Learning Gate Community School
16215 Hanna Rd, Lutz, FL 33549 813) 948-4190

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 _____ **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
____ Mid-morning: before snack
____ Before lunch
____ Dismissal
____ Before PE / Activity Time
____ After PE / Activity Time
____ Mid-afternoon
____ 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

(Rev. 5 2020)

An Environmentally Integrated K-8 Charter School

16215 Hanna Road

Lutz, Florida 33549

Tel: 813-948-4190 Fax: 813-948-7587

Authorization For Student to Carry and Independently Self-Administer Emergency Medication(s)/Procedure(s) for Life Threatening Medical Conditions

Date: _____

Student's Name: _____ **Birth date:** _____

School: _____

Teacher's Name: _____ **Grade / Homeroom** _____

To be completed by physician:

Diagnosis: _____

The above named student is under my care. I feel that this student has a life threatening illness and that he/she is capable of and has been instructed in the proper administration of the required medication(s) and/or procedure(s). The student has been instructed in the treatment plan, self-administration of their medications / procedures and has demonstrated the skill level necessary to manage their own care.

Telephone	*Printed Physician's Name*	*Signature*	*Date*

To be completed by parent:

I request and give permission for my child to carry and self-administer the medication(s) and/or procedure(s), as indicated in the physician's order during the school day, at school-sponsored activities or while in transit to or from schools. I have observed my child demonstrate the necessary skill level to implement the care plan prescribed by his/her health care provider. I am responsible for ensuring my child has all medications, procedure equipment and supplies for their life threatening condition. Adult supervision will not be provided. This form is effective only for this school year and includes all school sponsored activities and summer school.

By signing this form, I am indemnifying and holding LGCS harmless against any injury or claims that arise as a result of the student's self-management of life threatening condition. Permission is also granted for school personnel to contact the physician if there are questions or concerns about the medication(s) and/or procedure(s). We/I are aware the privilege of self-administration of medication(s)/procedure(s) can be withdrawn if abused by the student. The district reserves the right to seek emergency medical treatment for the student when deemed necessary and appropriate.

Telephone	*Printed Parent/Guardian Name*	*Signature*	*Date*

To be completed by student at school:

☐ I will keep my medication, supplies & equipment with me at school ☐ I will use only as prescribed by my doctor ☐ I will not allow any other person to use my medication(s) or procedure equipment ☐ I will notify a school staff member if I am having more difficulty than usual with my health condition.

Printed Student Name	*Signature*	*Date*
Printed Registered Nurse Name	***Signature***	***Date***

(Rev. 5-2020)

Learning Gate Community School

Diabetes Medical Management Plan Supplement For Student Wearing Insulin Pump

School Year _____ - _____

Student Name: _____ **Date of Birth:** _____ **Pump Brand/Model:** _____

Pump Resource Person : _____ Phone/Beeper: _____ (See basic diabetes plan for parent phone #)

Child-Lock On? _____ Yes _____ No How long has student worn an insulin pump? _____

Blood Glucose Target Range : _____ Pump: Insulin _____ Humalog _____ Novolog _____ Regular

Insulin: Carbohydrate Ratios: _____

(Student to receive carbohydrate bolus _____ *immediately before / minutes* before eating)

Lunch/Snack Boluses Pre-programmed? _____ Yes _____ No Times _____

Insulin Correction Formula for Blood Glucose Over Target: _____

Extra pump supplies furnished by parent/guardian: ☐ infusion sets ☐ reservoirs ☐ batteries ☐ dressings/tape ☐ insulin ☐ syringes/insulin pen

	STUDENT PUMP SKILLS	NEEDS HELP?		IF YES, TO BE ASSISTED BY AND COMMENTS:
1.	Independently count carbohydrates	☐ Yes	☐ No	
2.	Give correct bolus for carbohydrates consumed	☐ Yes	☐ No	
3.	Calculate and administer correction bolus	☐ Yes	☐ No	
4.	Recognize signs/symptoms of site infection.	☐ Yes	☐ No	
5.	Calculate and set a temporary basal rate.	☐ Yes	☐ No	
6.	Disconnect pump if needed.	☐ Yes	☐ No	
7.	Reconnect pump at infusion set	☐ Yes	☐ No	
8.	Prepare reservoir and tubing.	☐ Yes	☐ No	
9.	Insert new infusion set.	☐ Yes	☐ No	
10.	Give injection with syringe or pen, if needed.	☐ Yes	☐ No	
11.	Troubleshoot alarms and malfunctions.	☐ Yes	☐ No	
12.	Re-program basal profiles if needed.	☐ Yes	☐ No	

MANAGEMENT OF HIGH BLOOD GLUCOSE ***Follow instructions in basic diabetes medical management plan, but in addition:***

If blood glucose over target range _____ hours after last bolus or carbohydrate intake, student should receive a correction bolus of insulin using formula; Blood glucose **-** _____ ÷ _____ **=** _____ units insulin

If blood glucose over 250, check urine ketones.

1. **If no ketones** give bolus by pump and recheck in 2 hours.
2. **If ketones present or**, _____ Give correction bolus as an injection immediately and contact parent / health care provider.

If two consecutive blood glucose readings over 250 (2 hours or more after first bolus given).

1. Check urine ketones.
2. Give correction bolus as an injection.
3. Change infusion set.
4. Call parent.

MANAGEMENT OF LOW BLOOD GLUCOSE Follow instructions in Basic Diabetes Care Plan, but in addition:

If low blood glucose recurs without explanation, notify parent/diabetes provider for potential instructions to suspend pump.

If seizure or unresponsiveness occurs:

1. Call 911 (or designate another individual to do so).
2. Treat with Glucagon (See basic Diabetes Medical Management Plan).
3. Stop insulin pump by:
   - _____ Placing in "suspend or stop mode (See attached copy of manufacturer's instructions).
   - _____ Disconnection at pigtail or clip (Send pump with EMS to hospital).
   - _____ Cutting tubing.
4. Notify Parent.
5. If pump was removed, send with EMS to hospital.

ADDITIONAL TIMES TO CONTACT PARENT

_____ Soreness or redness at infusion site.
_____ Detachment of dressing / infusion set out of place.
_____ Leakage of insulin.
_____ Insulin injection given.
_____ Other: _____

Effective Date(s) of Pump Plan: _____

Parent's Signature: _____ Date: _____

School Nurse's Signature: _____ Date: _____

Diabetes Care Provider Signature: _____ Date: _____

(Rev. 5-2020)

An Environmentally Integrated K-8 Charter School

16215 Hanna Road

Lutz, Florida 33549

Tel: 813-948-4190 Fax: 813-948-7587

www.learninggate.org

GUIDELINES FOR ADMINISTRATION OF MEDICATION

It is recognized that medications may be essential for some students. When possible, all medications should be administered at home. If medication must be given at school, the following procedures are required:

1. A signed statement by the parent/guardian requesting the administration of medication must accompany all medication. The Parent Authorization for Administration of Medication form must be returned to school within two (2) days following the school's receipt of the medication. New authorization forms will be required when any changes with the orders occur. All medication/procedure forms must be updated annually.

2. **Medication must be sent to school via a parent or guardian.** It is not safe for children to deliver medicine to the school. This policy prevents safety concerns of lost or stolen medicines, students sharing medicines with friends, and students taking medicine unsupervised.

3. Medication must be in the prescription container with the name of drug, date prescribed, dosage prescibed, time of day to be taken, any special directions, with student's and physician's names clearly marked. Medication must remain in the container in which it was originally dispensed. Most pharmacies will provide an extra empty labeled bottle for school for parents if requested when the prescription is filled. No more than a month's supply should be brought in at a time. A new bottle with new expiration date is required every month.

4. All medications/procedure supplies received in the clinic must be counted with the parent or other staff and witnessed with two signatures on the Medication Count Sheet. The amount and date received are to be recorded. Parents are also to sign when picking up medication/supplies.

5. Parents should arrange for a separate supply of medication for school. Medication will not be transported between home and school on a daily or weekly basis. Exceptions by Florida statutes 1002.20(h)(i)(j)(k) are asthma inhalers and EpiPens, diabetes supplies and equipment, and pancreatic enzyme supplements which require special parent forms and physician forms/doctor's orders.

6. When any medications are <u>added</u> or <u>discontinued</u>, a new authorization form is required.

7. When medication dosages or times are changed, a new signed authorization form with the correct information must be completed and a <u>new label</u> from the pharmacist or <u>physician's order/prescription</u> indicating the change must be sent to the school. A fax is acceptable.

8. Medication will be stored in a locked cabinet at the school at all times. Exceptions by statutes are asthma inhalers, EpiPens, diabetic supplies and equipment, and pancreatic enzyme supplements. Students who self-carry require a special parent and physician form and doctor's orders.

GUIDELINES FOR ADMINISTRATION OF MEDICATION (cont.)

9. Since there is a number of students who receive medication during school hours, a school employee designated by the principal will administer medication. The designated employee will be trained by the Registered Professional School Nurse as permitted by Florida law. This includes field trips and when the student is away from school property on official school business. The medication container with pharmacy label/supplies and copies of paperwork will be sent with the trained staff member or an agency nurse hired by the principal. All medications must be dispersed out of the original container with the exception of field trips. Under no circumstances may medication be transferred from one container to another by anyone other than registered pharmacist with the exception of field trips which must be done by the registered nurse.

10. Oral non-prescription (over-the-counter) or sample drugs will be dispensed only when accompanied by written orders from a physician. Medication is always to remain in the container in which it was purchased and must be unopened when received by the school. Written parental authorization is needed for all non-prescription drugs. Cough drops will be treated as an over-the-counter medication. Students may not carry over-the-counter medicines at school. Possession of drugs of any kind can lead to serious disciplinary action.

11. All medications given at school must be U.S. Food and Drug Administration (FDA) approved. Substances not to be given at school are all unregulated products, such as herbs and food supplements, which are being used as treatments, dietary supplements, or folk remedies.

12. *No prescription narcotic analgesics* are to be dispensed at school. The side effects make it unsafe for students to attend school while medicated with narcotics.

13. Liquid medication will be given in a calibrated measuring device supplied by the parent.

14. All medications/supplies must be removed from the school premises within one week of the expiration date, upon appropriate notification of medication being discontinued, or at the end of the school year. Medications/supplies that are unused and unclaimed will be destroyed following proper disposal procedures.

15. Planning and protocols for any medication or treatment which requires a one-time dosage for a specific intent are the responsibility of the registered nurse ONLY.

16. Parents of students attending after-school programs, will need to make arrangements with the after-school programs when medicines or treatments are needed.

17. Non-medicated sunscreen and insect repellent may be administered without a prescription but a parent authorization form must be completed.

Florida Statue 1006.062 is the reference for the above guidelines.

Questions regarding these procedures should be directed to the Nurse assigned to the school your child attends 813-948-4190