School Lunch Time: ______________
JCPS Student ID #: ______________

Jefferson County Public Schools Health Services

Primary Care Provider (PCP) Authorization: Diabetes/ Blood Glucose Monitoring (Side One)

2014-2015 School Year

Student Name: ______________________ **Date of Birth:** __________ **School:** ________________

DIAGNOSIS:
☐ Type I Diabetes ☐ Type II Diabetes ☐ Pre-Diabetes
☐ Other Condition Requiring Glucose Monitoring______________

Where should blood glucose monitor & equipment be?
☐ kept with child ☐ kept in classroom/office/nurse's office

Required blood sugar testing/monitoring at school:
☐ Trained personnel must perform blood sugar test
☐ Trained personnel must supervise blood sugar test
☐ Student can perform testing independently

When should blood sugar monitoring be done?
☐ Before lunch ☐ Other (Specify): ____________
☐ As needed to determine hypoglycemia or hyperglycemia

Diet Requirements:
☐ No Concentrated Sweet Diet
☐ **Carbohydrate Count ________carbs/meal**
Please list any alternative breakfast foods for student________________

Does student require a SCHEDULED snack during the school day? ☐ Yes ☐ No

- If yes, do they need insulin with snack? (See Insulin dose on back) ☐ Yes ☐ No

HYPERGLYCEMIA (HIGH BLOOD SUGAR)

SIGNS & SYMPTOMS: • dry mouth • increased urination • tired • thirsty • sores or infections that will not heal • hungry • sleepy • dry, itchy skin • headache

*** If symptoms persist -- can lead to nausea, vomiting, stomach pain, fruity smelling breath**

<u>HIGH BLOOD SUGAR FOR THIS CHILD REQUIRING THE FOLLOWING INTERVENTIONS IS GREATER THAN</u> Fill in number __________

<u>Interventions:</u>
☐ Encourage extra liquids without sugar such as water. No extra juice or milk.
☐ Allow frequent trips to the restroom.
☐ Ketone monitoring: ______________________
(If student is positive for ketones, MUST notify parent/guardian)
☐ Other: ______________________

<u>PARENTS MUST PROVIDE SNACKS, EMERGENCY SUPPLIES, & WASTE CONTAINER FOR NEEDLES/SHARPS</u>

HYPOGLYCEMIA (LOW BLOOD SUGAR)

• dizzy • crying • headache • clammy sweat • nervous • unable to think clearly • shaky • blurry vision • restless • weak • combative • unusually sleepy • pale • pounding heart • confused or disoriented • stumbling around • change in personality (mean/hateful)

<u>LOW BLOOD SUGAR FOR THIS CHILD REQUIRING THE FOLLOWING INTERVENTIONS IS LESS THAN</u> Fill in number ________

Examples of a simple sugar are one of the following:
• 3-4 glucose tablets • 15 skittles • 1 small tube of glucose gel • 12 Sweet Tarts • 3-5 small sugar cubes • 2-3 rolls of Smarties • 2-3 packs of table sugar
Examples of a 15 gram complex carbohydrate are one of the following:
• 4 peanut butter or cheese crackers • ½ sandwich • 1 small bag of pretzels

<u>Interventions:</u>
☐ Give 15 grams of simple sugar and recheck in 15 minutes
☐ If no improvement within 15 minutes, then repeat simple sugar.
☐ Follow immediately with a 15 gram snack of complex carbohydrate **OR** lunch.
☐ Staff/student should check blood sugar 30 minutes after initial treatment.
☐ Call parent if the blood sugar does not rise above ________ mg/dl.
☐ Allow 30-60 minutes for complete recovery before resuming normal school activities (tests, PE). It may not be necessary to send the student home.
☐ Other: ______________________

Emergency Glucagon: Given only if ordered for a student when that student is having a **seizure, unconscious** or **severely neurologically impaired** related to severe hypoglycemia or low blood sugar. Glucagon kits are to be provided by the parent/guardian.

Does this student have glucagon? ☐ Yes ☐ No (see back for instructions)

Blood sugar should be checked 30 minutes before riding bus or walking home in the afternoon. If the box has been checked that the student can perform testing independently, the student should monitor their own blood sugar before afternoon dismissal.

Glucagon will not be transported on the bus except for field trips. During the field trip glucagon should be kept and administered by trained school personnel ONLY.

If the above treatments for low or high glucose are required, ALWAYS notify the parent/guardian or emergency contact by phone or in writing that day.

Please complete both sides of form. Form MUST be signed by Health Care Provider AND Parent/Guardian.

	Initials/Date
Reviewed by Health Services	________
Entered by Health Services	________
School received/sent to Health Services & School Staff	________

JCPS Student ID#:

Updated Orders:
☐ YES ☐ NO
Date Updated: ________

Jefferson County Public Schools Health Services

Primary Care Provider (PCP) Authorization: Diabetes/Blood Glucose Monitoring (Side Two)

2014-2015 School Year

Student Name: ______________________ **Date of Birth:** ______________ **School** ______________________

EMERGENCY PLAN OF ACTION

If student becomes unconscious or unresponsive, administer **GLUCAGON ______cc into the muscular area of the upper arm**, if kit provided by parent/guardian.

1. Call EMS 9-911.
2. Notify school personnel trained in CPR/first aid to respond and initiate CPR if needed prior to EMS arrival.
3. Contact parent/guardian or emergency contact immediately.
4. If EMS is called the student must be transported via EMS to emergency facility, or parent/guardian must sign release with EMS and then parent/guardian assumes responsibility for student. The student may not return to school that day.
5. When student is transported via EMS, JCPS staff must ride with student unless parent and/or emergency contact accompanies them.
6. If student requires medical treatment while on the bus, the driver will contact EMS.

Does this student require insulin during school?
☐**YES** ☐**NO**

Can this child administer his/her own insulin independently **if needed at school?**
☐ **YES** ☐ **NO**

Student can calculate his/her own insulin dose: ☐ **YES** ☐ **NO**

Insulin to be administered: ☐ **Before lunch** ☐ **After lunch**

Does this student have an insulin pump? ☐ **YES** ☐ **NO**

Should insulin dose calculations be rounded? ☐ **YES** ☐ **NO**
☐ **Half Unit** ☐ **Whole Unit**

If blood glucose meter reads "High" dose insulin on a blood sugar of 600
☐ **YES** ☐ **NO**

INSULIN DOSES (Humalog/NovoLog/Apidra/Regular)

Carbohydrate Dose (given with ANY carb containing food):
_____unit for every _____gram(s) of carbohydrate eaten

Correction Dose (given at mealtimes ONLY if > 4hours since last insulin dose):
_____ unit(s) for every _____ mg/dl points above ______ mg/dl

Additional Orders/ Pump Instructions: ______________________________

____

Nutritional information is available atwww.jefferson.k12.ky.us/Departments/NutritionServices or you may call 3186 for information.

If a student requires insulin while at school and cannot draw up and administer independently, or needs assistance with carbohydrate counting to determine insulin dosage a nurse will be provided for this service. A non-licensed person cannot administer insulin

______________ ______________ ______________ ______

Printed Name of MD, APRN, or PA | **Address** | **Signature of MD, APRN, or PA** | **Date**

*** Parent/guardian hereby acknowledges that if this medication i [illegible] by trained, unlicensed JCPS personnel. Parent/guardian acknowledges and agrees when authorizing their child to attend a school sponsored field trip thi [illegible] nteer. By signing this form, the parent/guardian acknowledges that the Jefferson County Board of Education, its employees and agents shall incur no liability as a result of any injury sustained by the student from any reaction to any medication to treat a hypoglycemic episode or from the administration of such medication, unless the injury is the result of negligence or misconduct on behalf of the school or its employees. The parent/guardian shall hold harmless the school and its employees against any claims made for any reaction to any medication to treat a hypoglycemic episode or the administration of such medication unless the reaction is due to negligence or misconduct on behalf of the school or its employees. Also, I hereby give permission for the healthcare provider completing and signing this form to verify this information with JCPS and to consult with JCPS staff regarding this information.**

______________ ______________ ______________

Signature of Parent/Guardian | Telephone No. | Date

****Parent/Guardian signature required only for INITIAL 2014-2015 PCP form. Parent/Guardian signature not required for updated 2014-2015 PCP forms.**

______________ ______________ ______________

Emergency Contact | Telephone No. | Relationship

Please return to: Jefferson County Public Schools Health Service Lam Building, 4309 Bishop Lane, Louisville, KY 40218
Telephone No. (502) 485-3387 Fax (502) 485-3670