



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: Yes _____ No _____

Type of Meter: _____ Target Range for BG: _____ mg/dl to _____ mg/dl

Time to be performed: _____ Before breakfast _____ Before PE / Activity Time
_____ Mid-morning: before snack _____ After PE / Activity Time
_____ Before lunch _____ Mid-afternoon
_____ Dismissal _____ PRN- for signs / symptoms of high or low blood sugars

II. INSULIN ADMINISTRATION:

To be performed by Student or Health Services Personnel: Yes _____ No _____

(If YES, complete the following section)

<u>TYPE OF INSULIN</u>	<u>DOSE</u>	<u>TIME TO BE ADMINISTERED</u>
_____ Humalog	_____	_____
_____ Regular	_____	_____
_____ NPH	_____	_____
_____ Lente	_____	_____
_____ Ultralente	_____	_____
_____ Other _____	_____	_____

_____ Insulin Delivery Method

_____ # unit(s) per _____ grams

Calculate Insulin dose for Carbohydrate

Intake Yes _____ No _____

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>	<u>Meal Event</u>	<u>Time/ Location</u>	<u>Food Content & CHO Amount</u>
_____ Breakfast	_____	_____	_____ Before PE/Activity	_____	_____
_____ Mid-morning	_____	_____	_____ After PE/Activity	_____	_____
_____ Lunch	_____	_____	_____ PRN for Low BG	_____	_____
_____ Mid-afternoon	_____	_____	_____ 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)

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 hard candies
- _____ 3 Glucose tablets
- _____ Concentrated gel or tube feeding
- _____ 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**
- _____ Other

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

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

LUZT PREPARATORY
School Health Services
Diabetes Medical Management Plan Supplement for Student Wearing Insulin Pump

Reviewed 3-2017

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: <input type="checkbox"/> infusion sets <input type="checkbox"/> reservoirs <input type="checkbox"/> batteries <input type="checkbox"/> dressings/tape <input type="checkbox"/> insulin <input type="checkbox"/> 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 hours 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).
 - _____ Disconnection 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.	_____ Insulin injection given.
_____ Detachment of dressing / infusion set out of place.	_____ Other: _____
_____ Leakage of insulin.	_____

Effective Date(s) of Pump Plan: _____

Parent's Signature: _____

Date: _____

School Nurse's Signature: _____

Date: _____

Diabetes Care Provider Signature: _____

Date: _____



SCHOOL HEALTH SERVICES

Parental Authorization for Administration of Medication (s)

Student Name _____ DOB ____/____/____ Grade/Class _____

As the parent/guardian of the student named above, I request the principal's designee to administer the medication(s) described below to our/my child at school.

Known Allergies:

Medication	Amount/ Strength	Dose	Med. Exp. Date	Time	Purpose of Medication	Date Begins	Date Ends

Physician's Name: _____ Phone Number: _____

I understand that the provision of Florida Statute 1006.062, school personnel cannot be held liable for reactions or side effects from the administration of the medication(s). I also grant permission for school personnel to contact the physician if there are questions or concerns about the medication(s). I hereby authorize School Health Services staff to reciprocally release verbal, written, faxed or electronic student health information regarding the above named child for the purpose of giving necessary medication or treatment while at school. I understand Hillsborough County Public School protects and secures the privacy of student health information as required by federal and state law and in all forms of records, including, but not limited to, those that are oral, written, faxed or electronic. I hereby authorize and direct that my child's medication or treatment be administered in the manner set forth in this authorization form. I understand that I am responsible to furnish/restock all supplies and medications and that any unused medication that is not retrieved by me at the end of the school year will be destroyed. I have read the attached guidelines and agree to abide by them.

Please list the medications your child take at home (include dosage and times):

Where does the child go after school? _____

PLEASE NOTE EARLY RELEASE DAYS MAY IMPACT ADMINISTRATION OF MEDICATION.

Early release time: 12:00pm Will medication be given? YES NO

Parent/Guardian Signature _____

Date _____

Daytime Contact Number _____



GUIDELINES FOR ADMINISTRATION OF MEDICATION

It is recognized that medications may be essential for some students. When possible, all medications should be administered at home. If medication must be given at school, the following procedures are required:

1. All medications given at school must be U.S. Food and Drug Administration (FDA) approved for the medical diagnosis.
 - a. Substances not to be given at school are all unregulated products, such as herbs and food supplements, which are being used as treatments, dietary supplements, or folk remedies.

- b. No IV access will be started, flushed, maintained, or discontinued in any circumstance.** No medications will be permitted via central venous catheter or peripheral intravenous central catheters (PICC lines or central lines) including antineoplastic agents, investigational drugs, total parenteral nutrition (TPN), blood or blood products, emergency medications, or antibiotics.

2. Oral non-prescription (over-the-counter) or sample drugs will be dispensed only when accompanied by written orders from a physician, APRN, or PA and must be U.S. Food and Drug Administration (FDA) approved for the medical diagnosis. Students may not carry over-the-counter medications at school.

There is one medication EXCEPTION, medication for the self-treatment of diagnosed Headaches, do not require a doctor's order and the student may self-carry (refer to self-carry form).

- a. Medication is always to remain in the container in which it was purchased and must be unopened when received by the school.

- b. Written parental authorization is needed for all non-prescription drugs.**

- c. Cough drops will be treated as an over-the-counter medication.

- d. Possession of drugs of any kind may lead to serious disciplinary action.

3. No prescription narcotic analgesics are to be dispensed at school. The side effects make it unsafe for students to attend school while medicated with narcotics.

4. A signed statement by the parent/guardian requesting the administration of medication must accompany all medication. The Parent Authorization for Administration of Medication form must be completed before receipt of the medication.

- a. New authorization forms will be required when any changes with the orders occur.

- b. All medication/procedure forms must be updated annually.

5. Medication must be sent to school by a parent/guardian. a. It is not safe for children to deliver medicine to the school. b. This policy prevents safety concerns of lost or stolen medicines, students sharing medicines with friends, and students taking medicine unsupervised.

6. Medication must be in the original prescription container with the: 1) name of drug, 2) date prescribed, 3) dosage prescribed, and 4) time of day to be taken, any special directions, with student's and physician, APRN, or PA names clearly marked.

- a. Medication must remain in the container in which it was originally dispensed.

- b. Most pharmacies will provide an extra empty labeled bottle for school for parents if requested when the prescription is filled. A separate prescription bottle should be provided for field trips.

- c. No more than a month's supply of controlled medication may be brought in at a time. d. All new prescription refills must remain in original container with current expiration date.

GUIDELINES FOR ADMINISTRATION OF MEDICATION (cont.)

7. All medications and/or supplies received must be documented with the parent/guardian, employee, and witness on the Medication and Supply Intake Form.

- a. The amount and date received are to be recorded.
- b. The parent/guardian is also required to sign Medication and Supply Intake Form when picking up medication/supplies.

8. The parent/guardian should arrange for a separate supply of medication for the school. a. Medication will not be transported between home and school. i. Exceptions by Florida statutes 1002.20(h)(i)(j)(k) which require a Parent Self Administration Form and a Physician Self Administration Form for: asthma inhalers, EpiPens, pancreatic enzyme supplements, and diabetes supplies and equipment.

9. When any medications are added or discontinued, a new authorization form is required.

10. When medication dosages or times are changed, a new signed authorization form with the correct information must be completed and a new label from the pharmacist or physician, APRN, or PA order/prescription indicating the change must be sent to the school. a. A fax is acceptable.

11. Medication will be stored in a locked cabinet at the school at all times. a. Exceptions by statutes are asthma inhalers, EpiPens, pancreatic enzyme supplements, and diabetic supplies and equipment. Students who self-carry require a Parent Self Administration Form and a Physician Self Administration Form.

12. Since many students receive medication during school hours, a school district employee designated by the principal will administer medication.

- a. The Registered Professional School Nurse as permitted by Florida law will train the designated employee. The training of designated staff includes HOST, field trips, and when the student is away from school property on official school business.

- b. The medication container with pharmacy label/supplies and paperwork will be sent with the trained staff member, agency nurse, or HOST staff personnel. All medications must be signed out and recorded on the Field Trip Medication Sign Out Sheet.

- c. Under no circumstances may medication be transferred from one container to another by anyone other than Registered Pharmacist with the exception of field trips. Clinic staff preparing for field trips will send medication in original container.

13. Liquid medication will be given in a calibrated measuring device supplied by the parent.

14. All medications/supplies must be removed from the school premises within one week of the expiration date, upon appropriate notification of medication being discontinued, or at the end of the school year. Medications/supplies that are unused and unclaimed will be destroyed following proper disposal procedures.

16. Non-medicated sunscreen and insect repellent may be administered without a prescription, but a parent/guardian authorization form must be completed.

Florida Statue 1006.062 is the reference for the above guidelines.