In the Absence of the Health Center Nurse:

[redacted]

qualified substitute nurse and the parents are not available, the parent will designate a

[redacted]

Deer Valley Unified School District No. 97

Nurse QUICK-LOOK Form

Name _____ Grade/ Teacher _____ School Year_____

Uses: Pump / Syringe / Pen Pump/Pen Name_____ Meter Name _____
Student can: do BG test - Yes / No administer insulin - Yes / No carry insulin/supplies- Yes / No

Blood Glucose Target Range: _____ to _____

If administering Insulin per pump, please refer to pump settings/instructions/parent for directions.

If administering Insulin per injection, Carb/Insulin Ratio: _____:_____
Correction Bolus Formula: BG minus divided by

Time: _____ BG Testing before lunch. If BG is _____ or higher, he/she is ok to go eat lunch. If lower than 80, please see below.* Student Will / Will Not pre-bolus before lunch.
Special Notes: _____

Time: _____ He/She will return after lunch for insulin correction given SQ/ thru the pump. Calculate

carbs eaten. Administer insulin via directed route per ratio calculation.
Special Notes: _____

Time: _____ He/She will come before / after PE&Specials
Special Notes: _____

IF HE/SHE COMES IN LOW (less than 80) –

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Diabetic Supply Checklist

Student Name _____ School _____

Grade/Teacher _____ School Year_____

1. Diabetes Treatment Plan for School
   From Physician/Endocrinologist
   From Nurse

2. Diabetes Questionnaire

3. Diabetes Self-Management Authorization

4. Supplies for School (circle supplies to be used for this student)
   Blood Glucose Meter, blood glucose test strips and batteries (Please supply 2 meters, 1 for class/ 1 for Health Office)

[redacted]

Insulin Pump supplies, extra sites, batteries
Insulin vials and syringes
Urine / blood ketone strips
Quick Carb resources (glucose tabs, sweet tarts, fruit chews, cake icing)
Snacks, protein snacks (cheese & crackers, string cheese, beef jerky)

Student: _____ DOB: _____

Grade/Teacher: _____ School: _____