NORTHBAY MANAGEMENT OF DIABETES FORM

Student: _____ Date of Birth: _____

School: _____

CONTACT INFORMATION

Parent/Guardian: _____ Home Phone: _____ Work: _____ Cell: _____

Other Emergency Contact: _____ Home Phone: _____ Work: _____ Cell: _____

INSULIN ORDERS

1. Insulin administration via: □ syringe and vial □ insulin pen □ insulin pump □ other:_____

If on insulin pump indicate type of pump _____ and basal rates _____ ***must also fill out insulin pump form**

2. Insulin Before Meals and at Bedtime: Name of insulin: _____

□ Routine dose: _____ Per sliding scale as follows:

Blood Glucose _____ to _____ give _____ units
Blood Glucose _____ to _____ give _____ units
Blood Glucose _____ to _____ give _____ units
Blood Glucose _____ to _____ give _____ units
Blood Glucose _____ to _____ give _____ units
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Blood Glucose _____ to _____ give _____ units
Blood Glucose _____ to _____ give _____ units
Blood Glucose _____ to _____ give _____ units

□ Calculated insulin dose (**add** carbohydrate coverage and correction dose for total insulin does):

Carbohydrate Coverage: Insulin to carbohydrate ratio
□ Give _____ units insulin per _____ grams carbohydrate
Correction:
□ Give _____ units insulin per _____ mg/dl of glucose **above** _____ mg/dl
□ Subtract _____ units insulin per _____ mg/dl of glucose **below** _____ mg/dl

□ Lantus: _____ units at bedtime

3. Other times insulin may be given:
□ Snack: Dose: _____ □ Calculated as above
□ Ketones: □ If ketones are _____ Give/Add _____ units
□ If ketones are _____ Give/Add _____ units

HEALTH CARE PROVIDER AUTHORIZATION FOR MANAGEMENT OF DIABETES AT NORTHBAY

My signature below provides authorization for the above written orders.

Health Care Provider Name: _____ **Signature:** _____

Address: _____ City: _____ Zip: _____

Phone: Fax: Date:

PARENT CONSENT FOR MANAGEMENT OF DIABETES AT NORTHBAY

I request designated NorthBay personnel to administer the medication and treatment orders as prescribed above. I agree

1. To provide the necessary supplies and equipment or my child will be sent home for his/her own safety
2. To notify the nurse if there is a change in the student's diabetes management or health care provider

I authorize the nurse to communicate with the health care provider as necessary.

Parent/Guardian Signature: _____ Date: _____

Student: _____

BLOOD GLUCOSE MONITORING

Target range for blood glucose monitoring: _____

□ After Snacks □ After Meals □As needed for symptoms of hypo/hyperglycemia □ Other times: _____
□ With signs and symptoms of illness □ 2 hours or _____ hours after meals □ 2 hours or _____ hours after a correction dose

HYPOGLYCEMIA – BLOOD GLUCOSE LESS THAN _____

□ Give _____ gms of fast acting carbohydrate (such as glucose tablets, glucose gel, cake, gel, juice). Recheck BG in 15 mins. Repeat treatment if BG less than _____ mg/dl
□ Provide extra protein and carbohydrate snack after treating low if next meal/snack is greater than _____ minutes away
□ Suspend pump for severe hypoglycemia for _____ minutes

□ If student is unconscious, having a seizure or unable to swallow, presume student is having a low blood sugar and Call 911, notify parent

□ Glucagon injection (1 mg in 1 cc) subcutaneous □ OK to use glucose gel inside cheek, even if unconscious, seizing
□ Other: _____

HYPERGLYCEMIA – BLOOD GLUCOSE GREATER THAN _____

□ Check urine ketones, follow care plan, administer insulin as per orders □ For pumps, insulin may be given by syringe or pen if needed
□ Encourage sugar free fluids, at least _____ ounces per _____
□ If student complains of nausea, vomiting or abdominal pain; check urine ketones & check insulin administration orders
□ Other: _____

MEAL PLAN

□ AM snack, time _____ □ PM snack, time _____ □ Avoid snack if blood glucose greater than _____ mg/dl
□ Carbohydrate goal per meal: _____

(Breakfast is served at 8:30am, Lunch at 12:00pm, Dinner at 6:00pm, and bedtime is 10:00pm)

EXERCISE

□ Fast-acting carbohydrate source must be available before, during and after:
swimming boating water skiing hiking ropes course rock climbing
land/gym sports mountain biking dance

□ If most recent blood glucose is less than _____, exercise can occur when blood glucose is corrected and above _____
□ Eat _____ grams of carbohydrate □ Before □ Every 30 minutes during □ After vigorous exercise
□ Avoid exercise when blood glucose is greater than _____ or ketones are _____

HEALTH CARE PROVIDER ASSESSMENT

□ Student can self-perform the following procedures (camp nurse and parent must verify competency):
□ Blood glucose monitoring □ Measuring Insulin □ Injecting insulin □ Determining insulin dose
□ Independently operating insulin pump
□ Other: _____

DISASTER PLAN (if needed for lockdown, 24 hr shelter in place):

□ Follow insulin orders as on Management Form
□ Additional insulin orders as follows: _____
□ Administer long acting insulin as follows: _____
□ Other: _____

Other Instructions: _____
_____

Health Care Provider Signature: _____Phone: _____ Date: _____

Parent's Signature: _____ Phone: _____ Date: _____