Hillsborough County Public Schools
Tampa, Florida
School Health Services ♦ 901 E. Kennedy Blvd ♦ Tampa, FL ♦ 33602 ♦ 813-273-7020

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:** _____

Teacher: **School:** **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 (requires affidavit): 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)

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 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)***

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 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