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**UAB Department of Pediatrics @
 Children's of Alabama**

**THE CHILDREN'S HOSPITAL DIABETES CENTER
 FAX COVER SHEET FOR BLOOD SUGAR MANAGEMENT**

OFFICE PHONE (205) 638-9107
 OFFICE FAX (205) 638-9821

TODAY'S DATE: _____
 CHILD'S NAME: _____
 DATE OF BIRTH: _____
 BEST DAYTIME PHONE NUMBER: _____
 (please include area code)
 CELL PHONE NUMBER: _____
 (please include area code)

ATTENTION:

Dr. Hussein Abdullatif _____
 Dr. Ambika Ashraf _____
 Dr. Joycelyn Atchison _____
 Dr. Giovanna Beauchamp _____
 Dr. Pallavi Iyer _____
 Dr. Rose James _____
 Dr. Kenneth McCormick _____
 Dr. Gail Mick _____
 Dr. Mary Lauren Scott _____
 Dr. Michael Stalvey _____
 Ava Mitchell, DNP CRNP _____
 Leslie Pitts, CRNP _____
 Alexandra Armstrong, CRNP _____

Diabetes Educators

Heather Armstrong, RN, CDE _____
 Becky Earman, RN, CDE _____
 Sheila Benton, RN, CDE _____
 Nicole Chilton, RN, CDE _____
 Deborah Chadwick, RN, CDE _____
 Jerilynn Gehri, RN _____
 Jasmine Barnett, RN _____
 Mary Heatherly, RN _____
 Leah Black, RN _____
 Amanda Nelson, RN _____
 Mary Cochran, RN _____
 LaToya Young, RN _____
 Shamblin Griffice, RN _____
 Desiree Hill, RN _____

Social Workers

Katie Martin _____
 Keisha Hunter _____

Nutrition

Rainie Carter _____
 Gary Atchley _____

****ONLY USE THIS FAX SHEET FOR ROUTINE CONCERNS/BLOOD SUGAR ADJUSTMENT****

Number of page including cover sheet: _____



Format to FAX Blood Sugars

Date: _____

Diabetes Doctor: _____

Child's Name: _____ Age: _____ Date of birth: _____

Caregiver's Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ FAX# _____

**** IMPORTANT** \Rightarrow Please complete { Child missed _____ days of school last week related to diabetes;
Behavior changes noticed over last 2 weeks? (Circle one) Yes / No

Current Dose

Average amount of carbohydrates each meal and snacks (if applicable): ___ Breakfast/ ___ lunch/ ___ Supper/ ___ snacks

Correction Formula (if applicable): _____

<u>Medication(s)</u>	<u>Morning</u>	<u>Lunch</u>	<u>Supper</u>	<u>Bedtime</u>	<u>Snack</u>
Humalog/ Apidra\ Novolog	_____	_____	_____	_____	_____
Lantus or Levemir	_____	_____	_____	_____	_____
Metformin (Glucophage)	_____	_____	_____	_____	_____
Byetta / Symlin	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____

Main Concern(s): _____

**** Ketones present:** ___ No; ___ trace; ___ small; ___ moderate; ___ large

List any frequent special activities and times (for example: Dance class 3-5 Mon., Wed., Friday or sports, etc.).

Blood Sugar Readings

Date	Before Breakfast	Mid-Morning	Before Lunch	Mid Afternoon	Before Supper	Before Bed	During the Nighttime

CONFIDENTIALITY & HIPAA PRIVACY NOTICE: Protected Health Information may be enclosed

IMPORTANT: This information is intended only for the use of the individual or entity to which it is addressed. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled.

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Children's of Alabama

Patient's Full Name: _____ Date of Birth: _____

Caregiver's Name: _____ phone # _____ cell phone: _____

Blood Sugar Log for the Week Starting (mm/dd/yy): _____

Insulin Type: _____ Correction Factor: AM _____ PM _____

Insulin to Carbohydrate Ratio/fixed dose: Breakfast _____ Lunch _____ Dinner _____ Snack _____

Lantus / Levemir / Basaglar / Tresiba / Toujeo (circle correct name) Dose and Time taken: _____

Dates m/d/yy	Breakfast			Lunch			Dinner			Bedtime			During the Night			Ketone Test Results	Notes
	Blood Sugar Before and Time	Insulin Dose	# of carbs	Blood Sugar Before and Time	Insulin Dose	# of carbs	Blood Sugar Before and Time	Insulin Dose	# of carbs	Blood Sugar Before and Time	Insulin Dose	# of carbs	Blood Sugar Before and Time	Insulin Dose	# of carbs		
Monday																	
Tuesday																	
Wednesday																	
Thursday																	
Friday																	
Saturday																	
Sunday																	

Comments: _____



Diabetes School Plan: Physical Activity (Exercise) and the Insulin Pump

Name: _____ DOB: _____

This patient has been diagnosed with Diabetes and is on an insulin pump. The current therapy includes: carbohydrate counting, and insulin pump and exercise. Thirty minutes of physical activity five times per week is important for everyone. One of the most important reasons for people with diabetes to exercise regularly relates to increasing insulin sensitivity. Please allow this student to participate in sports. One of the greatest advantages of insulin pump use is the ability to reduce insulin before, during or after exercise. There is no duration or intensity of exercise that cannot be handled using an insulin pump with planning and experience.

Frequent Blood Glucose testing, is the key. Check blood glucose every hour and follow the Diabetes School Plan: Insulin Pump instructions for treating Low and High blood glucose levels.

The two options for insulin pump management of blood glucose levels during exercise are as follows:

1. Adjust Basal Rates for Exercise with a Temporary Basal Rate.

- a. Low Level Activity: Less than 20 minutes. No change in dose is needed.
- b. Moderate Level Activity: 20-45 minutes. Decrease basal rate by 30%. Start temporary rate 30 minutes before the physical activity, each hour during, and for 1 hour after completing the activity.
- c. Intense Level Activity: More than 45 minutes. Decrease basal rate by 50%. Start temporary rate 30 minutes before the physical activity, each hour during, and for 1 hour after completing the activity.

2. Disconnect the Insulin Pump for physical activity.

- a. Never disconnect for longer than ONE HOUR at a time without checking blood glucose.
- b. Bolus for $\frac{1}{2}$ if the current basal rate to be missed for that hour.
- c. Give this bolus at the start of the hour the child is to be disconnected.
- d. After ONE hour reconnect and check blood glucose level.
- e. Treat according the Insulin Pump instructions for treating Low and High blood glucose levels.
- f. You may disconnect for multiple hours as long as the above instructions are repeated.

Check Blood Glucose before and each hour during activity. Treat as indicated per Diabetes School Plan. Bolus for correction and carbohydrates eaten as indicated.

Physician Signature _____

New 04/29/15;

Date: _____

Date of Plan: _____

Expiration Date: _____

DIABETES MEDICAL MANAGEMENT PLAN

STUDENT: _____ DOB: _____

DIAGNOSIS: Type 1 Type 2 Other Diabetes _____

Children's of Alabama (COA)

- Diabetes Office (205) 638-9107 or 1-877-276-6850
 - During business hours of 8:30am to 4pm (Monday through Friday)
- 24 hour emergency number (205) 638-9100 and ask for diabetes doctor on call

Notify parents/guardian or emergency contact in the following situations: Presence of moderate or large ketones with vomiting, high/low blood glucose readings, use of correction dose for high blood glucose, treatment of low blood glucose, and not feeling well.

_____ is a patient of COA with diabetes. Diabetes can cause blood glucose (sugar) levels to be too high or too low, both of which affect the student's ability to learn as well as seriously endangering the student's health both immediately and in the long term. It is very important that food intake, exercise, and insulin be in balance to ensure overall health and wellbeing. The information in this packet must be followed throughout the school day and school sponsored functions/activities to maintain blood glucose (sugar) level within acceptable range.

COA Diabetes Providers

Hussein Abdullatif, MD

Ambika Asraf, MD

Joycelyn Atchison, MD

Giovanna Beauchamp, MD

Pallavi Iyer, MD

Rose James, MD

Kenneth McCormick, MD

Gail Mick, MD

Mary Lauren Scott, MD

Michael Stalvey, MD

Heather Choat, MD

Jurhee Freese, MD

Erin Greenup, MD

Jessica Schmitt, MD

Bhuvana Sunil, MD

Alexandra Armstrong, CRNP

Bethany Heron, CRNP

Ava Mitchell, DNP, CRNP

Leslie Pitts, CRNP

Erin Tuanama, CRNP

The enclosed forms are endorsed by the COA Diabetes Team. The signed forms will serve as authorization to have and receive medication at school. The school medication prescriber authorization forms with this packet are the only forms COA will use. The COA Diabetes Team will not accept any outside forms.

Supplies Needed:

Caregiver is responsible for providing diabetes supplies and food to meet the needs of the student.

"It is strongly recommended that meter, strips, & lancet device be kept with student for use as needed."

Exercise (such as PE or recess)

Exercise is important for all children, and children with diabetes are no exception. **Exercise helps with their blood sugar control and allows their insulin to work more effectively.** A person with diabetes should not be and does not want to be treated differently because of having diabetes.

- The student is not required to check blood sugar prior to exercise unless showing signs/symptoms of high or low blood sugar or is added to the treatment/intervention form or is requested by parent(s)/caregiver(s).
- If student exhibit signs of high &/or low blood sugar readings, please check blood sugar.
- **If the student has a low, treat the low, make sure blood sugar readings are 100 and above (after treatment of the low) and send the student to PE. Remember the student can now exercise.**
- Fast acting carbohydrates should be made available at the site of exercise. Examples can include glucose tablets, glucose/cake gel, regular Gatorade, regular soda, and skim milk.
- **Cheese & crackers, meat sandwich, etc. are examples of other snacks that can be given after returning the blood sugar to 100 or above.**
- Student should have glucose meter and water always available. Increased water intake is recommended during exercise.
- Student should not exercise if moderate to large ketones are present or if student is ill with trace or larger ketones. (Ketones should be checked per the hyperglycemia algorithm, and anytime the child is not feeling well or vomiting)

Medication Route

Insulin Therapy

- **Injection** (See Treatment for Hyperglycemia/Hypoglycemia on pages 7 & 9)

Meal Time Dose – See medication prescriber/parent authorization form, labeled "meal dose" for dosage and route. **This is always given for food.**

Correction Dose – Use medication authorization form labeled "correction dose", for blood glucose above the target number. Example: $(\text{Blood sugar} - 150) / 50$; Target blood sugar is 150

CORRECTION FACTOR DOSE SHOULD NOT BE GIVEN ANY CLOSER THAN 3 HOURS APART

- If **NO** correction factor is needed at meal/snack time, **NO** correction factor can be given for high blood sugar, until it has been a **minimum of 2 hours** after the meal/snack dose.

SAMPLE CALCULATIONS

Order 1

- **Correction factor** = $(BS-120)/20$; use only if it has been **3 hours** since last correction dose
- **Meal ratio** = 1 unit per 7 grams of carbohydrates (plus correction factor if applicable)
- **Rounding** = round down to the nearest whole unit

Before lunch BS= 155

$$(155 - 120) / 20 = 1.7 \text{ correction dose for high BS}$$

Carbohydrates to eat = 96

$$96 / 7 = 13.7 \text{ meal dose}$$

**Total units = 15.4 add the two totals together first before rounding
(after rounding down to the nearest whole unit from 15.4)**

Total units to give = 15 units

Order 2

- **Correction factor** = $(BS - 150) / 125$; use only if it has been **3 hours** since last correction dose; the student received a correction dose at 9am for high blood sugar reading
- **Meal Ratio** = 1 unit Novolog per 40 grams of carbohydrates (plus correction factor if applicable)
- **Rounding** = round to the nearest half unit

Before lunch BS = 215 at 11:00am

has not been 3 hours or greater; **cannot use correction**

Carbohydrates to eat = 20

$$20 / 40 = 0.5 \text{ meal dose}$$

Total units = 0.5 for meal

Student will receive only the insulin for his/her meal only; it is too soon to give a correction dose.

Order 3

- **Correction factor** = $(BS - 150) / 100$; use only if it has been **3 hours** since last correction dose
- **Fixed dose** = 5 unit Humalog before lunch (plus correction factor if applicable)
- **Rounding** = round down to the whole unit

Before lunch BS = 322

$$(322 - 150) / 100 = 1.7 \text{ correction dose for high BS}$$

Insulin for meal = 5 units

$$5 \text{ meal dose}$$

Total units = 6.7 for meal

Total units to give = 6 units

- **If rounding stated** = round up to the nearest whole unit, then total units to give for this example is 7 unit.

Order 4

- **Correction factor only** = $(BS - 150) / 100$; use only if it has been **3 hours** since last correction dose;
- Use to correct high blood sugar (**meal time and in between**); only if it has been **3 hours or greater** since last correction dose
- At lunch time BS = 230; $(230 - 150) / 50 = 1.6$ rounding down to the nearest whole unit

Total units = 1 unit to give

Rounding

<p>Round to the nearest half unit</p> <p>0.1 – 0.4 = Round down to the whole unit 0.5 = Keep dose as is 0.6 – 0.9 = Round up to the whole unit</p>	<p>Round down to the nearest half unit</p> <p>0.1 – 0.4 = Round down to the whole unit 0.5 = Keep dose as is 0.6 – 0.9 = Round down to the half unit</p>	<p>Round up to the nearest half unit</p> <p>0.1 – 0.4 = Round up to the half unit 0.5 = Keep dose as is 0.6 – 0.9 = Round up to the whole unit</p>
<p>Round to the nearest whole unit</p> <p>0.1 – 0.4 = Round down to the whole unit 0.5 – 0.9 = Round up to the whole unit</p>	<p>Round down to the nearest whole unit</p> <p>0.1 – 0.4 = Round down to the whole unit 0.5 – 0.9 = Round down to the whole unit</p>	<p>Round up to the nearest whole unit</p> <p>0.1 – 0.4 = Round up to the whole unit 0.5 – 0.9 = Round up to the whole unit</p>

Continuous Glucose Monitor (CGM): Yes No

Brand/Model: _____; CGM may be worn daily or occasionally

- Please check if student has a **Dexcom G5 or G6 Mobile System** (smart device such as a cell phone can be used to monitor glucose data without carrying a receiver). A student wearing a **Dexcom G5 or G6 CGM** must carry his/her smart device on self. The smart device such as a cell phone is the receiver for the CGM.
- Dexcom G6 CGM** readings **can** be used for dosing with insulin per FDA approval. (ex. At meal times, or to correct hyperglycemia, unless the parent states they require a finger stick blood glucose). If the symptoms of the student do not correspond with the reading, then a finger stick is needed. **If the CGM reading is greater than 300 or less than 70 the reading should be confirmed with a blood glucose check, using the student's meter, and treated according to the instructions on the pathway.**
- Dexcom G4 or Dexcom G5** readings are **not** to be used for treatments decisions during meal times, or to correct hyperglycemia. The readings can be used for times that do not require treatment with insulin (ex. Before leaving school, before PE, unless the parent states they require a finger stick blood glucose). If the symptoms of the student do not correspond with the reading, then a finger stick is needed. **If the CGM reading is greater than 300 or less than 70 the reading should be confirmed with a blood glucose check, using the student's meter, and treated according to the instructions on the pathway.**
- Freestyle Libre** readings are **not** to be used for treatments decisions during meal times, or to correct hyperglycemia, per FDA. The readings can be used for times that do not require treatment with insulin (ex. Before leaving school, before PE, unless the parent states they require a finger stick blood glucose). If the symptoms of the student do not correspond with the reading, then a finger stick is needed. **If the CGM reading is greater than 300 or less than 70 the reading should be confirmed with a blood glucose check, using the student's meter, and treated according to the instructions on the pathway.**

□ **Medtronic 630G or 670G with the Guardian CGM readings are not to be used for treatments decisions during meal times, or to correct hyperglycemia, per FDA. The readings can be used for times that do not require treatment with insulin (ex. Before leaving school, before PE, unless the parent states they require a finger stick blood glucose). If the symptoms of the student do not correspond with the reading, then a finger stick is needed. (Note: insulin pumps in AutoMode will self adjust basal insulin) If the CGM reading is greater than 300 or less than 70 the reading should be confirmed with a blood glucose check, using the student's meter, and treated according to the instructions on the pathway.**

□ **Pump Therapy (see Treatment for Hyperglycemia / Hypoglycemia on pages 6 & 8)**

- Correction dose can be used every 2 hours as needed when given through an insulin pump because of the programmed feature of active insulin time.
- **For pump failure or loss of infusion site. (remove insulin pump and the student will need to resume insulin injections by syringe or pen):**
 - Independent students with supplies may reinsert infusion set.
 - Recheck blood glucose in 2 hours or next scheduled time, whichever comes first.
 - **Notify caregiver(s) so long acting insulin can be administered. (such as Lantus, Tresiba, Basaglar, etc.)**
 - **If you cannot reach the caregiver(s), suspend and remove the pump and begin manual insulin injections by syringe or pen.**
 - The rapid acting insulin may be administered by syringe injection for insulin to carbohydrate ratio and correction factor doses using the pump prescriber authorization form.
 - **Remember you must wait 3 hours between correction dose administrations while on injections, but give meal dose as scheduled.**
 - Student does not need to go home unless has moderate to large ketones and/or shows signs or symptoms of illness.

Hyperglycemia Insulin Pump



If blood glucose is greater than **250mg/dL** then check for ketones

Check infusion set, site, and pump for kinks, leakage, or failure (if ketones present)

- For pump failure or bad pump site contact family
- If unable to reach family then suspend/remove insulin pump and start manual insulin syringe injection pathway
- Refer to insulin pump Prescriber Authorization form for dosing if insulin pump removed (*Correction factor given every 3 hours per pen/syringe pathway)

Ketones Negative

1. Administer correction factor by insulin pump
2. Return to class with sugar free/caffeine free fluids
3. Resume normal activities
4. Recheck blood glucose and ketones in 2 hours. Give a correction factor bolus if needed
5. If ketones present with recheck then follow appropriate guidelines

Ketones Present without Nausea/Vomiting

Ketones Present (Trace/Small) without Nausea/Vomiting

1. Administer correction factor by insulin pump
2. Return to class with sugar free/caffeine free fluids
3. Resume normal activities
4. Recheck blood glucose and ketones in 2 hours. Give correction factor bolus if needed
5. If ketones present with recheck then follow appropriate guidelines

Ketones Present (Moderate/Large) without Nausea/Vomiting

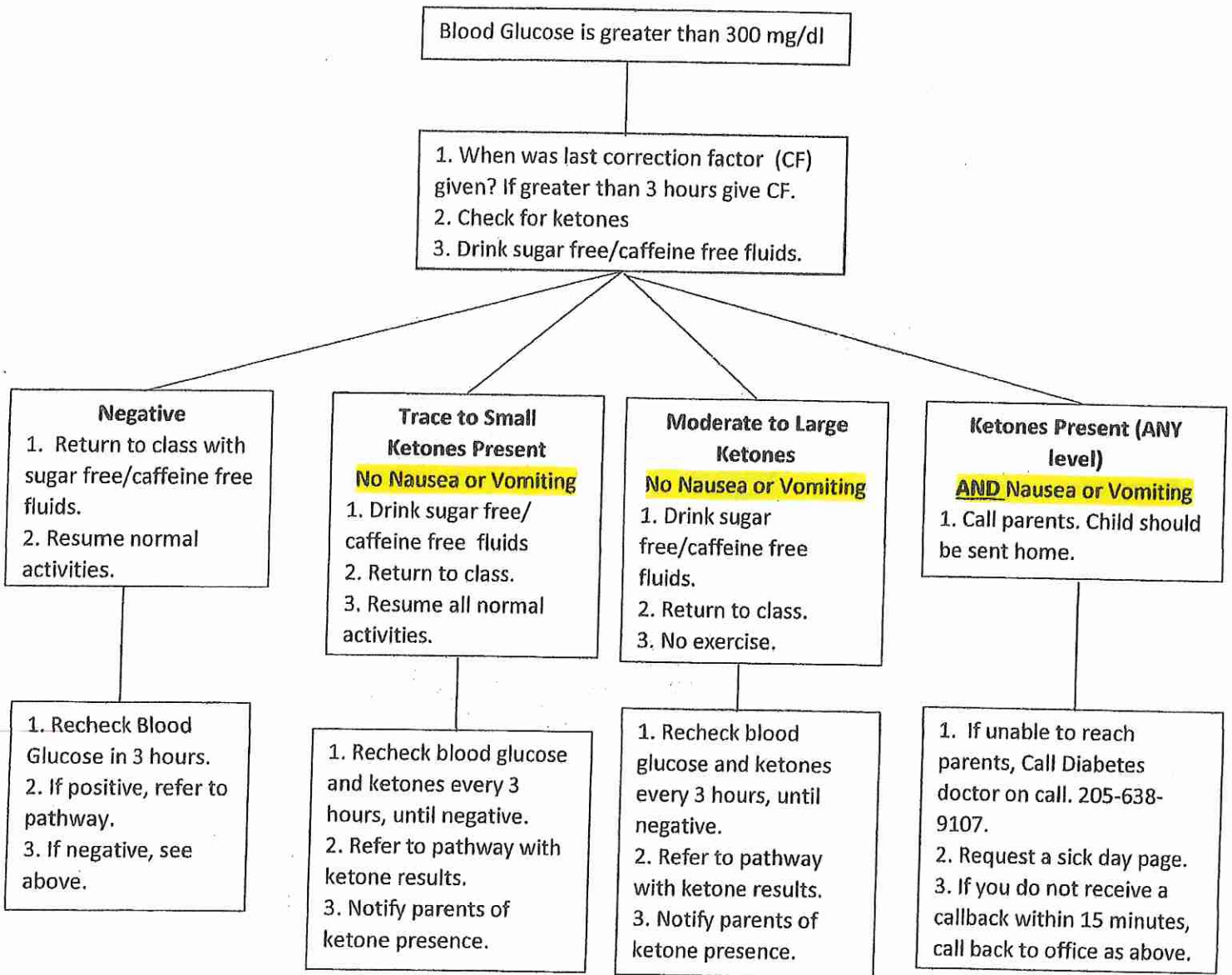
1. Remove insulin pump
2. Administer correction factor by pen/syringe injection rather than with pump
3. Student will need to change insulin pump infusion set, site/pod and refill reservoir/pod with insulin. If student is not marked independent in care then contact family.
4. Return to class with sugar free/caffeine free fluids
5. No physical activity
6. Recheck blood glucose and ketones in 3 hours

Ketones Present with Nausea/Vomiting

1. Remove insulin pump
2. Correction dose of insulin by syringe/pen injection
3. Student will need to change insulin pump infusion set, site/pod, and refill reservoir/pod with insulin. If student is not marked independent in care then contact family.
4. Call parents. Child should be sent home.
5. If unable to reach parents, Call Diabetes doctor on call (205-638-9107) and request a sick day page.
6. If you do not receive a callback within 15 minutes, call back to office as above or call (205-638-9100) and ask for the Diabetes doctor on call.

- Student shall be permitted to have access to water, by keeping a water bottle in his/her possession at his/her desk, or by allowing student unrestricted access to drinking fountain.
Student is not to miss class by sitting in the nurses' office or be sent home unless vomiting or feeling poorly

Hyperglycemia Pen/Syringe Injection



- Student shall be permitted to have access to water, by keeping a water bottle in his/her possession at his/her desk, or by allowing student unrestricted access to drinking fountain.

Student is not to miss class by sitting in the nurses' office or be sent home unless vomiting or feeling poorly

Hypoglycemia Insulin Pump



**Mild/Moderate
Signs/Symptoms**
Pale, Weak, Shaky, Dizzy, Headache, Sweaty, Hungry,
Tired, Falling Asleep, Confused, Irritable, Restless

**Severe
Signs/Symptoms**
Combative, Unable to respond to commands,
Seizure, or Loss of Consciousness

Check Blood Glucose, if less than * remain with student.

If it is meal time and blood glucose is 60mg/dL OR Higher without symptoms:

1. Send the student to lunch
2. Wait to bolus until immediately after eating (no longer than 30 minutes after the first bite of food)
3. Enter the **pre meal low blood glucose** and the amount of carbohydrates eaten into the insulin pump
4. In this situation the insulin pump will adjust the carbohydrate bolus to compensate for the low blood glucose

DO NOT SKIP MEAL INSULIN DOSE FOR LOW BLOOD GLUCOSE

If it is NOT meal time OR If blood glucose less than 60mg/dL at mealtime:

1. Give **up to** 15 grams of fast-acting carbohydrates. (For example **up to** 4 glucose tablets, 4 oz. fruit juice, or 4 oz. of regular soda)
 - If unable to safely swallow, elevate head & use 15 grams of glucose/cake decorating gel applied to inner cheeks.
2. Wait 15 minutes & recheck blood glucose.
3. If blood glucose is still below * retreat and **suspend the insulin pump**.
4. Continue to repeat treatment & recheck blood glucose every 15 minutes until blood glucose is greater than *
5. Resume insulin pump

Remain with student

1. **Immediately stop/suspend insulin pump**
2. Give nothing by mouth
3. Give prescribed dose of **Glucagon** intramuscular - refer to Prescriber Authorization Order as directed
4. Place student on side
5. Call 911 in the event student does not respond to Glucagon within 15 minutes. Follow your school's procedure for notifications.
6. Call parent/guardian
7. Call Diabetes Provider (205-638-9107)
8. Stay with student until help arrives

* Use this "age-specific guide" below to insert the appropriate age in the **highlighted boxes**:

90 = students less than 6 years
80 = students 6 to less than 13 years
70 = students 13 years and greater

Non-meal time...

2. Give student 15 gram carbohydrate snack with protein. (For example 4 peanut butter/cheese crackers)
2. Student to return to class

Meal time...

1. Send student to lunch
2. Wait to bolus until immediately after eating no longer than 30 minutes after the first bite of food
3. Enter the **pre meal low blood glucose** reading into the insulin pump and amount of carbs eaten

For OmniPod users: enter carbs only at meal time. It will not do calculations if blood glucose less than 60mg/dL

Hypoglycemia Pen/Syringe Injection



Mild/Moderate
Signs/Symptoms
Pale, Weak, Shaky, Dizzy, Headache, Sweaty,
Hungry, Tired, Falling Asleep, Confused,
Irritable, Restless

Severe
Signs/Symptoms
Combative, Unable to respond to
commands, Seizure, or Loss of
Consciousness

Check Blood Glucose, if less
than * remain with student.

Remain with student

- Give nothing by mouth
- Place student on side
- Give prescribed dose of Glucagon intramuscular- refer to Prescriber Authorization Order as directed
- Call 911 if student is not responding to Glucagon within 15 minutes. Follow your school's procedure for notifications.
- Call parent/guardian
- Call Diabetes Provider (205-638-9107)
- Stay with student until help arrives

Give **up to** 15 grams of fast acting carbohydrates.

- Ex. **Up to** 4 glucose tablets, 4 oz fruit juice or regular soda

* If unable to safely swallow, elevate head & use 15 grams of glucose/cake decorating gel applied to inner cheeks/gum area.

1. Wait 15 minutes & recheck blood glucose.
2. Repeat treatment & recheck blood glucose every 15 minutes until blood glucose is greater than *

If meal/snack is , less than 1 hour away.....

1. Student ok to return to class/lunch.
2. May receive meal/snack dose insulin immediately after eating (within 30 minutes of first bite) as ordered.

DO NOT SKIP INSULIN FOR LOW BLOOD GLUCOSE

If meal/snack is less than 1 hour away....

1. Give student 15 grams of carbohydrates with protein.

* Use this "age-specific guide" below to insert the appropriate age in the **highlighted boxes**:

90 = students less than 6 years
80 = students 6 to less than 13 years
70 = students 13 years and greater

Glucagon/Glucagen Administration in the School
For Use in Case of Severe Low Blood Sugars (Hypoglycemia)

Symptoms for Use:

- Combativeness
- Inability to swallow
- Disorientation
- Seizures
- Loss of consciousness

Protocol for administering glucagon/glucagen:

1. Remove the plastic caps/covers from the syringe and the vial.
2. Inject all the sterile water from the syringe into the small vial of glucagon/glucagen powder/pill. **Roll** until pill is fully dissolved.
3. Once the solution is clear, draw out (also refer to medication prescriber authorization form)
 - a. 0.5mg into the syringe = ½ ml or the first line you see on the syringe when it is inverted if the student is 44 pounds or less.
 - b. 1mg into the syringe = 1ml or the second line you see on the syringe when it is inverted if the student is greater than 44 pounds
4. Inject glucagon/glucagen in upper/outer thighs, or upper arms, or buttocks.
5. Turn the child on his/her side and check blood sugar. Wait 15 minutes and assess signs of improvement. Call the paramedics while waiting since you are in a school setting. Recheck blood sugar every 15 minutes until blood sugar returns to normal or paramedics arrive.

Follow the steps below when the student responds to treatment, becomes conscious, and more cooperative:

1. Offer 4 oz. of regular soda, regular Gatorade, or juice. Student may only tolerate sips of liquid at this time.
2. Check the blood sugar if a meter is available.
3. Offer a snack or let the child go to lunch for a full meal (with supervision from an adult) if not nauseated or vomiting.
4. Notify the Children's of Alabama (COA) Diabetes Team at (205) 638-9107 or toll free 1-877-276-6850 and ask for the diabetes doctor on call or the diabetes educator.
5. Recheck the blood sugar in 30 minutes to 1 hour, and continue to follow MD instructions received.
6. Call the parent/caregivers ASAP.
7. Instruct the parent/caregivers to call the student's diabetes doctor.

Plan for Athletes with Diabetes

“Our plan is to ensure safe physical activity for student’s with diabetes”

Student: _____

Sport: _____ Coach/Trainer: _____

If a complete sport physical is needed, please obtain from his/her Primary Medical Doctor/Nurse Practitioner.

Prior to the beginning of the sports season the school nurse will:

- o Meet with the coaches and/or athletic trainers to discuss the emergency plan
- o Provide the coach and trainer with a diabetes emergency kit containing:
 - o Glucose/cake gel
 - o Glucose tablets
 - o Juice box / Gatorade or other sports drinks
 - o Cheese crackers
 - o Copies of the student health plan, emergency plan, and glucagon orders
 - **Contact the family to refill supplies**
- o Confirm that EMS can administer glucagon/glucagen and they carry it on their trucks (parents can administer glucagon/glucagen if present)

Prior to practice/game/event:

- o Many students with diabetes may change his/her insulin dose on days he/she anticipates a practice/game/event. Notifying the parents of scheduling changes (extra practices or cancellations) as soon as possible helps the students (and parents) determine insulin needs.
- o The student will be informed by the coach the location of the diabetes kit, encourage the student to stop the sport if he/she feels “low” and need to check his/her blood sugar or have a snack.
- o The nurse will review with the student expectations for participating in sports and review the emergency procedures.
- o The student should have a means of signaling the coach/trainer if he/she needs to leave the playing field.
- o The student will check and record blood sugars prior to practice/game/event
 - o Student will have a snack for blood sugars less than 100
 - o Student will check for ketones for blood sugars greater than 250
 - For negative, trace, or small ketones with no signs of illness, drink sugar free fluids and participate in practice/game/event.
 - If moderate to large ketones or signs of illness are present the nurse and parent will be notified. The student will not participate in practice/event/game.

After the practice/game/event:

- o The student will check blood sugar at the end of the practice/game/event and will treat for a low blood sugar and have a snack for blood sugars less than 90 prior to leaving the practice/game/event.
- o Students are not allowed to drive with a blood sugar less than 90.
- o **Note: If student has a history of severe hypoglycemia following exercise we strongly recommend having blood sugar greater than 100 prior to driving.**

Emergency Plan: (see actual plan for treating hypoglycemia pages 6 & 9)

- o If the student is **awake and able to swallow** – he/she will check his/her blood sugar and treat accordingly with a quick acting glucose followed by a snack.
- o For severe hypoglycemia (combative, loss of consciousness, or seizures) – the coach will activate EMS, apply glucose/cake gel to the inner cheek/gum area per hypoglycemia pathway. If unconscious, position the student on his/her side and then apply gel. Monitor the student until paramedics arrive.
- o The paramedics will check the blood glucose and administer glucagon according to their protocol and the MD orders.

The school nurse will be notified of all incidences of severe hypoglycemia.

If parents are present at an athletic event or practice and severe hypoglycemia occurs, parent may immediately administer glucagon/glucagen.

Transportation by School Bus

It is important for the student with diabetes to take some food with him/her on the bus. If the student feels low, he/she must be allowed to treat the low with fast acting carbohydrates, followed by long acting carbohydrate with protein.

- If the student has an afternoon snack scheduled, and it is not time for the snack, **please allow the student to carry his/her snack on the bus.**
 - Student will need his/her snack, if scheduled, and fast acting carbohydrates for treating lows prior to boarding the bus. (review pages 8 & 9 for examples of fast and long acting carbohydrates)
 - Parents will provide this snack, as well as a copy of the student's daily schedule listing meal and snack times.

Check blood sugars as ordered by the provider, if the student feels low, signs/symptoms of hypoglycemia noted, and/or asked by the caregivers. Please ensure that the student's blood sugar is **80** or above or less than **350** before boarding the bus with no ketones or vomiting present.

If student is:

- **80mg/dl or below**
 - Treat as described on pages 8 & 9 and notify parent(s)/caregiver(s)
 - If blood sugar is greater than 80, 15 minutes after treatment, place on bus
 - If blood sugar is less than 80, 15 minutes after treatment, continue to follow hypoglycemia pathway and arrange alternate transportation with parent(s)/caregiver(s)
- **81mg/dl – 350mg/dl**
 - Allow student to board the bus
- **Above 350mg/dl with no ketones, no vomiting, and feeling well**
 - Student may ride the bus
- **Above 350mg/dl, with urine ketones, and feeling well**
 - Treat as described on pages 6 & 7 and notify parent(s)/caregiver(s)
 - Student may ride the bus unless that bus ride is longer than 1 hour in duration, otherwise alternate transportation should be arranged.
- **Above 350mg/dl, with urine ketones, and not feeling well**
 - Treat as described on page 6 & 7
 - Notify parent(s)/caregiver(s), and arrange for alternate transportation.

**FYI
BLOOD GLUCOSE MONITORS**

I have included the ranges for the meters we have and use below. If you receive a "HI" on one of the meters listed below, plug that number into your formula for the correction factor, or use for dose on sliding scale.

<u>Meter</u>	<u>Range</u>	
	<u>If the meter reads "LO"</u>	<u>If the meter reads "HI"</u>
Accu-chek Nano/Connect	20	600
Accu-chek Aviva	10	600
Accu-check Guide	10	600
Contour	10	600
Contour Next EZ & Next & Next ONE	20	600
Contour USB	20	600
Freestyle	20	500
Freestyle Freedom	20	500
Freestyle Lite	20	500
OneTouch Ultra Mini	20	500
OneTouch Ultra 2	20	600
One Touch Verio IQ	20	600
Relion	20	600

**DIABETES TREATMENT / INTERVENTION
STUDENT INFORMATION FORM**



Student's Name: _____ Date of Birth: ____/____/____

Start Date: ____/____/____

Stop Date: ____/____/____

(DO NOT DISCARD THIS FORM UNTIL THE STOP DATE AS LISTED ABOVE)

STUDENT'S SELF-CARE SKILLS:

Ind = independent self-management; **total** = total care by nurse; **Ino** = independent in nurses office; **kept** = kept on person;
NA = my child is not doing or using this

Blood glucose testing	<input type="checkbox"/> NA	<input type="checkbox"/> Ind	<input type="checkbox"/> total	<input type="checkbox"/> Ino	<input type="checkbox"/> kept
Ketone testing	<input type="checkbox"/> NA	<input type="checkbox"/> Ind	<input type="checkbox"/> total	<input type="checkbox"/> Ino	<input type="checkbox"/> kept
Glucose tablet/gel	<input type="checkbox"/> NA	<input type="checkbox"/> Ind	<input type="checkbox"/> total	<input type="checkbox"/> Ino	<input type="checkbox"/> kept
Count Carbohydrates	<input type="checkbox"/> NA	<input type="checkbox"/> Ind	<input type="checkbox"/> total	<input type="checkbox"/> Ino	<input type="checkbox"/> kept
Give insulin by injection	<input type="checkbox"/> NA	<input type="checkbox"/> Ind	<input type="checkbox"/> total	<input type="checkbox"/> Ino	<input type="checkbox"/> kept
Give insulin by pump	<input type="checkbox"/> NA	<input type="checkbox"/> Ind	<input type="checkbox"/> total	<input type="checkbox"/> Ino	<input type="checkbox"/> kept
Troubleshoot alarms	<input type="checkbox"/> NA	<input type="checkbox"/> Ind	<input type="checkbox"/> total	<input type="checkbox"/> Ino	<input type="checkbox"/> kept
Change infusion set	<input type="checkbox"/> NA	<input type="checkbox"/> Ind	<input type="checkbox"/> total	<input type="checkbox"/> Ino	<input type="checkbox"/> kept

BLOOD GLUCOSE MONITORING

Check blood glucose **before meals and anytime student exhibits signs of high &/or low blood glucose**. Student should also be checked before:

other _____
Treatment Order for **HIGH and LOW** blood glucose levels: Refer to pages 6-9 of Diabetes Medical Plan

URINE KETONE TESTING

Check urine when **blood glucose is greater than 300 mg/dl, anytime student is sick, and/or vomiting**. Dip urine and read strip in 15 seconds.

Treatment Order for Ketones: Refer to pages 6-7 of Diabetes Medical Plan

GLUCOSE TABLET / GLUCOSE (CAKE) GEL

Use to treat **low blood glucose on a student who is conscious and can swallow (see hypoglycemia pathway)**.

Dosage: Gel – 15 gram tube or **up to 3-4 tablets (up to 15 grams of carbohydrates)**; Route: inner cheek/gum area

Frequency/time(s) to be given: As needed; follow hypoglycemia pathway for treating low glucose

Treatment Order in the event of an adverse reaction: Refer to pages 8-9 of Diabetes Medical Plan

Signature of Parent _____ Date _____ Phone _____ Cell _____

Witness _____ Date _____

Provider's Signature: _____ Date: _____

Please print provider's name: _____

COA Diabetes Providers

Hussein Abdullatif, MD; Ambika Asraf, MD; Joycelyn Atchison, MD; Giovanna Beauchamp, MD; Pallavi Iyer, MD; Rose James, MD; Kenneth McCormick, MD; Gail Mick, MD; Mary Lauren Scott, MD; Michael Stalvey, MD; Heather Choat, MD; Jurhee Freese, MD; Erin Greenup, MD; Jessica Schmitt, MD; Bhuvana Sunil, MD; Alexandra Armstrong, CRNP; Bethany Heron, CRNP; Ava Mitchell, DNP, CRNP; Leslie Pltts, CRNP; Erin Tuanama, CRNP

The above form is endorsed by the COA Diabetes Team; outside forms are not accepted

Student's Name: _____ Date of Birth: ____/____/____ Age: _____

No known drug allergies----if drug allergies list: _____ Weight: _____ pounds

START DATE: ____/____/____

STOP DATE: ____/____/____

Round up / down / to the nearest whole / half unit

When a correction is needed with the meal dose...please add the correction and meal dose together before rounding

CORRECTION DOSE

Name of Medication: **Insulin** (_____); Frequency/Time(s) to be given: **Correction Factor can be used as long as it has been 3 hours or greater since last correction dose given.** Route: **Subcutaneous**

Dosage: Correction Factor = (Blood sugar - _____) ÷ _____

Name of Medication: **Insulin** (_____); Route: **Subcutaneous**

Insulin to carbohydrate ratio + correction factor (if needed) = total amount of insulin to be given

Remember you must wait 3 hours between correction dose administrations but can give meal dose as scheduled

MEAL/SNACK DOSE

Dosage: _____ unit(s) for every _____ grams of carbohydrate eaten; Time to be given: before breakfast (if applicable)

Dosage: _____ unit(s) for every _____ grams of carbohydrate eaten; Time to be given: before lunch

Dosage: _____ unit(s) for every _____ grams of carbohydrate eaten; Time to be given: before dinner (if applicable)

Dosage: _____ unit(s) for every _____ grams of carbohydrate eaten; Time to be given: before snack (if applicable)

Reason for taking medication:

Control blood sugars

Potential side effects/contradictions/adverse reactions:

Low blood sugars

Treatment order in the event of an adverse reaction:

See pages 8-9 of Medical Plan

SPECIAL INSTRUCTIONS

Is the medication a controlled substance?

Yes No

Is self-medication permitted and recommended?

Yes No Supv

If "yes" I hereby affirm this student has been instructed on proper self-administration of the prescribed medication.

Do you recommend this medication be kept "on person" by student?

Yes No

Unopened insulin must be refrigerated

Name of Licensed Healthcare Provider: _____ Phone: (205)638-9107 Fax: (205) 638-9821

Signature of Licensed Healthcare Provider: _____ Date: _____

The above form is endorsed by the COA Diabetes Team; outside forms are not accepted

PRESCRIBER AUTHORIZATION STUDENT INFORMATION



Revised 2/2019

Student's Name: _____ Date of Birth: ____/____/____ Age: ____
No known drug allergies----if drug allergies list: _____ Weight: _____ pounds

START DATE: ____/____/____ STOP DATE: ____/____/____

SLIDING SCALE

Name of Medication: Insulin (_____); Frequency/Time(s) to be given: Sliding Scale can be used as long as it has been 3 hours or greater since last correction dose given. Route: Subcutaneous

Dosage:

Table with 2 columns and 8 rows for dosage ranges: units if blood glucose is _____ to _____ mg/dl

Name of Medication: Insulin (_____); Route: Subcutaneous

Sliding Scale + correction factor (if needed) = total amount of insulin to be given

Remember you must wait 3 hours between sliding scale dose administrations but can give meal dose as scheduled

MEAL/SNACK DOSE

Dosage: _____ unit(s) plus correction (if applicable); Time to be given: before breakfast (if applicable)

Dosage: _____ unit(s) plus correction (if applicable); Time to be given: before lunch

Dosage: _____ unit(s) plus correction (if applicable); Time to be given: before dinner (if applicable)

Dosage: _____ unit(s) plus correction (if applicable); Time to be given: before snack (if applicable)

Reason for taking medication:

Control blood sugars

Potential side effects/contradictions/adverse reactions:

Low blood sugars

Treatment order in the event of an adverse reaction:

See pages 8-9 of Medical Plan

SPECIAL INSTRUCTIONS

Is the medication a controlled substance?

Yes [] No [x]

Is self-medication permitted and recommended?

Yes [] No [x] Supv []

If "yes" I hereby affirm this student has been instructed on proper self-administration of the prescribed medication.

Do you recommend this medication be kept "on person" by student?

Yes [] No [x]

Unopened insulin must be refrigerated

Name of Licensed Healthcare Provider: _____ Phone: (205)638-9107 Fax: (205) 638-9821

Signature of Licensed Healthcare Provider: _____ Date: _____

The above form is endorsed by the COA Diabetes Team; outside forms are not accepted

ALABAMA STATE DEPARTMENT OF EDUCATION
SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

STUDENT INFORMATION

Student's Name: _____ School: _____

Date of Birth: ____/____/____ Age: _____ Grade: _____ Teacher: _____

No Known Drug Allergies---if drug allergies list: _____ Weight _____ pounds

PRESCRIBER AUTHORIZATION (To be completed by licensed healthcare provider)

Medication Name: Glucagon

Dosage: 1/2mg if 44 pounds or less; 1mg if greater than 44 pounds

Give IM injection in upper outer thigh, upper arm, or buttocks ; Place on side and obtain medical help immediately

Frequency/Time(s) to be given: As needed

Start Date: ____/____/____ Stop Date: ____/____/____

Reason for taking medication:

Combativeness, inability to swallow, disorientation, seizures, loss of consciousness

Potential side effects/contraindications/adverse reactions:

Nausea, Vomiting

Treatment order in event of an adverse reaction:

SPECIAL INSTRUCTIONS:

Is the medication a controlled substance?

Yes No

Is self-medication is permitted and recommended?

Yes No

If "yes" I hereby affirm this student has been instructed

On proper self-administration of the prescribe medication.

Do you recommend this medication be kept "on person" by student?

Yes No

Emergency Drug required during Bus Transportation

Yes No

Cake Icing Gel ONLY for Diabetic Student during Bus Transportation

Yes No

Printed Name of Licensed Healthcare Provider: _____

Phone: (205) 638-9107 Fax: (205) 638-9821

Signature of Licensed Healthcare Provider: _____

Date: _____

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.

Prescription Medication must be registered with School Nurse or trained Medication Assistants. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be registered with the School Nurse or Trained Medication Assistant, OTC's in the original, unopened and sealed container. Local Education Agency Policy for OTC medication to be followed:

Parent's/Guardian's Signature: _____

Date: ____/____/____ Phone: () ____ - ____

SELF-ADMINISTRATION AUTHORIZATION

(To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent: _____

Date: ____/____/____ Phone: () ____ - ____



Student's Name: _____ Date of Birth: ____/____/____ Age: _____

No known drug allergies---if drug allergies list: _____ Weight: _____ pounds

Start Date: ____/____/____ Long Acting Insulin Stop Date: ____/____/____

Name of Medication: Insulin (_____) Frequency/Time(s) to be given: Before lunch

Dosage: _____ unit(s); Route: Subcutaneous

Reason for taking medication: Control blood sugars
Potential side effects/contraindications/adverse reactions: Low blood sugars. See Medical Plan
Treatment order in the event of an adverse reaction: See pages # 8-9 of Medical Plan

SPECIAL INSTRUCTIONS:

Is the medication a controlled substance? Yes No
Is self-medication permitted and recommended? Yes No Supv
If "yes" I hereby affirm this student has been instructed on proper self-administration of the prescribed medication.
Do you recommend this medication be kept "on person" by student? Yes No

Unopened insulin must be refrigerated

Other Medication

Name of Medication: _____ Frequency/Time(s) to be given: _____

Dosage: _____; Route: _____

Reason for taking medication: Control blood sugars
Potential side effects/contraindications/adverse reactions: Low blood sugars. See Medical Plan
Treatment order in the event of an adverse reaction: See pages # 8-9 of Medical Plan

SPECIAL INSTRUCTIONS:

Is the medication a controlled substance? Yes No
Is self-medication permitted and recommended? Yes No Supv
If "yes" I hereby affirm this student has been instructed on proper self-administration of the prescribed medication.
Do you recommend this medication be kept "on person" by student? Yes No

Unopened insulin must be refrigerated

Printed Name of Licensed Healthcare Provider: Jurhee Freese, MD Phone: 205-638-9107 Fax: 205-638-9821

Signature of Licensed Healthcare Provider: _____ Date: _____

The above form is endorsed by the COA Diabetes Team; outside forms are not accepted

ALABAMA STATE DEPARTMENT OF EDUCATION
SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

STUDENT INFORMATION

Student's Name: _____ School: _____
 Date of Birth: ____/____/____ Age: _____ Grade: _____ Teacher: _____
 No Known Drug Allergies---if drug allergies list: _____ Weight _____ pounds

PRESCRIBER AUTHORIZATION (To be completed by licensed healthcare provider)

Medication Name: Metformin Dosage: _____ mg Route: Mouth
 Frequency/Time(s) to be given: _____ Start Date: ____/____/____ Stop Date: ____/____/____

Reason for taking medication: Control Blood Sugars
 Potential side effects/contraindications/adverse reactions: Nausea, Upset Stomach, Diarrhea
 Treatment order in event of an adverse reaction: Refer to the Diabetes Medical Management Plan

SPECIAL INSTRUCTIONS:

Is the medication a controlled substance? Yes No
 Is self-medication is permitted and recommended? Yes No
 If "yes" I hereby affirm this student has been instructed
 On proper self-administration of the prescribe medication.
 Do you recommend this medication be kept "on person" by student? Yes No
 Emergency Drug required during Bus Transportation Yes No
 Cake Icing Gel ONLY for Diabetic Student during Bus Transportation Yes No

Printed Name of Licensed Healthcare Provider: _____ Phone: (205) 638-9107 Fax: (205) 638-9821

Signature of Licensed Healthcare Provider: _____ Date: _____

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.

Prescription Medication must be registered with School Nurse or trained Medication Assistants. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be registered with the School Nurse or Trained Medication Assistant, OTC's in the original, unopened and sealed container. Local Education Agency Policy for OTC medication to be followed:

Parent's/Guardian's Signature: _____ Date: ____/____/____ Phone: () ____ - _____

SELF-ADMINISTRATION AUTHORIZATION

(To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent: _____ Date: ____/____/____ Phone: () ____ - _____



Student's Name: _____ Date of Birth: ____/____/____ Age: _____
 No known drug allergies---if drug allergies list: _____ Weight: _____ pounds

Start Date: ____/____/____ Stop Date: ____/____/____

PUMP THERAPY

Name of Medication: Insulin (_____)

<u>Correction/Supplemental Dose</u>	<u>Time Frame</u>
Blood sugar - (_____) = <u> x </u> units (_____)	_____
Blood sugar - (_____) = <u> x </u> units (_____)	_____

<u>Dosage:</u>	<u>Start Time</u>	<u>Basal Rate</u>
_____	_____	_____ units/hr
_____	_____	_____ units/hr
_____	_____	_____ units/hr
_____	_____	_____ units/hr
_____	_____	_____ units/hr
_____	_____	_____ units/hr
_____	_____	_____ units/hr

Bolus Ratio

- _____ unit per _____ grams of carbohydrate at _____ meals and snacks
- _____ unit per _____ grams of carbohydrate at _____ meals and snacks
- _____ unit per _____ grams of carbohydrate at _____ meals and snacks
- _____ unit per _____ grams of carbohydrate at _____ meals and snacks
- _____ unit per _____ grams of carbohydrate at _____ meals and snacks
- _____ unit per _____ grams of carbohydrate at _____ meals and snacks

Time Ratio

For pump failure (remove pump and resume insulin injections) – (See page 5 of Diabetes Medical Plan):

Notify caregiver(s) so long acting insulin can be administered

The above rapid acting insulin may be administered by syringe injection for insulin to carbohydrate ratio and correction factor doses.

Remember you must wait 3 hours between correction factor dose administrations but give meal dose as scheduled.

Student does not need to go home (unless he/she meets criteria on page 5 or 9 of Diabetes Medical Plan)

Reason for taking medication:

Control blood sugars

Potential side effects/contraindications/adverse reactions:

Low blood sugars. See Medical Plan

Treatment order in the event of an adverse reaction:

See pages # 8-9 of Medical Plan

SPECIAL INSTRUCTIONS:

Is the medication a controlled substance?

Yes No

Is self-medication permitted and recommended?

Yes No Supv

If "yes" I hereby affirm this student has been instructed on proper self-administration of the prescribed medication.

Do you recommend this medication be kept "on person" by student?

Yes No

Unopened insulin must be refrigerated

Printed Name of Licensed Healthcare Provider: _____ Phone: 205-638-9107 Fax: 205-638-9821

Signature of Licensed Healthcare Provider: _____ Date: _____

Emergency Medication for Severe Hypoglycemia in the School Setting

For Use in Case of Severe Low Blood Sugars (Hypoglycemia)

Symptoms for Use:

- Combativeness
- Inability to swallow
- Disorientation
- Seizures
- Loss of consciousness

Administer one of the following ordered emergency medications:

Steps for administering glucagon/glucagen:

1. Remove the plastic caps/covers from the syringe and the vial.
2. Inject all the sterile water from the syringe into the small vial of glucagon/glucagen powder/pill. **Roll** until pill is fully dissolved.
3. Once the solution is clear, draw out (also refer to medication prescriber authorization form)
 - a. 0.5mg into the syringe = ½ ml or the first line you see on the syringe when it is inverted if the student is 44 pounds or less.
 - b. 1mg into the syringe = 1ml or the second line you see on the syringe when it is inverted if the student is greater than 44 pounds
4. Inject glucagon/glucagen in upper/outer thighs, or upper arms, or buttocks.
5. Turn the child on his/her side and check blood sugar. Wait 15 minutes and assess signs of improvement. Call the paramedics while waiting since you are in a school setting. Recheck blood sugar every 15 minutes until blood sugar returns to normal or paramedics arrive.

Steps for administering Baqsimi:

1. Remove the shrink-wrap by pulling on the red stripe.
2. Open the lid and remove the device from the tube
3. Hold the device between fingers and thumb. Do Not push plunger yet.
4. Insert tip into one nostril until fingers touch the outside of the nose
5. Push Plunger firmly all the way in. Dose is complete when the Green Line disappears

Steps for administering G-Voke Pre-filled Syringe:

1. Pinch the skin at the injection site and keep pinching for the entire injection
2. Insert the needle into the skin at a 90° angle without touching the plunger
3. Push the Plunger down as far as it will go to inject all the liquid into the skin. Push the plunger quickly.

Steps for administering G-Voke Hypo Pen:

1. Pull red cap off
2. Push yellow end down on skin and hold 5 seconds. Window will turn red.
3. Administer into upper arm, stomach, or thigh.