

Student's Name: _____

Date of Birth: _____

NOTIFY PARENT of the following conditions: (If unable to reach parent, call diabetes provider office.)

- a. Loss of consciousness or seizure (convulsion) immediately after calling 911 and administering glucagon.
- b. Blood sugars in excess of 300 mg/dl, when ketones present.
- c. Abdominal pain, nausea/vomiting, fever, diarrhea, altered breathing, altered level of consciousness.

SPECIAL MANAGEMENT OF INSULIN PUMP:

- Contact Parent in event of:
 - Pump alarms or malfunctions
 - Detachment of dressing / infusion set out of place
 - Leakage of insulin
 - Student must give insulin injection
 - Student has to change site
 - Soreness or redness at site
 - Corrective measures do not return blood glucose to target range within _____ hrs.
- Parents will provide extra supplies including infusion sets, reservoirs, batteries, pump insulin, and syringes.

This student requires assistance by the School Nurse or Trained Diabetes Personnel with the following aspects of diabetes management:

- Monitor and record blood glucose levels
- Respond to elevated or low blood glucose levels
- Administer glucagon when required
- Calculate and give insulin injections
- Administer oral medication
- Monitor blood or urine ketones
- Follow instructions regarding meals and snacks
- Follow instructions as related to physical activity
- Respond to CGM alarms by checking blood glucose with glucose meter. Treat using Management plan on page 1.
- Insulin pump management: administer insulin, inspect infusion site, contact parent for problems
- Provide other specified assistance: _____

This student may independently perform the following aspects of diabetes management:

- Monitor blood glucose:
 - in the classroom
 - in the designated clinic office
 - in any area of school and at any school related event
- Monitor urine or blood ketones
- Calculate and give own injections
- Calculate and give own injections with supervision
- Treat hypoglycemia (low blood sugar)
- Treat hyperglycemia (elevated blood sugar)
- Carry supplies for blood glucose monitoring
- Carry supplies for insulin administration
- Determine own snack/meal content
- Manage insulin pump
- Replace insulin pump infusion set
- Manage CGM

LOCATION OF SUPPLIES/EQUIPMENT: (Parent will provide and restock all supplies, snacks and low blood sugar treatment supplies.)

This section will be completed by school personnel and parent:

	Clinic room	With student		Clinic room	With student
Blood glucose equipment	<input type="checkbox"/>	<input type="checkbox"/>	Glucagon kit	<input type="checkbox"/>	<input type="checkbox"/>
Insulin administration supplies	<input type="checkbox"/>	<input type="checkbox"/>	Glucose gel	<input type="checkbox"/>	<input type="checkbox"/>
Ketone supplies	<input type="checkbox"/>	<input type="checkbox"/>	Juice /low blood glucose snacks	<input type="checkbox"/>	<input type="checkbox"/>

My signature provides authorization for the above Diabetes Mellitus Medical Management Plan.

I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.

SIGNATURE of AUTHORIZED PRESCRIBER: _____ **DATE:** _____

Authorized Prescriber: MD, NP, PA

Name of Authorized Prescriber: _____

Address: _____

Phone: _____

SIGNATURES

I, (Parent/Guardian) _____ understand that all treatments and procedures may be performed by the student and/or Trained Diabetes Personnel 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 give permission for school personnel to contact my child's diabetes provider for guidance and recommendations. I have reviewed this information form and agree with the indicated information. This document serves as the Diabetes Medical Management Plan as specified by Georgia state law.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

SCHOOL NURSE SIGNATURE: _____ DATE: _____