School Lunch Time: _____
JCPS Student ID # _____

Jefferson County Public Schools Health Services

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

2017-2018 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

*****Please note, if a student has a pump, blood sugar must be entered into the pump every time it is checked*****

Diet Requirements:
☐ **Carbohydrate Count _____carbs/meal**
Please list any food to omit _____
Please list any alternative breakfast/lunch/snack 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**

HIGH BLOOD SUGAR FOR THIS CHILD REQUIRING THE FOLLOWING INTERVENTIONS IS GREATER THAN **Fill in number** _____
Interventions:
☐ Encourage extra liquids without sugar such as water. **No** extra juice or milk.
☐ Allow frequent trips to the restroom.
☐ If BG is GREATER than _____ X _____ consecutive BG checks, check **KETONES**
If **Ketones are positive**, parent/guardian MUST BE NOTIFIED, see **side 2 for insulin orders**
☐ Other: _____
_____

PARENTS MUST PROVIDE SNACKS, EMERGENCY SUPPLIES, & WASTE CONTAINER FOR NEEDLES/SHARPS. IF STUDENT IS INDEPENDENT, STUDENT IS RESPONSIBLE FOR MAINTAINING ALL SNACKS/SUPPLIES. SPACE WILL BE PROVIDED AT THE SCHOOL TO KEEP SNACKS/SUPPLIES IF NECESSARY.

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

HYPOGLYCEMIA (LOW BLOOD SUGAR)

SIGNS & SYMPTOMS: •hunger • staring • becoming very quiet • 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)

LOW BLOOD SUGAR FOR THIS CHILD REQUIRING THE FOLLOWING INTERVENTIONS IS LESS THAN **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

Interventions:
☐ 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: _____

Does this student have **Glucagon**? ☐ Yes **____ cc** ☐ No

****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.****

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.

If any interventions for low or high blood sugar are required, ALWAYS notify the parent/guardian or emergency contact by phone or in writing that day.

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

*JCPS Student ID#*_____

Jefferson County Public Schools Health Services

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

2017-2018 School Year

Updated Orders: ☐ Yes ☐ No
Date Updated: _____

Student Name: _____ **Date of Birth:** _____ **School**_____

EMERGENCY PLAN OF ACTION

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**. Glucagon kits are to be kept in area accessible to trained staff** and not to be carried by the student.

1. Call EMS 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.

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

Additional Orders: _____

_____

_____

THIS FORM MUST BE SIGNED BY HEALTH CARE PROVIDER AND PARENT/GUARDIAN.

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

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

Student can calculate his/her own insulin dose **independently if needed at school** :
☐ **YES** ☐ **With Adult Supervision** ☐ **NO**

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

Does this student have an insulin pump? ☐ **YES** ☐ **NO**
(If Yes, see attached for Pump Orders)

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

INSULIN REPLACEMENT FOR KETONES

Small Ketones ____ unit
Moderate Ketones ____ unit
Large Ketones ____ unit

Printed Name of MD, APRN, or PA	Signature of MD, APRN, or PA	Address	Telephone # /Fax #	Date

*** Parent/guardian hereby acknowledges that if this medication is not self-administered, it will most likely be administered by trained, unlicensed JCPS personnel. Parent/guardian acknowledges and agrees when authorizing their child to attend a school sponsored field trip this medication may also be administered by a licensed volunteer. 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 #	Date

****Parent/Guardian signature required only for INITIAL (not updated) 2017-2018 PCP form.**

Emergency Contact	Telephone #	Relationship

Equal Opportunity/Affirmative Action Employer
Offering Equal Educational Opportunities

Please return to: Jefferson County Public Schools Health Services Department, Lam Building,
4309 Bishop Lane, Louisville, KY 40218
Telephone # (502) 485-3387 Fax # (502) 485-3670

Final 3/31/17