Diabetes Communication and Treatment Authorization Form
North Branch Area Public Schools - ISD #138

Student name: _____ DOB: _____ Grade: _____
Parent/Guardian _____ Phone: _____ Cell: _____
Clinic/Physician _____ Phone _____

Type 1 diabetes is an autoimmune disease in which the insulin producing cells of the pancreas no longer produce insulin resulting in a deficiency of insulin. The daily regimen for managing Type 1 diabetes includes blood glucose monitoring; insulin injections and management of high and low blood glucose levels.

Blood Glucose Monitoring
Blood Glucose Target Range: _____mg/dl

- ❑ Blood Glucose Testing Times: _____
- ❑ PRN Blood Glucose Testing Symptoms of Hypoglycemia/Hyperglycemia
- ❑ Permission to test independently
- ❑ Supervision of testing/results
- ❑ Student will need assistance with testing and blood glucose management.
- ❑ Results sent home: _____

Diabetes Medication

- ❑ No insulin at school: Current regimen at home: Insulin_____ Shots/day _____
- ❑ Insulin at school:
  Current Regimen: Insulin pump _____   Insulin type(s)_____
  - ❑ Follow Bolus Wizard setting/dosage calculator program in insulin pump
  - ❑ Dose calculation based on food intake and current blood glucose (see scale below)
    - **Meal bolus _____# units of insulin/carbohydrate choice (15 gm)**
    - **Blood glucose correction scale: ____ unit/____points BG is >_____**

Correction bolus can be given with meals or every 3 hours if blood glucose levels are high.
**Note: Insulin dose is a total of meal bolus and correction bolus

Blood Glucose Value	Units of Insulin
Less than 100	
100-150	
151-200	
201-250	
251-300	
301-350	
351-400	
More than 400	

- ❑ Parent/Guardian may adjust insulin doses as needed.
Device Used: Pen _____   Syringe _____   Pump _____
(Insulin pens expire 28 days after opening, NPH pen cartridges expire after 14 days, insulin vials expire 30 days after opening, unopened vials/cartridges may be used through expiration dates)

My Meal Plan
15 Grams of carbohydrate = 1 carbohydrate choice

- ❑ Meal Plan variable
- ❑ Meal plan prescribed (see below)
Breakfast: time_____   # carb choices = _____
Morning Snack time _____   # carb choices = _____
Lunch time: _____   # carb choices = _____
Afternoon Snack Time: _____   # carb choices = _____

GUIDELINES FOR RESPONDING TO BLOOD GLUCOSE LEVELS

HYPOGLYCEMIA
Blood Sugar Level 70-100

        1._____

        2._____

        3._____

Blood Sugar Level 50-69

        1._____

        2._____

        3._____

Blood Sugar Level Below 50

        1._____

        2._____

        3._____

Highlight any further action to be taken:
___If using an insulin pump, suspend pump until blood glucose is > _____
___Provide quick sugar source as above; wait 10-15 minutes and recheck blood glucose
___Repeat carb source as above if symptoms persist or if blood glucose is less than:_____
___Administer glucagon as prescribed (turn child onto side, notify parent and EMS)
___Administer Glucogel as provided
Other:_____ _____

    When in doubt, always TREAT FOR HYPOGLYCEMIA

HYPERGLYCEMIA
Blood Sugar Level above: _____

        1._____

        2._____

        3._____

Highlight any further actions to be taken:
____Encourage student to drink water or sugar-free drinks
____If child is vomiting or blood glucose is > _____ notify parent.
____Ketostix at school for prn use (if ketones are present encourage water, do not exercise, notify parent)

I give my consent for_____
to participate in Blood Glucose Monitoring in the school health office following OSHA guidelines, school procedure and physician orders. The school may contact the physician regarding the management of this student's diabetes at school and will also be called if parents are unavailable during an emergency.

_____
Parent/Guardian Signature   Date

_____
Licensed Medical Provider/Prescriber   Date

_____
Licensed School Nurse   Date