Lutz Preparatory School
School Health Services
17951 North US HWY 41 • Lutz, FL • 33549 • 813-428-7100

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:** _____

Grade: _____

My permiss ion 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

Time to be performed:

_____ Before breakfast
_____ Mid-morning: before snack
_____ Before lunch
_____ Dismissal
_____ Before PE / Activity Time
_____ After PE / Activity Time
_____ Mid-afternoon
_____ 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	TIME TO BE ADMINISTERED
_____ 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)

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

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

IV. MANAGEMENT HIGH BLOOD SUGAR (>200 mg/dl) Range for this student _____

(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) Range for this student _____

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:

_____ 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 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

Physician Stamp

LUTZ 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: ☐ 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 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.
_____ 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: _____

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.

Emergency Plan of Action for: DX: Diabetes

Student Name:	Class/Grade:
Parent Name:	Parent Phone:
Physician Name:	Physician Phone:

If you see this!	Do this!
Diabetes is a disorder in which the body can't use glucose normally because the pancreas doesn't produce insulin. The disease is controlled by administration of insulin either by syringe or by Insulin Pump. Students test their blood glucose. The goal is to balance diet, insulin and physical activity. Hypoglycemia is low blood glucose. Hyperglycemia is high blood glucose.	**PREVENTION**: 1. When student requests to go to the nurse for help, allow them to go with 2 escorts. 2. Allow student to eat their snacks as needed 3. Report concerns about habits or missed meals that may affect the student's health 4. Don't use food as a reward. 5. Recognize symptoms or behaviors that are different or unusual and report to nurse. 6. Report safety problems in classroom
HYPOGLYCEMIA (Low Blood Glucose): Please indicate_____ Shaky, sweating, dizzy, anxious, blurry vision, fatigue, headache, irritable, fast heartbeat. If needed, please list any other symptoms: _____ _____	1. **Symptoms**: Call the school nurse; 2. **Blood Glucose**: Check right away; 3. **Treatment:** for Low Blood Glucose per MD's orders 4. For emergency situations treat anyway: per MD's orders 5. **Re-check**: blood glucose after 15 min. If still low, treat per MD's order. Call parents.
HYPERGLYCEMIA (High Blood Glucose): Please indicate_____ Extreme thirst, need to go to the bathroom often, hungry, drowsy, dry skin. If needed, please list any other symptoms: _____ _____	1. Take student to the clinic if displays symptoms; 2. **Blood Glucose**: Check per MD's orders 3. **Treatment**: for High Blood Glucose per MD's orders 4. Call the parents.
BLOOD GLUCOSE TESTING: May be done at the clinic or sometimes in other areas.	1. Allow student to check BG levels per MD's orders: daily and/or when student requests to do so; DAILY TIMES: _____ 2. Allow student to check BG Levels in class, in clinic, or other areas per MD's orders.
EMERGENCY: Low Blood Glucose Levels can cause loss of consciousness, seizures & respiratory/cardiac arrest. Recognizing problems & treating quickly can prevent extreme reactions.	1. **Please indicate emergency medication: _____.** Designated SHS Staff Personnel or Trained Staff to administer if available. 2. Call for CPR/AED Team; Bring trauma bag, AED to location; 3. Call 911 4. CAll Parents
SNACKS: Scheduled meals & snacks are vital to maintaining Blood Glucose levels; Scheduled or PRN snacks, as needed. Parents will provide snacks.	1. Snack Times: allow student to have snacks at designated times:_____ 2. Support student eating regularly and with adequate amounts of food; 3. Contact Clinic Staff or SHS, if student changes eating habits.
Physical Activity: Increased physical activity and warm weather may cause symptoms of hypoglycemia	1. Check for symptoms of low Blood Glucose 2. Treat for Low BG per MD's orders (see above) 3. **Blood Glucose:** Allow student to check BG levels related to PE times & days as ordered by MD; *Please indicate PE- Days & times:_____
Insulin Pump: A device that delivers insulin to the student's body intermittently throughout the day via a very small catheter. Problems with the pump can alter the Blood Glucose levels.	Allow student to go to School Clinic for support if Insulin pump is malfunctioning. Parent will be contacted

Known Allergies:

Please attach a copy of the Emergency Card to this form.

If an Emergency occurs: **1. Stay with child** **2. Call or have someone else call for the School's Health Assistant, LPN or Registered Nurse** **3. Call for the activation of the AED Team to your location, if the student requires CPR or the use of the AED**	
Physician Name:	Physician Phone #:

Principal Signature/Date:	**Parent Signature/Date:**