Patient Sticker

WE MAKE LIVES BETTER
UT HEALTH SCIENCE CENTER SAN ANTONIO

Emergency pager 210 -235-0732

Christus Santa Rosa
333 N. Santa Rosa St.
San Antonio, TX 78207
Ph (210)704-3611 Fax (210)704-2812

Texas Diabetes Institute
701 S. Zarzamora St.
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Diabetes Management and Treatment Plan

1. Authorized Health Care Provider Opinion on student's competence with Procedures:
[ ] Blood Glucose testing
[ ] Carry supplies for blood glucose monitoring
[ ] Testing in classroom
[ ] Self treatment for mild lows
[ ] Measuring and injecting insulin
[ ] Independently operating insulin pump
[ ] Carry Supplies for insulin administration
[ ] Self manage diabetes if policy allows

2. Blood Glucose testing
(Desired range ___ mg/dl to ___ mg/dl)
[ ] Before AM snack
[ ] Before lunch
[ ] 2 hrs after lunch
[ ] 2 hrs after a correction dose
[ ] For suspected hypoglycemia
[ ] At Student's discretion
[ ] Always check BS for suspected hypoglycemia
[ ] NO blood glucoses testing at school at this time

3. Mild hypoglycemia
([ ] BG < 70 mg/dl or [ ] BG < ____ mg/dl) **Student must never be alone when hypoglycemia is suspected and should be treated on site.**
Give [ ] 15 gm or [ ] ____ gm fast-acting glucose and recheck in [ ] 15 minutes or [ ] ____ minutes.
If still hypoglycemic, treat again with same dose of glucose and recheck at same interval until normal.
Notify parent if not improved after 3 treatments.
[ ] Provide extra protein and carb snack after treating lows if next meal/snack not scheduled for ____ 1 hr ____2 hr. Call parent for symptoms of hypoglycemia, but BG is normal

4. Severe hypoglycemia (seizure, unconscious, combative, unable to swallow). **Call 911, ensure open airway**.
[ ] OK to use glucose gel inside cheek ONLY IF conscious.
[ ] Use Glucagon injection IM if unconscious or seizing
[ ] 0.5 mg [ ] 1 mg

5. Hyperglycemia :(BG greater than_____mg/dl) , please check Ketones in___blood ____urine. Encourage fluids. If student is ill or vomiting, call parent to strongly consider pick up. **For confusion, labored breathing or coma, call 911**
[ ] If BG >_____ WITH Ketones moderate or large: call parent to pick up child
[ ] If BG>_____ WITH Ketones negative to small, child may remain at school if not ill or vomiting.

For **BOTH ABOVE** Initiate insulin per sliding scale ONLY IF more than two hours have passed since last insulin dose and encourage sugar free fluids. **DO NOT give insulin more frequently than every 2 hours**.
[ ] If student has pump, immediately troubleshoot the pump, infusion set and site. Use pump for initial correction dose and recheck blood sugar within one hour to assure adequate delivery of insulin

6. Illness: If a student is ill, check ketones and blood glucose. If ketones are ___ or larger, provide fluids, call parents and consider pick up. If ketones and blood sugar are within range, follow standard procedures for an ill child and notify parents.

7. Bus Transportation:

[ ] Blood glucose test not required prior to boarding bus
[ ] Test blood sugar 10-15 min prior to boarding bus and treat hypoglycemia appropriately
[ ] Notify parent if BS >_____ mg/dl prior to boarding bus
** Recommend Caution if giving insulin prior to transportation

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8. Pump: Basal and bolus settings as programmed
*Food/Bolus insulin dose per pump settings:
[ ] ___ units insulin per __ gram carbs
[ ] Varied preprogrammed Carb ratio per pump/time
*Correction Dosing ("sensitivity"):
[ ] Give ___ unit(s) for every ____ above ____ mg/dl
[ ] Varied preprogrammed correction per pump/time

9. Insulin orders:
Brand name of insulin:_____
Insulin administration via:
[ ] Syringe [ ] Pump [ ] Pen [ ] other:____
***Routine administration times**:
[ ] Breakfast [ ] AM snack [ ] Lunch
[ ] Other:_____
***Food/Bolus insulin dose**:
[ ] Insulin to carb ratio: ___ units insulin per __ gram carbs
***Fixed Insulin dosing**:
[ ] Breakfast dose____ units
[ ] AM snack dose ____ units
[ ] Lunch dose ____ units
[ ] Other dose _____ units
***Correction Dosing**:
Give ___ unit(s) for every ____ above ____ mg/dl
Blood glucose from ____ to ____= ___ Units
Blood glucose from ____ to ____= ___ Units
Blood glucose from ____ to ____= ___ Units
Blood glucose from ____ to ____= ___ Units
Blood glucose from ____ to ____= ___ Units
Blood glucose from ____ to ____= ___ Units
Blood glucose from ____ to ____= ___ Units
Blood glucose from ____ to ____= ___ Units
Blood glucose from ____ to ____= ___ Units
Blood glucose from ____ to ____= ___ Units
[ ] OK to add food/bolus to correction dose

10. Meal Plan:
Meal/snack will be considered mandatory unless otherwise specified. Timing of snacks will be per school/daycare schedule unless otherwise indicated.

- [ ] AM snack [ ] at student's discretion
  [ ] special time:_____
- [ ] Lunch [ ] at student's discretion
  [ ] special time:_____
- [ ] After school snack [ ] at student's discretion [ ] special time:_____

Content of snack will be specified by:
[ ] Parent [ ] Student [ ] Health Care provider
[ ] NO snack needed

11. Exercise:
Liquid/solid carb sources must be available.
Follow Hypoglycemia, illness, and hyperglycemia protocols when relevant.

- ❖ Eat ___ extra grams of carbs with vigorous exercise
  [ ] Before Exercise
  [ ] every 30 minutes during exercise
  [ ] After exercise
  [ ] Other
- ○ Student may disconnect pump for up to ____ hrs
- ○ Student may decrease basal rate at their discretion

12. Other Needs:
_____
_____
_____
_____
_____

The signatures below provide authorization for the above written orders and show agreement that all procedures must be implemented in accordance with state laws and regulations. This authorization is for a maximum of one year. If changes are indicated, new written authorization or a signed addendum to this form will be needed.

Physician:_____Signature:_____ Date: _____

Parent/Guardian:_____ Signature:_____ Date:_____

School Nurse:_____ Signature:_____ Date: _____

Principal:_____ Signature:_____ Date: _____

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(7/2011)