student's Emergency Card to this form.

Date: _____

Student's Name _____

Birth Date: _____

My permission is hereby granted to **School Health Services Personnel / and or to Principal's Designee** to administer and / or allow Student to self-administer the following medications and treatments.

I. BLOOD GLUCOSE MONITORING: To be performed at school: Yes _____ No _____
To be performed by the Student or the Principal's Designee (requires affidavit): Yes _____ No _____

Type of Meter: _____ Target Range for BG: _____ mg/dl to _____ mg/dl
Before PE / Activity Time

Time to be performed: _____ Before breakfast
_____ Mid-morning: before snack _____ After PE / Activity Time
_____ Before lunch _____ Mid-afternoon
_____ Dismissal _____ PRN for signs / symptoms of ↓BS

II. INSULIN ADMINISTRATION: To be performed by Student or Health Services Personnel: Yes _____ No _____
(If YES, complete the following section)

TYPE OF INSULIN	DOSE	No	
		TIME TO BE ADMINISTERED	
Humalog	_____	_____	Insulin Delivery Method _____ # unit(s) per _____ grams CHO Calculate Insulin dose for Carbohydrate Intake Yes _____ No _____
Regular	_____	_____	
NPH	_____	_____	
Lente	_____	_____	
Ultralente	_____	_____	
Other _____	_____	_____	

SLIDING SCALE:

Blood Sugar: _____ Amount of Insulin: _____
Blood Sugar: _____ Amount of Insulin: _____
Blood Sugar: _____ Amount of Insulin: _____
Blood Sugar: _____ Amount of Insulin: _____

ADDITIONAL INSTRUCTIONS:

III. MEALS/SNACKS INSTRUCTIONS: Can student determine correct portions & number of carbohydrate servings? Yes _____ No _____
(Parents to provide snacks if necessary and will restock supplies as needed)

<u>Meal Event</u>	<u>Time/ Location</u>	<u>Food Content & CHO Amount</u>
Breakfast	_____	_____
Mid-morning	_____	_____
Lunch	_____	_____
Mid-afternoon	_____	_____

<u>Meal Event</u>	<u>Time/ Location</u>	<u>Food Content & CHO Amount</u>
Before PE/Activity	_____	_____
After PE/Activity	_____	_____
PRN for Low BG	_____	_____
Special Snacks	_____	_____
Instructions:	_____	_____

IV. MANAGEMENT OF HIGH BLOOD SUGAR (>200 mg/dl)

(Follow sliding scale as indicated above; if nausea / vomiting – call parent; student to be sent home)

USUAL SIGNS / SYMPTOMS FOR THIS CHILD:

- _____ Increased thirst, urination, appetite
- _____ Tired / drowsy / less energy
- _____ Blurred vision
- _____ Warm, dry, or flushed skin
- _____ Other _____

INDICATE TREATMENT CHOICES:

- _____ Sugar free fluids
- _____ Avoid concentrated sweets
- _____ Frequent bathroom privileges
- _____ May not need snack
- _____ Other _____

V. MANAGEMENT OF VERY HIGH BLOOD SUGAR (>500 mg/dl)

USUAL SIGNS / SYMPTOMS FOR THIS CHILD:

- _____ Nausea / vomiting
- _____ Abdominal pain
- _____ Rapid, shallow breathing
- _____ Weakness / muscle aches
- _____ Dry mucous membranes
- _____ Extreme thirst
- _____ Fruity breath odor
- _____ Other _____

INDICATE TREATMENT CHOICES:

- _____ Check urine for **Ketones**
- _____ Notify parents if signs/symptoms present
- _____ From previous column
- _____ If unable to reach parents, call 911
- _____ Sugar-free fluids if tolerated
- _____ Frequent bathroom privileges
- _____ Stay with student and document changes in status
- _____ Other _____

VI. MANAGEMENT OF LOW BLOOD SUGAR (range of low BS for this student)

Less than < mg/dl (may vary for individual student)

**EMS will be called for
Extreme Low BS**

USUAL SIGNS / SYMPTOMS FOR THIS CHILD:

- _____ Change in personality
- _____ Weak/ shaky/ tremors
- _____ Tired/ drowsy/ fatigue
- _____ Dizzy/ staggering walk
- _____ Headache
- _____ Inattentive/ confused
- _____ Nausea/ loss of appetite
- _____ Clammy/ sweating
- _____ Blurred vision
- _____ Irritability/ crying/ aggressive
- _____ Loss of consciousness
- _____ Slurred speech
- _____ Seizures

INDICATE TREATMENT CHOICES:

- _____ Call EMS if unconscious or seizure
- _____ 4-6 oz. Fruit juice or sweetened drink
- _____ 4-6 Sugar cubes or hand candies
- _____ 3 Glucose tablets
- _____ Concentrated gel or tube frosting
- _____ Honey, syrup, table sugar
- _____ Retest BG 15-20 minutes post snack
- _____ Repeat treatment until good response
- _____ Follow treatment with snack of _____
- _____ Protein/ carbohydrates
- _____ *Glucagon Injection (requires affidavit)
- _____ Other _____

VII. LIST ANY OTHER MEDICATIONS TO BE GIVEN AT SCHOOL:

Medication	Dose	Time	Route	Possible side effects

I understand that treatments and procedures are being performed by the Student, School Health Staff or Principal Designee within the school or by EMS in the event of loss of consciousness or seizure. I also understand that the school is not responsible for damage, loss of equipment, or expenses utilized in these treatments and procedures. I have reviewed and agree with the indicated instructions.

		Name of School
_____	_____	_____
Physician's Signature / Date	Parent's Signature / Date	School Nurse Contact
_____	_____	_____
Phone Number	Phone Number	Phone Number