Health Care Provider Orders for Student with Diabetes on Injections/Oral Medication

To be completed by the Health Care Provider and used in conjunction with the Standards of Care for Diabetes Management in the School Setting – Colorado
www.coloradokidswithdiabetes.org

Student:	DOB:	School:	Grade:
Physician/Provider:		Phone:	
Diabetes Educator:		Phone:	

TARGET RANGE – Blood Glucose:	**mg/dl TO mg/dl**			
☐< 5y.o. 80-200mg/dl	☐ 5 – 8 y.o 80-200mg/dl	☐ 9-11y.o 70-180mg/dl	☐ 12-18y.o. 70-150mg/dl	☐ >18y.o. 70-130mg/dl
Notification to Parents: Low < *target range* and High > 300 mg/dl or ***Other:*** less than____ **mg/dl** and			greater than:____ **mg/dl**	

☐ Continuous glucose monitoring: Always *Confirm glucose level with a fingerstick/meter prior to treatment unless student has a Dexcom G5 or G6, it may be used for dosing and treatment. Please follow* ***Collaborative*** **Guidelines for Dexcom G5 & G6: Therapeutic Dosing in the School Setting (www.coloradokidswithdiabetes.org)**

Hypoglycemia: Follow *Standards of Care for Diabetes Management in the School Setting – Colorado*, unless otherwise indicated here:

____

For *Severe Symptoms:* Call 911 & Administer **Glucagon Dose:** **mg** **Intramuscular in** ☐**Arm** ☐**Buttocks** ☐**Thigh**

Hyperglycemia: Follow *Standards of Care for Diabetes Management in the School Setting – Colorado*, unless otherwise indicated here:

____

Ketone Testing: *per Standards of Care for Diabetes Management in the School Setting – Colorado* OR Other: | Other:

When to Check Blood Glucose: *For provision of student safety while limiting disruption to learning*

☐**Always for signs & symptoms of low/high blood glucose, when does not feel well and/or behavior concerns**
☐**Check before meals and as mutually agreed upon by parent and school nurse**
☐ **Other:**

Blood Glucose Correction and Insulin Dosage Using (Rapid Acting/Short Acting) Insulin Type: *Injections should be given subcutaneously & rotated*

Lunchtime Correction: Give ☐ Prior to lunch ☐ Immediately after lunch ☐ Split ½ before lunch & ½ after lunch ☐ Other :

☐**Insulin** Dosing Attached

☐**Sensitivity/Correction Factor:** _____ unit insulin for every _____mg/dl above _____starting at _____mg/dl

Blood Glucose Range:	**mg/dl to mg/dl**	Administer:	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to mg/dl**	Administer:	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to mg/dl**	Administer:	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to mg/dl**	Administer:	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to mg/dl**	Administer:	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to mg/dl**	Administer:	**units**	☐ Check ketones

☐ Parent/guardian authorized to increase or decrease sliding scale +/- 2 units of insulin *per Guidelines for Insulin Management**

When hyperglycemia occurs other than at lunchtime:
☐ If it has been greater than **3 hours** since the last dose of insulin, the student may be given insulin via injection using the indicated correction factor on the provider orders **if approved by the school nurse and parent is notified.**
☐ **Cont**act Health Care Provider for One-time order

Carbohydrates and Insulin Dosage: ☐ **Breakfast** ☐**Snack** ☐**Lunch** ☐**Other:**
(To be given in conjunction with the correction dose as indicated)

Insulin to Carbohydrate Ratio: _____**unit(s)** for every _____ **grams** of carbohydrate to be eaten ☐Dosing Attached

☐ Parent/guardian authorized to increase or decrease insulin to carb ratio 1 unit +/- 5 grams of carbohydrates

☐ **Oral Medication:** _____ _____mg Time: _____

☐ **NPH Insulin** Dose: _____units SQ Time: _____

Student's Self Care: ☐No supervision ☐Full supervision, ☐Requires some supervision: ability level to be determined by school nurse and parent unless otherwise indicated here:

Additional Information:

Signatures: My signature below provides authorization for the written orders above and exchange of health information to assist the school nurse an Individualized Health Plan. I understand that all procedures will be implemented in accordance with state laws and regulations and may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This order is for a maximum of one year.

Physician: _____ Date: _____

Parent: _____ Date: _____

School Nurse: _____ Date: _____

Health Care Provider Orders for Student with Diabetes on Insulin Pump

To be completed by the Health Care Provider and used in conjunction with the Standards of Care for Diabetes Management in the School Setting
www.coloradokidswithdiabetes.org

Student:	DOB:	School:	Grade:
Physician/Provider:			Phone:
Diabetes Educator:			Phone:

TARGET RANGE – Blood Glucose:	**mg/dl TO mg/dl**			
☐< 5y.o. 80-200mg/dl	☐ 5 – 8 y.o 80-200mg/dl	☐ 9-11y.o 70-180mg/dl	☐ 12-18y.o. 70-150mg/dl	☐ >18y.o. 70-130mg/dl
Notification to Parents: Low < *target range* and High > 300 mg/dl or ***Other:***	less than____ **mg/dl** and	greater than:____ **mg/dl**		
☐ Continuous glucose monitoring: Always *Confirm glucose level with a fingerstick/meter prior to treatment unless student has a Dexcom G5 or G6, it may be used for dosing and treatment. Please follow* ***Collaborative*** **Guidelines for Dexcom G5 & G6: Therapeutic Dosing in the School Setting (www.coloradokidswithdiabetes.org)**				

Hypoglycemia: Follow *Standards of Care for Diabetes Management in the School Setting – Colorado*, unless otherwise indicated here: ____		
For *Severe Symptoms:* Call 911, Disconnect Pump, Administer **Glucagon Dose:**	**mg**	**Intramuscular in ☐Arm ☐Buttocks ☐Thigh**
Hyperglycemia: Follow *Standards of Care for Diabetes Management in the School Setting – Colorado*, unless otherwise indicated here: ____		
Ketone Testing: *per Standards of Care for Diabetes Management in the School Setting – Colorado* OR Other:		

When to Check Blood Glucose: *For provision of student safety while limiting disruption to learning*
☐Always for signs & symptoms of low/high blood glucose, when does not feel well and/or behavior concerns
☐Check before meals and as mutually agreed upon by parent and school nurse
☐ **Other:**

Insulin Pump: *Follow Guidelines for Insulin Administration by School Staff, Diabetes Resource Nurses February 2013*

- Pump settings are established by the student's healthcare provider and should not be changed by the school staff. All setting changes to be made at home or by student providing self care as indicated on IHP.
- Internal safety features for the insulin pump should be active at all times while the student is at school - (Alarms set conservatively).

Insulin Pump Brand: ____	Type of Insulin in pump____

Correction Bolus:

- Provide Correction bolus per pump calculator. All BG levels should be entered into the pump for administration of pump-calculated corrections unless otherwise indicated on the provider orders.

☐**Sensitivity/Correction Factor:**	_____ unit insulin for every _____mg/dl above target BG range starting at _____**mg/dl**
☐ **Insulin**Dosing Attached	

☐ If blood glucose is ***less than ___ mg/dl,*** wait to give meal bolus until after meal

When Hyperglycemia occurs other than at lunchtime:
☐ If it has been greater than **3 hours** since the last dose of insulin, the student may be given insulin via injection using the indicated correction factor on the provider orders **if approved by the school nurse and parent is notified.**
☐ **Cont**act Health Care Provider for One-time order

Carbohydrates and Insulin Dosage per pump: ☐ **Breakfast** ☐**Snack** ☐**Lunch** ☐**Other:** ☐ **Insulin** Dosing Attached

Insulin to Carbohydrate Ratio: _____**unit(s)** for every _____ **grams** of carbohydrate to be eaten

Bolus for carbohydrates should occur immediately ☐ Prior to lunch/snack ☐**A**fter lunch/snack ☐ Split ½ before lunch & ½ after lunch ☐ Other: _____

☐ Parent/guardian authorized to increase or decrease insulin to carb ratio 1 unit +/- 5 grams of carbohydrates

Pump Malfunctions: Disconnect pump when malfunctioning
If pump calculator is operational then the insulin dosing should be calculated by using the pump bolus calculator and then insulin given by injection
If pump calculator is not operational: ☐ School Nurse or Parent to give insulin according to Insulin to Carbohydrate Ratio and/or Correction Factor
☐ Call Parent and Health Care Provider (for orders)

Student's Self Care: ☐No supervision ☐Full supervision, ☐Requires some supervision: ability level to be determined by school nurse and parent unless otherwise indicated here:

Additional Information:

Signatures: My signature below provides authorization for the written orders above and exchange of health information to assist the school nurse an Individualized Health Plan. I understand that all procedures will be implemented in accordance with state laws and regulations and may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This order is for a maximum of one year.

Physician: _____ Date: _____
Parent: _____ Date: _____
School Nurse: _____ Date: _____

CONFIDENTIAL **District:**

Student Picture

Individualized Health Plan: Diabetes in School Setting

Date of Plan: _____ **Date of Orders:** _____

To be completed by School Nurse in consultation with Parent, School staff and per HealthCare Provider Orders
See Colorado Diabetes Standard of Care Guidelines for the School Setting

Student: _____ DOB: _____

School: _____ Grade: _____ Teacher: _____

Health Concern: ☐ Type 1 Diabetes ☐ Type 2 Diabetes Other: _____ Date of Diagnosis: _____

Mother/Guardian: _____ Preferred Tel #: _____

Father/Guardian: _____ Preferred Tel #: _____

School Nurse: _____ Work#: _____

Physician: _____ Work#: _____

Diabetes Educator: _____ Work#: _____

Hospital of Choice: _____ 504 on file? ☐ Yes ☐ No

Comments: _____

TARGET RANGE – Blood Glucose:	_____mg/dl	**TO**	**_____mg/dl**
Notify Parents if Blood Glucose values below:	**_____mg/dl**	**or greater than:**	**_____mg/dl**

Medications: Insulin Dosing – see *Insulin Injection Administration or Pump Administration Addendum*

Insulin Delivery Device: ☐ Insulin Pen ☐ Insulin Pump ☐ Syringe & Vial Insulin Type: _____

☐ Parent/guardian elects to give insulin needed at school Notify parent/guardian for correction if Blood Glucose ≥ **_____mg/dl**

Glucagon Dose: _____mg Intramuscular in ☐ **Arm** ☐ Buttock ☐ Thigh - *See Severe Hypoglycemia Care

Required Blood Glucose Monitoring at School *(See Blood Glucose Treatment Plan)*

Where to check Blood Glucose: ☐ Health Room ☐ Classroom Other: _____

☐ Student can carry supplies and test where needed and when needed

☐ Continuous glucose monitoring: *Always Confirm glucose level with a fingerstick/meter prior to treatment*

Alarms set for: **Low: _____mg/dl High: _____mg/dl**

When to Check Blood Glucose:

☐ As needed for signs/symptoms of low/high blood glucose and/or does not feel well ☐ Behavior Concern

☐ Before School Program ☐ Before Snack ☐ Mid-morning ☐ After School Program/Extracurricular Activity

☐ Before Lunch ☐ After Lunch ☐ Recess ☐ Before PE ☐ After PE

☐ School Dismissal ☐ Before riding bus/walking home ☐ 2.5 hrs after correction Other: _____

Student's Schedule: Location of Snacks: _____ Location Eaten: _____

Lunch: _____ PE: Recess: Snack: am pm

Class School Parties or Events with Food:

☐ In the event of Class Party – may eat the treat and insulin dosage per Provider Orders

☐ Student able to determine whether to eat the treat

☐ Replace with parent supplied treat ☐ May *NOT* eat the treat ☐ Contact Parent Prior to event for instructions

Classroom Emergency Preparedness: ☐ Snack/Water in classrooms (provided by parent)

Supplies to be kept: (indicate location)

Standardized Academic Testing Procedures: School Staff to notify Parents and School Nurse of upcoming standardized testing in order to create a plan for Blood Glucose monitoring and treatment.

Student's Self Care (ability level to be determined by School Nurse and Parent with input from Health Care Provider prn)

Totally Independent Management	☐ Yes	☐ No	☐ Agreement for Student's Independent Management Completed
Assist/supervise blood glucose testing by trained staff	☐ Yes	☐ No	
Blood glucose testing to be done by trained staff	☐ Yes	☐ No	
Administers Insulin Independently	☐ Yes	☐ No	
Insulin injections to be done by trained staff	☐ Yes	☐ No	
Self-Injects with verification of dose & supervision	☐ Yes	☐ No	
Monitors own snack and meals	☐ Yes	☐ No	
Trained staff to monitor food intake	☐ Yes	☐ No	
Independently Counts Carbs	☐ Yes	☐ No	
Trained staff to assist with carb counting	☐ Yes	☐ No	
Self-treats mild hypoglycemia	☐ Yes	☐ No	
Tests and interprets urine/blood ketones	☐ Yes	☐ No	

Other: _____

*See Pump Addendum for self-care pumps skills

Additional Information

Field Trip Information and Special Events:

1. Notify parent and school nurse in advance so proper training can be accomplished
2. Adult staff must be trained and responsible for student's needs on field trip
3. Extra snacks, BG meter, copy of health plan, glucagon, insulin & emergency supplies must accompany student on field trip
4. Adult(s) accompanying student on a field trip will be notified of student's health accommodations on a need to know basis

Exercise and Sports:

☐ Snack prior to PE ☐ Snack after PE ☐ Snack before Recess ☐ Snack after Recess # of Snack Carbs:

In general, there are no restrictions on activity except in these cases:

Student should not exercise if blood glucose is >300 and ketones is > small or until hypoglycemia/hyperglycemia is resolved

A source of fast-acting glucose & glucagon should be available in case of hypoglycemia

Special Instructions: _____

Staff Trained:	Monitor blood glucose & treat hypo/hyperglycemia	Give Insulin	Give Glucagon
1. _____	☐	☐	☐
2. _____	☐	☐	☐
3. _____	☐	☐	☐

Further Instructions: _____

See Addendum(s): ☐ Emergency Action Plan: Glucose Monitoring & Treatment ☐ Insulin Pump ☐ Insulin Injection & Medication Management ☐ Continuous Glucose Monitor ☐ Supplies ☐ Activity Plan

PARENT/GUARDIAN PERMISSION

I understand that:

- Medication orders are valid for this school year only & need to be renewed at the beginning of each school year.
- New Physician Orders are needed when there are any changes in the medication orders. (e.g. at quarterly clinic visits)
- Medication orders will become part of my child's permanent school health record.
- Medications must be in original container and labeled to match physician's order for school use including field trips.
- I have the responsibility for notifying the school nurse of any changes in Medication or care orders.
- I give permission to the school nurse to share information with appropriate school staff relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.
- I give permission to the school nurse to contact the above health care provider for information relevant to the prescribed medication administration, provider orders, and related student health information appropriate for my child's health and safety.
- I give my permission to the school nurse and designated staff to perform and carry out the diabetes tasks as outlined in this Individualized Health Plan (IHP).
- I understand that the information contained in this plan will be shared with school staff on a need-to-know basis.
- Parent/Guardian & student are responsible for maintaining necessary supplies,snacks,blood glucose meter,medications & other equipment.

Parent Name:	Parent Signature:	Date:
School Nurse:	School Nurse Signature:	Date:

Emergency Action Plan:
Glucose Monitoring Treatment

PHOTO:

STUDENT:		DOB:	GRADE/TEACHER:

☐TREATMENT PLAN: Low Blood Glucose (Hypoglycemia): Below _____ mg/dl

Causes: •Too much insulin •Too much exercise •High excitement/anxiety •Too few carbohydrates eaten for the amount of insulin given

If you see this:	Follow this: ACTION PLAN
Signs of Mild Low Blood Glucose **(STUDENT IS ALERT)** ▪ Headache ▪ Sweating, pale ▪ Shakiness, dizziness ▪ Tired, falling asleep in class ▪ Inability to concentrate ▪ Poor coordination ▪ Other: _____	1. Responsible person accompany student to health room or check blood glucose on site 2. Check blood glucose 3. If less than _____**mg/dl,** give one of the following sources of glucose: (~15gms for fast-acting sugar (student < 5 y.o. give 7.5gms) *(Checked are student's preferred source of glucose but if not available any of these may be used)* ☐ 2-4 glucose tablets ☐ 6-9 Sweettarts® candies ☐ 2-4 oz. Orange or other 100% juice ☐ 8 oz of milk ☐ 4-6 oz. sugar soda (not sugar-free) ☐ Other: _____ 4. After 10-15 minutes, **re-check** blood glucose 5. Repeat giving glucose & re-check if necessary until blood glucose is > _____mg/dl. *Do not give insulin for the carbs used to bring up glucose level* ☐ Follow with a 15gm complex carb snack (do not give insulin for these carbs) **OR** if lunch time – Send to lunch (give insulin per orders). *Notify parent/guardian & school nurse* Comments: _____
Signs of Moderate Low Blood Glucose **(Student has decreased alertness)** ▪ Severe confusion ▪ Disorientation ▪ May be combative	1. Check blood glucose 2. Keeping head elevated, give one of the following forms of glucose: • 1 tube Cake Mate® gel or instant glucose applied between cheek and gum 3. After 10-15 minutes, check blood glucose again 4. Re-treat if necessary, until blood glucose is **> _____mg/dl,** Follow with 15gm complex carb snack (do not give insulin for these carbs) 5. Suspend/disconnect pump. *Notify parent/guardian & school nurse* Comments: _____
Signs of Severe Low Blood Glucose ▪ Not able to or unwilling to swallow ▪ Unconsciousness ▪ Seizure **GIVE NOTHING BY MOUTH!**	**1. Call 911, activate Emergency response,** place student on their side, **CHECK BG** 2. If personnel are authorized give **Glucagon,** prescribed dose: _____**mg(s)** Intramuscular 3. Suspend/disconnect pump & send pump to hospital with parent/EMS 4. Remain with student until help arrives . *Notify parent/guardian and school nurse* Comments: _____

☐Treatment Plan: High Blood Glucose (Hyperglycemia) Blood Glucose above _____ mg/dl

Causes:: •Illness •Underestimated carbohydrates and bolus •Hormonal Changes •Increased stress/anxiety •Insulin pump not delivering insulin

Signs of High Blood Glucose **(STUDENT IS ALERT)** **Symptoms could include:** • Extreme Thirst • Headache • Abdominal Pain • Nausea • Increased Urination • Lethargic • Other: ***Note:*** • If on a pump, insulin may need to be given by injection – Contact school nurse & parent. • *Allow to carry water bottle & use rest room unrestricted.*	1. Provide blood glucose correction as indicated in Provider Orders or per pump. ***Recheck in 2 hours.*** 2. When hyperglycemia occurs other than at lunchtime – contact school nurse & parent to determine correction procedure per provider orders or one-time orders. *3. Encourage to* drink water or DIET pop (caffeine free)*: 1 ounce water/year of age/per hour* ***4. Notify parents and school nurse if BG > 300mg or _____as indicated on provider orders. Contact the school nurse for Exercise Restrictions and School Attendance per Standards.*** ***5.*** ☐Check urine/blood ketones if BG is over **300mg/dl X2 or** _____*as indicated on provider orders.* & it has been > than 2 hours since last insulin dose. Recheck blood glucose in 2 hours following correction. Contact school nurse & parent with results. 6. ☐ Check urine ketones or ☐ blood ketones, if glucose **> 350mg/dl** or when ill, nausea, stomachache, lethargic, and/or vomiting. Contact school nurse & parent with results. 7. If BG **>300mg/dl** & urine ketones are **moderate to large or if blood ketones are greater than 1.0** mmol, **call parent & school nurse immediately! No exercise.** Recommend: Student to be released to parent/guardian for treatment/monitoring at home 8. **For PUMP users:** If BG > 350 mg/dl & ketones are positive, insulin to be given by injection by School Nurse or delegated staff (can use pump calculator to determine bolus) and set change by parent/guardian or independent student. If ketones negative, give an insulin bolus via pump and retest in 1-2 hours. Then if the BG continues to be > 350mg/dl, the correction bolus should be given by injection (can use pump calculator to determine bolus) and set change (to be changed by parent/guardian or independent student). Notify parents of BG results, ketone levels and actions. 9. If student's BG level is **>350 mg/dl & symptomatic** (illness, nausea, vomiting) - notify school nurse & parent. Student must go home to be treated/monitored by adult. Comments: _____

Parent Signature:		Date:	
School Nurse Signature:		Date:	

STUDENT HEALTH PLAN: DIABETES CLASSROOM DAILY CARE

Insert Photo

STUDENT:		DOB	District:	
School:		Grade/Teacher:		504:

NOTE: ***A comprehensive Individualized Health Plan is kept in the health offic***

Health Concern:	☐Type 1 Diabetes	☐Type 2 Diabetes	Other:		Date of Diagnosis:	
Mother/Guardian:				Preferred Tel #:		
Father/Guardian:				Preferred Tel #:		
School Nurse:				Work#:		

TARGET RANGE – Blood Glucose: ____ mg/dl TO ____ mg/dl
Notify Parents if Blood Glucose values below: ____ mg/dl Or above: ____ mg/dl

When to Check Blood Glucose:

☑As needed for signs/symptoms of low/high blood glucose and/or does not feel well ☑Behavior Concern

☐ Before School Program ☐ Before Snack ☐ Mid-morning ☐ After School Program/Extracurricular Activity

☐ Before Lunch ☐ After Lunch ☐ Recess ☐ Before PE ☐ After PE

☐ School Dismissal ☐ Before riding bus/walking home ☐ 2 hrs after correction Other: ____

Diet Restrictions:	Location of Snacks:	Location Snack Eaten:
Student Schedule: Lunch:	PE: Recess:	Snack: ____ am ____ pm

Health Concern #1 ✣Low Blood Glucose (Hypoglycemia) < ____ mg/dl

Emergency situations may occur with low blood glucose

Symptoms: shaky, feels low, feels hungry, confused

- Student is treated when blood glucose is below ___ **mg/dl** or if symptomatic.
- If treated outside the classroom, a responsible person should accompany student to the clinic.
- Follow directions on **Hypoglycemia Flow Chart**. - **GIVE FAST ACTING SUGAR** then provide follow-up care by trained school staff/school nurse & notify parents
- **IF UNCONSCIOUS – Trained personnel to give *GLUCAGON* & Call 911**

Health Concern #2 ✣High Blood Glucose (Hyperglycemia) > ____ mg/dl

Symptoms: increased thirst, increase in urination, headache, stomachache

- Student is treated when blood glucose is above ___ **mg/dl.**

Follow directions on **Hyperglycemia Flow Chart** then provide follow-up care by trained school staff (may need insulin) & notify parent

✣ Call 911 for the following:	1. Student is unable to eat or drink anything. 2. Decreasing alertness or loss of consciousness. 3. Seizure–never put anything in mouth of unconscious person. Roll student onto side & protect from injury.

Medication at School: **Insulin via:** ☐ Pump ☐ Syringe ☐ Pen ☐ None **Scheduled Insulin Bolus:** ☐Yes Times: ____

Glucagon: ☐ Yes ☐ No Location in school:

Equipment at School: ☐Pump ☐Blood Glucose Meter ☐Continuous Glucose Monitor

Additional Information: ***Notify parents & School Nurse of any concerns***	1. Student is allowed access to fast-acting glucose, to carry a water bottle, and have unrestricted bathroom privileges. 2. ***Substitute teachers*** must be aware of the student's health situation and responsibilities 3. **NOTE:** Blood glucose levels can affect ability to concentrate and perform properly on tests. Prior to & during timed tests, standardized tests, etc. have student check their blood glucose. If blood glucose out of range during test, treat per care plan. Allow for student to continue taking test when student returns to normal range and asymptomatic. 4. Always have fast-acting sugar available in each classroom.

FIELD TRIPS AND SPECIAL EVENTS: Notify parents of all field trips/special events.. Supervising staff will review Health Plans.Trained /delegated staff should accompany student & provide necessary interventions for daily management and emergency care. All necessary supplies will accompany student during the trip.

As parent/guardian of the above named student, I give my permission to the school nurse & other designated staff to perform & carry out the diabetes tasks as outlined in this Student Health Plan & for my child's health care provider to share information with the school nurse for the completion of this plan. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis.

Other:

Parent Signature:		Date:
School Nurse Signature:		Date:

Student Health Plan: Diabetes (Independent Management) ☐ Type 1 ☐ Type 2

Student:	_____	**DOB:**	_____	**Home Phone:**	_____
Mother:	_____	Work Phone:	_____	Cell Phone:	_____
Father:	_____	Work Phone:	_____	Cell Phone:	_____
Guardian:	_____	Phone:	_____		
School Nurse:	_____	Phone:	_____		
School:	_____	Grade:	_____	Teacher:	_____
Physician:	_____	Phone:	_____	Fax:	_____
Diabetes Educator:	_____	Phone:	_____		
Hospital of Choice:	_____	504 Plan on file:	☐ Yes ☐ No		

Student is independent with daily diabetes management and self-care

Blood Glucose Monitoring: Student is able to check as needed during the school day.

Target range: ___ mg/dl to ___ mg/dl.

NOTE: ***A comprehensive Individualized Health Plan is kept in the health office.***

Health Concern #1 **Low Blood Glucose (Hypoglycemia)**

Emergency situations may occur with low blood glucose.
Symptoms: shaky, feels low, feels hungry, confused

- Student is treated when blood glucose is below ___ mg/dl or if symptomatic.
- If treated outside the classroom, a responsible person should accompany student to the clinic.
- Follow directions on **Hypoglycemia Flow Chart**.

Health Concern #2 **High Blood Glucose (Hyperglycemia)**

Symptoms: increased thirst, increase in urination, headache, stomachache

- Student is treated when blood glucose is above ___ mg/dl.
- Follow directions on Hyperglycemia Flow Chart.

Call 911 for following

1. Student is unable to cooperate to eat or drink anything.
2. Decreasing alertness or loss of consciousness.
3. Seizure–never put anything into the mouth of a person who is unconscious or having a seizure. Roll student onto side and protect from injury.

NOTE: If Glucagon is prescribed and available, immediately contact delegated staff to administer.

Comments:

Medication at School: Insulin via: ☐ Pump ☐ Syringe ☐ Pen ☐ None
Glucagon: ☐ Yes ☐ No Location in school: _____
Staff delegated to administer Glucagon: _____

Additional Information:

1. **Student is allowed access to fast acting glucose and test blood glucose as needed.**
2. **Student will be allowed to carry a water bottle and have unrestricted bathroom privileges.**
3. **Substitute teachers must be aware of the student's health situation**
4. **Be aware that blood glucose levels can affect ability to concentrate and perform properly on tests.**
5. **Prior to and during timed tests, i.e., CSAPs, have student monitor their blood glucose. If blood glucose out of range during test, treat per care plan. Allow for student to continue taking test when student returns to normal range and asymptomatic.**
6. **Notify Parent(s) when blood glucose below ___ mg/dl or above ___ mg/dl and for emergencies**.

FIELD TRIPS AND SPECIAL EVENTS: Notify parents of all field trips and special events. Supervising staff will review Student Health Plan. Trained and delegated staff will provide necessary interventions for daily management and emergency care. All necessary supplies will accompany student during the trip and may include: blood glucose meter, snack and drinks, fast acting glucose, Glucagon.

As parent/guardian of the above named student, I give my permission to the school nurse and other designated staff to perform and carry out the diabetes tasks as outlined in this School Health Plan and for my child's health care provider to share information with the school nurse for the completion of this plan. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis.

_____	_____	_____	_____
Parent	Date	School Nurse	Date

AGREEMENT FOR STUDENTS INDEPENDENTLY MANAGING THEIR DIABETES

Student: _____ **School/Grade:** _____

STUDENT

☐ I agree to dispose of any sharps either by keeping them in my kit and disposing at home, or placing them in the sharps container provided at school.

☐ I will notify the health office if my blood sugar is below ___ mg/dl or above ___ mg/dl.

☐ I will not allow any other person to use my diabetes supplies.

☐ I plan to keep my diabetes supplies: _____ with me _____ in the school health office _____ in an accessible and secure location (located in _____)

☐ I understand that the freedom to manage my diabetes independently is a privilege and I agree to abide by this contract.

Student's Signature: _____ Date: _____

PARENT/GUARDIAN

☐ I agree that my child can self manage his/her diabetes and can recognize when he/she needs to seek the help of a staff member.

☐ It has been recommended to me that back up supplies be provided to the health office for emergencies.

☐ I understand that this contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contingencies.

Parent's Signature: _____ Date: _____

SCHOOL NURSE

☐ School staff members that have the need to know about the student's condition and the need to carry their diabetes supplies have been notified.

School Nurse's Signature: _____ Date: _____