**Northside Independent School District**
**Health Services Department**

## Medical Diabetic Supplies Insulin Pump

| Student Name | Date of Birth | Home Phone | |
|---|---|---|---|
| Address | City | State | Zip |
| Health Care Provider | | Office Phone/Fax | |
| Diagnosis | Diabetes is D **Stable** D **Sensitive** D **Unstable** | | |

**Provision for Diabetes in School**

| **The Student Requires the Following Supplies:** | **YES** | **NO** |
|---|---|---|
| Blood glucose meter and strips | | |
| Lancets and lancet device | | |
| Urine ketone test strips | | |
| Glucagon emergency kit | | |
| Glucose tablets or other sugar source | | |
| Complex carbohydrate snacks | | |
| 6 insulin syringes (3/10cc) | | |
| 1 Bottle of quick-acting (lispro) insulin-unopened and refrigerated | | |
| Alcohol wipes or antibacterial skin cleanser | | |
| 1 Insulin pump cartridge | | |
| 1 Infusion set | | |
| 1 Transparent dressing | | |
| Extra insulin pump batteries | | |
| Pump Manuel | | |
| Sharps container | | |
| **The Student Should:** | | |
| Check blood glucose immediately before lunch | | |
| Check blood glucose any time student does not feel well | | |
| Check urine ketones if blood glucose >250 or when ill | | |
| Have blood glucose meter and check blood glucose in the classroom | | |
| Have water bottle, snacks and source of rapid-acting sugar in the classroom | | |
| Have liberal bathroom privileges or permanent hall pass, especially if blood glucose has been elevated | | |

**Parent Consent and Physician Authorization**

**For Management of Diabetes at School and School Sponsored Events**

Individual School Healthcare Plan (ISHP) and Standard Procedures will provide details for Implementation

| **Name:** | **DOB:** | **School:** | **Grade:** |
|---|---|---|---|

Physician's Written Authorization: Please initial and check all boxes that apply

1. **Blood Glucose Testing**: Before meals As needed

2. **Routine Care of Hypoglycemia when below 70:**
   __ Self treatment of mild lows Assistance for all lows
   Notify Physician when:_____

3. **Emergency Care of Severe Hypoglycemia:**
   __ Glucose gel: Conscious Unconscious
   __ Glucagon injection: 0.5mgm 1mgm Notify the Physician when:_____

4. **Care of Hyperglycemia:**
   __ 240 or above 300 or above Other:_____
   Check for ketones if 300 or above
   Notify physician when: _____

5. **Insulin at School:**
   __ Not at this time
   __ Correction Dose (see next column)
   __ Breakfast AM snack Lunch PM snack (see next column)

**If insulin at school: Brand Name and Type:**

_____

**Insulin Administration Equipment:**
__ Syringe and vial Insulin pump
__ Insulin pen Other:_____

**Insulin Dose Determined By (**Check all that apply**):**

__ **Standard lunchtime dose**:_____

__ **Insulin to Carbohydrate Ratio:**
- ___ # of unit(s) insulin per _gms Carbohydrate

__ **Correction Calculation:**
- Give_____unit(s) for every mg/dl above _____mg/dl (target blood sugar)
- Decrease correction by % unit(s) if PE or increase activity is anticipated after correction dose, or last dose was given less than 2 hours before
- Other: _____

___ **Written sliding scales as follows:**
Blood Glucose from_____to_____=_____Units
Blood Glucose from_____to_____=_____Units
Blood Glucose from_____to_____=_____Units
Blood Glucose from to = Units

Other Needs (specify):

**Parent Consent for Management of Diabetes at School**

We (I), the undersigned, the parent/guardian (of the above named pupil, request that the following specialized physical health care service for Management of Diabetes in school be administered to our (my) child in accordance with state laws and regulations. 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 doctor'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 _____
**Print Name:**

**Physician Authorization for Management of Diabetes at School**

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that healthcare services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one school 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 Individualized School Healthcare Plan (ISHP).

**Physician Signature**_____**Date**_____

**Address**_____**City**_____**Zip** _____
(use office Stamp)

**Office Number** **Fax Number**

**Received by School Nurse (Signature)**_____**Date** _____