VENTURA UNIFIED SCHOOL DISTRICT
Health Programs/Services

SPECIALIZED PHYSICAL HEALTH CARE SERVICES (SPHCS)
DIABETES MANAGEMENT

Parent/Guardian Request and Physician Authorization -- valid *for current school year* _____

Date _____ School _____ Grade _____

Name of Student _____ Birthdate _____
Last First Middle Initial

Dear Parent/Guardian:

1. Please review and complete **Part 1: Parent/Guardian Request for SPHCS** and respond to the Diabetes Questions, on reverse side, in order to assist the school nurse in formulating a healthcare plan for your child.
2. **Part 2: Physician Authorization** must be completed by a physician. **A new Physician Authorization must be received annually in order to change diabetes care during a school year.**
3. Specialized physical health care service(s) **will not** be performed at school until both **Part 1** and **Part 2** are completed and returned to the school nurse.
4. To ensure your child's safety at school, he/she will not be permitted to attend school until a school nurse provides the necessary training for designated school personnel. Effort will be made to create a safe school environment, as soon as possible, so your child may attend school.

Return both Part 1 and Part 2 to the school nurse. Your prompt response is appreciated.

R.N., School Nurse Phone:

Part 1: Parent/Guardian Request for SPHCS: *California Education Code 49423.5 allows specialized physical health care services to be performed by designated school personnel under the training/supervision of the credentialed school nurse.*

I, the undersigned, as the parent/guardian of the above student, request that SPHCS for Diabetes Management be provided for my child. I give permission for the school nurse to contact the physician authorizing these services for my child and/or my child's diabetes team members. I understand the school nurse may initiate a Student Agreement to support my child's ability to self-manage diabetes as authorized by the physician.

As parent/guardian, **I will....**

1. Provide all necessary material and equipment; maintain blood glucose testing equipment (cleaning and performing control testing per manufacturer's instructions).
2. Provide supplies to treat hypoglycemia, including fast acting carbohydrates, extra snacks and a glucagon emergency kit, if authorized by physician.
3. Update the school nurse within 24 hours of any change in my child's health status, medication, or treatment regime.
4. Provide emergency phone numbers for parent/guardian and the diabetes care team for use in case of diabetes-related question and/or during emergencies.
5. Provide a 3-day supply of medication, necessary food/snacks and equipment for disaster preparedness and/or for pump malfunction.

- CONTINUED -

Diabetes Questions	***Parent/Guardian Response*** *(check appropriate boxes and complete blanks)*
Diagnosis information	At what age? Type of diabetes?
Physician/s monitoring child's diabetes?	Name Address and Phone
How often is child seen by this physician?	Include date last seen:
Nutritional needs	♦ Snack ❑ ____AM ❑ ____PM ❑ Only in case of low blood glucose ❑ Student may determine ♦ Best time to eat lunch _____ ❑ Other: _____ ♦ In the event of a class party ❑ may eat the treat ❑ may NOT eat the treat ❑ student able to determine whether to eat the treat ❑ replace with parent supplied treat ❑ cover w/standard insulin/carb ratio per physician's orders
Child's most common signs of low blood glucose	❑ trembling ❑ tingling ❑loss of coordination ❑ dizziness ❑ moist skin/sweating ❑slurred speech ❑ heart pounding ❑ hunger ❑confusion ❑ weakness ❑ fatigue ❑seizure ❑ pale skin ❑headache ❑unconsciousness ❑ change in mood or behavior ❑ other (indicate) _____
How often does child experience low blood glucose and how severe?	**Mild** ❑ once a day ❑ once a week ❑ once a month Indicate date(s) of last mild episode(s) _____ **Severe** (i.e. unconscious, unable to swallow, seizure, or needed Glucagon) Include date(s) of recent episode(s)
Episode(s) of ketoacidosis	Include date(s) of recent episode(s)
Field trip	Parent/guardian intends to accompany child during field trips? ❑ YES ❑ NO
Serious illness, injuries or hospitalizations this past year	Date(s) and describe
List any other medications currently being taken	
Other concerns and comments	

Signature Parent/Guardian _____ Phone_____ Date _____

PART 2: PHYSICIAN AUTHORIZATION ATTACHED

Return this form with Physician's Authorization to School Nurse

VENTURA UNIFIED SCHOOL DISTRICT
Health Programs/Services

For School Use Only
M.D. Authorization
Date: _____

SPECIALIZED PHYSICAL HEALTH CARE SERVICES (SPHCS)
DIABETES MANAGEMENT

Part 2: Physician Authorization for SPHCS **Valid for current school year ____-____**

Date _____ School _____ Grade _____

Name of Student _____ Birthdate _____
Last First Middle Initial

Dear Physician:
Please respond to the items outlined below. Check applicable boxes, complete requested information, review standard of care, modify as necessary, and indicate accommodations for this student's diabetes care at school. The school nurse will provide training and supervision of unlicensed assistive personnel for the Specialized Physical Health Care Services indicated. The parent/guardian is responsible to provide the school site with all necessary medication and equipment.
A new Physician Authorization must be received annually and in order to change diabetes care at school during the year.

R.N., School Nurse Phone: _____

1. Diagnosis: Diabetes Mellitus ❑ Type 1 ❑ Type 2 ❑ Gestational
❑ other _____

2. Target Blood Glucose (BG) Range: ❑ 70-150 mg ❑ 70-180 mg
❑ other _____

3. HbA1c: Result/date _____/_____
Result/date _____/_____
Result/date _____/_____

4. Monitoring of Blood Glucose at School:
❑ YES ❑ NO If yes, when: ❑ before lunch ❑ before snack ❑ before PE
❑ PRN s/s of hypo/hyperglycemia or signs of illness
Level of self-management: ❑ independent ❑ assistance needed
Equipment: ❑ student to carry glucose meter ❑ glucose meter stored class/office
❑ other _____
Where to test: ❑ any campus setting ❑ health office
❑ other _____

5. Meals and Snacks:
Level of self-management: ❑ independent ❑ adult supervision necessary
Indicate any dietary accommodations: _____
_____

6. Physical Exercise:
❑ Do <u>not</u> exercise if BG is < _____ mg **OR** > _____ mg with ketones present
OR > _____ mg without ketones
❑ Number of grams of CHO: _____ grams before exercise ____ grams after exercise
❑ Restrictions on activity, indicate: _____
❑ Other _____

Student Name: _____ Birthdate: _____

7. Hypoglycemia - defined as: ❑ BG < 70 mg
Level of self-management: ❑ independent, unless cognition impaired ❑ assistance needed

Standard Treatment of Mild-Moderate Low BG

Step 1	Always treat symptoms if unable to test BG level.
Step 2	Give 15 grams of **readily available** fast acting carbohydrate: i.e. *4 oz. apple or orange juice or 4 oz. soda (regular not diet) or 3- 4 glucose tablets or 6 Lifesaver candies (circle with hole) or 15 grams of glucose gel or 1 tablespoon sugar with or without 4 ounces of water.*
Step 3	Rest while being monitored for 15 minutes, then ♦ Recheck BG. Upon recheck, if BG is still <70 mg or if symptoms persist or recur, repeat Step 2. ♦ Once symptoms subside and/or BG is >70 mg, if lunch or snack is more than one hour away, give one of the following complex carbohydrates: *3 graham cracker squares, or 6 saltine squares, or a piece of bread/toast. Other:*_____
Step 4	♦ Resume usual activity. ♦ Notify parent/guardian and school nurse as soon as reasonably possible.

Standard Treatment of Severe Low BG *(Loss of consciousness, cannot swallow, or seizure activity)*

Step 1	Place one of the following into the cheek pouch (side closest to the ground) and massage gently: 15 grams of glucose Substitute or Glucose gel. If not available, use 1 tablespoon sugar while preparing Glucagon.
Step 2	Administer Glucagon per training **DOSE:** ❑ 0.3 mg IM/SQ ❑ 0.5 mg IM/SQ ❑ 1 mg IM/SQ **Call 911. Keep student on side.**
Step 3	Monitor for 10 minutes, if no improvement, may repeat Glucagon once if 2nd dose available.
Step 4	Notify parent/guardian, school nurse and physician as soon as reasonably possible.

8. Insulin Administration- Standard Practice: At school, insulin may be administered by this student, R.N., parent/guardian or non-school individual designated and trained by family.
At home: Type/s and time of administration _____
Administer Insulin at School: ❑YES ❑ NO **(If NO, proceed to # 9)**
Level of self-management: ❑ independent ❑ adult supervision ❑ adult must administer
Where to administer: ❑ any campus setting ❑ health office
❑ other _____
Type of insulin: _____
Method of administration: ❑ syringe ❑ pen ❑ pump ❑ prefilled syringe by pharmacy
❑ other _____
Time/dose: ❑ daily before lunch* BG ____-____ mg = _____ units SQ
❑ before snack BG ____-____ mg = _____ units SQ
❑ pump: basal rate _____ units/hr bolus dose _____ units/15 grams CHO
** **OR** if **elevated** BG before lunch use Correction Scale below and notify parent/guardian:*
BG 151-200 = _____units SQ __ parent may instruct to adjust dose
BG 201-250 = _____units SQ
BG 251-300 = _____units SQ
BG 301-350 = _____units SQ
BG 351-400 = _____units SQ

If pump malfunctions or dislodged, parent will be contacted.
__Student can reinsert
__Syringe and insulin pen provided

Student Name: _____ Birthdate: _____

9. Oral Agent:
Administer at school: Medication _____ Dose _____ Time of Dose _____
Administer at home: Medication _____ Dose _____ Time of Dose _____

10. Ketone Testing:
Level of self-management: ❑ independent ❑ assistance needed

Standard Practice

Step 1	Check for ketones if BG > _____ mg., and • if ketones are present, phone parent/guardian immediately • for moderate to large ketones, school nurse to phone physician immediately
Step 2	Even if ketones are **not** present, if BG is > _____ mg, call physician and parent immediately.
Step 3	Give student extra sugarless fluid or water.

11. Disaster Preparedness Plan/ Standard Practice/Extended Field Trip Orders

A minimum 3-day supply of medication may be kept at school.
BG testing as indicated in Item 4.

TIME	INSULIN TYPE	INSULIN	DOSE/SQ	COMMENTS
Breakfast*	Rapid/short-acting			***Only give insulin if food available for each meal***
Lunch*	Rapid/short-acting			
Dinner*	Rapid/short-acting			
* **OR** if elevated BG at mealtime use _____ Insulin and follow *Correction Scale:* BG 151-200 = _____ units SQ BG 201-250 = _____ units SQ BG 251-300 = _____ units SQ BG 301-350 = _____ units SQ BG 351-400 = _____ units SQ				
Breakfast	Intermediate/long-acting			***Only give insulin if food available for next 24 hours***
Dinner	Intermediate/long-acting			

Oral Agent: Medication Name: _____ Dose _____ Time of day _____AM
other _____ Dose _____ Time of day _____PM

I, the undersigned, recommend the SPHCS as indicated.

Physician Signature _____ Phone _____ Date _____

_____
Physician's Stamp

Return this form to School Nurse

Distribution: ❑ Student Cumulative Record ❑ IEP ❑ Health Record