San Diego Unified
SCHOOL DISTRICT

Nursing and Wellness Program

Student's Name:	
School:	
School Nurse/contact number:	
Itinerant Nurse/contact number:	
Parent's phone number:	
Alternate ER number:	

Algorithms for Blood Glucose Results at School
SCHOOL ACTION PLAN

Below: _____

1. Give fast acting sugar source*. If blood glucose is ≤ 50, give 30 gm carbohydrates. If blood glucose ≥ 50, give 15 gm carbohydrates
2. Observe for 10 – _____ minutes.
3. Retest blood glucose. If ≤ than _____repeat sugar source*. If ≥ _____ give carbohydrate and protein snack (see samples below) or within one hour to next meal feed early.
4. Notify school nurse if two or more episodes in one week.

If Student conscious but not very cooperative, Give Glucose Gel 15gm

If Student Becomes Unconscious, Seizures, or is Unable to Swallow:

1. Call 911
2. Give glucagon
   ☐ 0.3mg ☐ 0.5mg ☐ 1.0mg
3. Turn student on side to ensure open airway/avoid aspiration
4. Notify school nurse and parents
5. Notify physician when:
   _____
   _____
   _____

Check Blood Glucose

From:_____ To:_____

1. If student feels OK, may resume school activities.
2. If the student does not feel OK, retest blood glucose immediately.

   *If ≤_____, treat for "below_____"

   *If ≥ _____, and not feeling well, consult with school nurse

Above: _____

Check ketones ☐ Yes ☐ No

Student Feels OK – Ketones Neg. – Sm.	Student Does Not Feel OK - Ketones Mod.- Large
1. Give correction insulin if ordered	1. Give correction insulin if ordered
2. Give 1-2 glasses of water every hour until ketones are negative	2. Consult immediately with school nurse. Notify parents.
3. Give insulin if ordered	3. Provide 1-2 glasses of water every hour until ketones are negative. ***Unlimited bathroom privileges**
4. ☐ Have student exercise	**If at any time student vomits, becomes lethargic, and/or has labored breathing CALL 911**
5. Notify parents if small ketones are present	
6. Notify school nurse if two or more episodes occur in one week	
7. Student ☐ may exercise ☐ may not exercise (PE, recess) if ketones are: ☐ negative ☐ small	

Fast Acting Sugar Sources (15 gm carbohydrate)	
• 3-4 glucose tablets	• ½ C apple juice
• 15 gm. glucose gel	• ½ C grape juice
• ½ C sugared soda	• ½ tube cake mate
• ½ C orange juice	• 3 tsp. sugar (in water)
• 3 graham cracker (2.5"ea)	• 8 animal crackers

Protein/15 Gm carbohydrate snacks	
• Cheese & crackers	• Protein bar
• Trail mix (3T/1oz.)	• ½ meat/cheese sandwich
• Peanut butter & crackers	• Granola bar
• Beef jerky (1oz.)	• 2 graham crackers & 1/2 C milk
• _____	

MD Signature:_____ Date:_____

San Diego Unified
SCHOOL DISTRICT

Nursing & Wellness Program

Parent Consent and Health Care Provider Authorization for Management of Diabetes at School and School Sponsored Events

(ATTACH "ALGORITHMS FOR BLOOD GLUCOSE RESULTS")

Student _____ DOB _____ School _____ Grade _____

PHYSICIAN'S WRITTEN AUTHORIZATION: PLEASE SIGN AND CHECK ALL BOXES THAT APPLY

1. Blood Glucose Testing:

☐ Before meals ☐ Before snacks ☐ As needed

☐ Before PE: If BG ≤ _____ give _____ gm snack

☐ After PE: If BG ≤ _____ give _____ gm snack

☐ Before bus ride of ≥ _____ minutes

☐ Per Exercise orders sheet

Treat BG < _____ or > _____ per attached Algorithm

Hemoglobin A_{1C} _____ mg/dl on _____ (date)

2. Daily Carbohydrate Regimen

		Insulin: CHO
Breakfast	_____ # of CHO;	1u : ___ gms
A.M. Snack	_____ # of CHO;	1u : ___ gms
Lunch	_____ # of CHO;	1u : ___ gms
P.M. Snack	_____ # of CHO;	1u : ___ gms

Snacks:

☐ None ☐ Morning ☐ Afternoon ☐ Optional

☐ Snack < _____ CHO does not require insulin coverage

3. Insulin Regimen at School - Carb Counting:

☐ No insulin at this time

☐ Insulin at lunch time

☐ Insulin for snacks > _____ CHO

☐ Correction dose if > _____ hrs since breakfast;

☐ and ☐ or > _____ hrs until lunch

Insulin Type/Brand: _____

Delivery Method: ☐ Syringe ☐ Insulin Pen ☐ Insulin Pump

☐ Always round down to the nearest ☐ HALF unit ☐ FULL unit

4. Sliding Scale Insulin – No Carb Counting

Blood Glucose from _____ to _____ = _____ Units
Blood Glucose from _____ to _____ = _____ Units
Blood Glucose from _____ to _____ = _____ Units
Blood Glucose from _____ to _____ = _____ Units

☐ Before meals ☐ Before snacks

☐ As needed for BG > _____, if > 2hrs since last dose and > 2 hrs until next scheduled dose

5. Insulin Calculation Formula

Blood Glucose (BG) – Target BG + Sensitivity = Correction Dose (Correction Factor)

Target Glucose = _____

Sensitivity = _____

☐ Calculate at ☐ lunch time ☐ snack time

☐ Add CHO dose & Correction dose before rounding down

Exceptions: _____

_____

_____

6. Insulin Pump Regimen at School:

☐ MD orders for Pump Settings are required if licensed nurse is needed to manipulate pump and/or administer insulin (Must be attached)

☐ Do not give any bolus (meal or correction) more often than every two hours

☐ If correction factor has been given > 1 hr ago but <2 hrs ago, lunch bolus can be given ONLY IF BG is decreasing. If BG is not decreasing, wait 2 hrs to check BG and treat according to algorithm

For emergencies, disasters or pump failure, check BG every _____ hours and give insulin via syringe/pen using previous orders in:

☐ Section 2 ☐ Section 4
☐ Section 3 ☐ Section 5

A site or district Registered Credentialed School Nurse will determine the appropriate level of nursing care and supervision required if the student is not independent in all aspects of care.

_____ _____
Physician's Signature Date

_____ _____
Phone Number Fax Number

Parent Consent for Management of Diabetes at School

Student _____ DOB _____ School _____ Grade _____

We(I), the undersigned, the parent(s)/guardian(s) of the above named pupil, request that the specialized physical health care service for Management of Diabetes at School and School Sponsored Events be administered to our (my) child in accordance with Education Code Section 49423.5. **I will:**

1. Provide the necessary supplies and equipment.
2. Notify the school nurse if there is a change in pupil health status or attending physician.
3. Notify the school nurse immediately and provide new consent for any changes in physician's orders.

I authorize the school nurse to communicate with the physician when necessary.
I understand that I will be provided a copy of my child's completed Individual School Healthcare Plan (ISHP).

Parent/Guardian Signature _____ Date _____

Physician Authorization for Management of Diabetes at School

My signature below provides authorization for the written orders. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization (may be faxed).

- ☐ I request that the School Nurse provide me with a copy of the completed Individual School Healthcare Plan (ISHP).
- ☐ I have instructed _____ (Child's Name) in the proper way to use his/her **medication(s)**.

It is my professional opinion that this student be allowed to carry and administer such **medication(s)** by himself/herself. **Physician Initial** _____

Physician Name _____ (Print) Physician Signature _____ Date _____

Address _____ City _____ Zip _____

Phone # _____ Fax # _____