Diabetes Medication Administration Record (MAR) Part 1

A completed form must be provided to the school principal and/or nurse before the student may be assisted in their diabetes management at school

Student name A	❑ Male ❑ Female Date of birth	Home address	Student ID# _____
Grade/Class	Teacher	School	

Student Photo (Must attach)

Medication orders must be completed and signed by prescriber

1 Emergency Situations

Severe Hypoglycemia

I. Give glucagon ❑ 1 mg IM or SQ or ❑ ____mg IM or SQ and CALL 911 PRN for unconsciousness, unresponsiveness, seizure, or inability to swallow

❑ 2. Turn student onto his/her side in case of nausea or vomiting

❑ 3. Stay with student until emergency help arrives (have someone contact parent(s)

❑ 4. When student awakens and is able to swallow, encourage to take small sips of fluid of a carb-containing fluid (fruit juice/regular soda). If tolerated, follow with 15 grams of a carb and fat-containing food (peanut butter/crackers). Check blood glucose every 15 minutes and repeat snacks until BG is above 200mg/dl

❑ 5. Other _____

Risk for Diabetic Ketoacidosis (DKA)

1. ❑ Ketones: Test ketones if hyperglycemic*, ill, vomiting, or fever >100.5 oral
If small or trace, give unlimited water and restroom pass. Re-test ketones and BG in __hours.
If initial or retest ketones are moderate or large, give unlimited water and restroom pass and:

❑ Call parent ❑ and/or MD ❑ No gym/recess

❑ If vomiting, unable to take by mouth, and MD not available. Call 911

❑ Give insulin bolus, if ordered

2 Diagnosis and Home Meds

Diagnosis

❑ Type 1 Diabetes ❑ Pre-diabetes

❑ Type 2 Diabetes ❑ Other _____

Home Medications (Name, dose, frequency, and time)

Insulin_____

Other home meds _____

3 Blood Glucose (BG) Testing

BG Testing

❑ May check BG without supervision ❑ Test BG prior to eating meals/snacks that contain carbohydrates

❑ May check BG with supervision ❑ Test BG for symptoms/signs of a high or low BG

❑ Must have school personnel check BG ❑ Test BG if student is ill

4 Hypoglycemia Low Blood Glucose < __ mg/dl

Hypoglycemia

❑ If the BG is less than ❑ ___ or ❑ 70 mg/dl (children 6 years and older) or less than ❑ ___ or ❑ 80 mg/dL (children less than 6 years old) and the child can safely consume food/drink, give 15 grams of fast-acting carbs (4 oz juice or regular pop, 3-4 glucose tablets or 5-8 lifesavers)

❑ Retest BG in 15 minutes. Give additional 15 grams until BG is greater than 70 mg/dL (children 6 years and older) or greater than 80 mg/dL (children less than 6 years old)

❑ If the low BG occurs at meal or snack time, treat the low BG as above and then give the usual insulin dose

❑ If unable to test BG, but child is symptomatic of low BG, treat as noted above

❑ Contact the parent(s) if the child required two or more carb treatments for a low BG or if the BG was less than 50 mg/dL

❑ If meal more than one hour away, give additional _____ gm of snack with protein

❑ If participating in exercise, give additional _____ gm of snack with protein

5 Insulin Orders and Carb Coverage

Insulin Orders and Carb Coverage

Check one box only

❑ Carb coverage ❑ Carb coverage plus correction when BG > target BG or sliding scale ❑ Sliding scale ❑ No insulin at school — glucose monitoring **ONLY**

Name of Insulin ❑ insulin lispro (Humalog®) ❑ insulin aspart (Novolog®)

❑ insulin glulisine (Apridra®) ❑ Other _____

❑ Syringe ❑ Pen ❑ Pump

☑ Store unopened vial of insulin in the refrigerator (36-46 degree F). After vial is opened, it may be kept at room temperature. Discard after four weeks. Keep several syringes at school in case injection is needed.

Target Blood Glucose (BG) = _____ mg/dL

Insulin: Carb Ratio: (I:C) For breakfast _____ of insulin _____ gm carb

For lunch_____ of insulin _____ gm carb

For dinner _____ of insulin _____ gm carb

6 Insulin Pump Orders

Insulin Pump

(brand/model) _____

❑ In school Basal Rate(s) _____ units/hour

❑ Gym or temp. ____ % basal rate for _____ hours

❑ Disconnect pump for gym

For Pump

❑ Follow pump recommendation for bolus dose (if not using pump recommendation round DOWN the dose, down to nearest 0.1 unit)

❑ For BG>_____ mg/dL that has not decreased _____hours after correction consider pump failure Notify parent

❑ For suspected pump failure: DISCONNECT pump and give insulin by syringe or pen

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Student name A	Grade/Class

Sliding Scale 7

Sliding Scale ❑ Not Applicable

❑ Pre lunch	bG Range	Insulin Units	❑ Other time	bG Range	Insulin Units
Name of Insulin_____ _____	_____ to _____	_____	_____	_____ to _____	_____
Please do NOT overlap ranges (e.g. 100-200. 200-300. etc.)	_____ to _____	_____	_____	_____ to _____	_____
If ranges overlap, the lower dose will be given	_____ to _____	_____	_____	_____ to _____	_____
	_____ to _____	_____	_____	_____ to _____	_____

Snack 8

Snack Time of Day _____ No. of Carbs Allowed _____ Food Choice_____

❑ Student may carry and self administer snacks

Prescriber Authorization B

Special Instructions _____

Possible severe adverse reaction _____

❑ See Emergency Action Plan

PRESCRIBER AUTHORIZATION

Prescriber name (print) _____ Prescriber address _____ Prescriber Emergency phone_____

Prescriber signature _____ Fax_____

Parent Authorization C

PARENT AUTHORIZATION

☑ I authorize an employee of the school board to administer the above medication.

☑ I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.

☑ I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist should a question come up about the medication.

☑ Medication form must be received by the principal, his/her designee, or the school nurse.

☑ I understand that the medication must be in the **original** container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.

Parent/Guardian signature	Date	1# contact phone ( )	#2 contact phone ( )

Diabetic Medication Administration Record (MAR) Part 2

Prescriber order(s) and signature required on page 2 of the Diabetic Medication Administration Record (Part 1). A completed form must be provided to the school principal and/or nurse before prescription medication may be administered in school

Student Information

A

Student name	Date of birth
Student address	Grade/Classroom

Parent Authorization

B

- ☑ I authorize a designated employee of the school board to administer the prescriber's medication as ordered for my child
- ☑ I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed
- ☑ I also authorize the licensed health care professional to talk with the prescriber or pharmacist should a question come up about the medication
- ☑ Medication and medication form must be received by the principal, his/her designee, or the school nurse
- ☑ I Understand that the medication must be in the **original container** and be **properly labeled** with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug expiration when appropriate
- ☑ I agree that it is important to keep diabetic medication and supplies at the school's designated location
- ☑ I understand I must come into the school office/clinic when my child's medication is discontinued by the prescriber or at the end of the school year, or medication will be disposed of one week post-discontinuation orders or school year end

Parent/Guardian signature	Date	#1 Contact Phone	#2 Contact Phone

Do not write below (For school staff only)

C

Reviewed by	Title/Position	Date
Comments		

❑ File per district policy