Houston County Board of Education

Health Related Services

Family and Physician Student Information
Diabetic Management Plan

Student's Name: _____ Student's ID#:_____ Date of Birth: _____School Year:_____

Effective Date: _____School Name: _____ Grade: _____ Homeroom: _____

CONTACT INFORMATION:

Parent/Guardian #1: _____Phone #: Home: _____Work: _____ Cell/Pager: _____

Parent/Guardian #1: _____Phone #: Home: _____Work: _____ Cell/Pager: _____

Diabetes Care Provider: _____ Phone #: _____

Other Emergency Contact: _____ Relationship: _____

Phone Numbers: Home: _____ Cellular/Pager: _____

Insurance Carrier: _____Group/Policy #:_____Sponsor:_____

EMERGENCY NOTIFICATION: Notify parents of the following conditions:

a. Loss of consciousness or seizure (convulsion) immediately after calling *911* and administering Glucagon.
b. Blood sugars in excess of _____ mg/dl.
c. Positive urine ketones.
d. Abdominal pain, nausea/vomiting, fever, diarrhea, altered breathing, altered level of consciousness

STUDENT'S COMPETENCE WITH PROCEDURES: (Must be verified by parent and school nurse)

- ☐ Blood glucose monitoring
- ☐ Determining insulin dose
- ☐ Measuring insulin
- ☐ Injecting insulin
- ☐ Independently operates insulin pump
- ☐ Carry supplies for BG monitoring
- ☐ Carry supplies for insulin administration
- ☐ Monitor BG in classroom
- ☐ Self treatment for mild low blood sugar
- ☐ Determine own snack/meal content

MEAL PLAN:	**Time**	**Location**	**CHO Content**		**Time**	**Location**	**CHO Content**
☐ Bkft	_____	_____	_____	☐ Mid-PM	_____	_____	_____
☐ Mid-AM	_____	_____	_____	☐ Before PE	_____	_____	_____
☐ Lunch	_____	_____	_____	☐ After PE:	_____	_____	_____

Meal/snack will be considered mandatory. Times of meals/snacks will be at routine school times unless alteration is indicated. School nurse will contact diabetes care provider for adjustment in meal times. Content of meal/snack will be determined by:
☐ Student ☐ Parent ☐ School Nurse ☐ Diabetes Provider

Parent to provide and restock snacks and low blood sugar supplies box.

LOCATION OF SUPPLIES/EQUIPMENT: *(To be completed by school personnel)*

Blood glucose equipment: ☐ Clinic/health room ☐ With student

Insulin administration supplies: ☐ Clinic/health room ☐ With student

Glucagon emergency kit: _____ **Glucose gel**: _____ **Ketone testing supplies**: _____

Fast acting carbohydrate: ☐ Clinic/health room ☐ With student **Snacks**: ☐ Clinic/health room ☐ With student

Confidential Diabetic Information Release: I understand that all treatments and procedures may be performed by the student and/or unlicensed personnel within the school or by EMS in the event of loss of consciousness or seizure. I also understand that the school is not responsible for damage, loss of equipment, or expenses utilized in these treatments and procedures. I give permission for school personnel to contact my child's diabetes provider for guidance and recommendations. I have reviewed this information form and agree with the indicated information. This form will assist the school in developing a health plan and in providing appropriate care for my child.

PARENT SIGNATURE: _____ DATE: _____

HEALTH CARE PROVIDER AUTHORIZATION FOR SCHOOL MANAGEMENT OF DIABETES

STUDENT: _____ DOB: _____ DATE: _____

BLOOD GLUCOSE MONITORING: (Target range: _____ mg/dl to _____ mg/dl.)

- ☐ None required at this time.
- ☐ Before meals
- ☐ Midmorning
- ☐ Before PE/activity time
- ☐ After PE/activity time
- ☐ Mid-afternoon
- ☐ 2 Hrs after correction
- ☐ PRN for suspected low/high BG
- ☐ Before Dismissal

INSULIN ADMINISTRATION: Dose changes determined by: ☐ Student ☐ Parent ☐ Strict Sliding Scale

Insulin delivery system: ☐ Syringe ☐ Pen ☐ Pump (Use supplemental form for Student Wearing Insulin Pump)

Insulin Type: _____ CHO Insulin Ratio: _____ units per _____ gms. CHO

☐ Correction Bolus Dose: ***(Check only those which apply)***

- ☐ Use the following formula: BG - _____ / _____
- ☐ Sliding Scale:
  BG from _____ to _____ = _____ u
  BG from _____ to _____ = _____ u
  BG from _____ to _____ = _____ u
  BG from _____ to _____ = _____ u
  BG from _____ to _____ = _____ u

- ☐ Decrease correction dose by _____ units or _____% if PE/activity is anticipated < 1 hr after correction dose.
- ☐ Decrease correction dose by _____ units if given following a low blood glucose level.
- ☐ Add CHO bolus to correction bolus for total insulin dose

MANAGEMENT OF LOW BLOOD GLUCOSE: (below _____ mg/dl)

MILD: BG < _____

- ☐ Never leave student alone
- ☐ Give 15 gms glucose; recheck in 15 min.
- ☐ If BG < 70, retreat and recheck q 15 min x 3
- ☐ Notify parent if not resolved.
- ☐ Provide snack with CHO, fat, protein after treating and meal not scheduled > 1 hr

SEVERE: Loss of consciousness or seizure

- ☐ Call *911*. Open airway. Turn to side.
- ☐ Glucagon injection _____ mg IM/SQ if unconscious
- ☐ Notify parent.
  (Be prepared for seizure activity)

MANAGEMENT OF HIGH BLOOD GLUCOSE: (Above _____ mg/dl)

- ☐ Sugar-free fluids/frequent bathroom privileges
- ☐ If BG is greater than _____ , initiate insulin orders
- ☐ If BG is greater than _____, check for ketones. Notify parent if ketones are present.
- ☐ May not need snack.
- ☐ Note and document changes in status.
- ☐ Notify parent per "Emergency Notification" Section.

EXERCISE:
Child should NOT exercise if blood glucose levels are below _____ mg/dl or above _____ mg/dl + ketones.
☐ Eat _____ gms. CHO for vigorous exercise ☐ Before ☐ During ☐ After exercise.
☐ Student may disconnect insulin pump for _____ hr. or decrease basal rate by _____.

My signature provides authorization for the above orders. I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.

- ☐ **If changes are indicated, I will provide new written authorized orders (may be faxed).**
- ☐ **Dose/treatment changes may be relayed through parent.**

Dr. Signature: _____ **Date:** _____

SUPPLEMENTAL INFORMATION FOR STUDENT WEARING AN INSULIN PUMP AT SCHOOL

Student's Name: _____Student ID#: _____ Date of Birth: _____ Pump Brand/Model:_____
Pump Resource Person: _____ Phone/ Beeper _____ (See diabetes care plan for parent phone #)
Blood Glucose Target Range: _____ Pump Insulin: Humalog ☐ Regular ☐
Insulin Correction Factor for Blood Glucose Over Target: _____
Insulin Carbohydrate Ratios: _____
(Student to receive insulin bolus for carbohydrate intake immediately before / _____ minutes before eating. Circle appropriate interval)
Location of Extra Pump Supplies _____

☐ ***INDEPENDENT MANAGEMENT***

This student has been trained to independently perform routine pump management and to troubleshoot problems including but not limited to:

- Giving boluses of insulin for both correction of blood glucose above target range and for food consumption.
- Changing of insulin infusion sets using universal precautions.
- Switching to injections should there be a pump malfunction.
  Parents will provide extra supplies to include infusion sets, reservoirs, batteries, pump insulin and syringes.

☐ ***NON-INDEPENDENT MANAGEMENT (Child Lock On? Yes ☐ No ☐)***

Because of young age or other factors, this student cannot independently evaluate pump function nor independently change infusion sets.

- Insulin for meals and snacks will be given and verified as follows: _____
  _____
- Insulin for correction of blood glucose over _____ will be give and verified as follows:
  _____

PARENT NOTIFICATION: (*Refer to basic diabetes care plan and check ✓all others that apply. Contact the Parent in event of:*

☐ Pump alarms / malfunctions ☐ Corrective measures do not return blood glucose to target range within ___ hrs.
☐ Soreness or redness at site ☐ Student has to change site
☐ Detachment of dressing / infusion set our of place
☐ Leakage of insulin
☐ Student must give insulin injection
☐ Other: _____

MANAGEMENT OF HIGH / VERY HIGH BLOOD GLUCOSE: Refer to previous sections and to basic Diabetes Care Plan

MANAGEMENT OF LOW BLOOD GLUCOSE: *Follow instructions in basic Diabetes Care Plan, but in addition:*

If low blood glucose recurs without explanation, notify parent / diabetes provider for potential instructions to suspend pump.

If seizure or unresponsiveness occurs:

1. Give Glucagon and / or glucose gel (See basic Diabetes Health Plan)
2. CALL ***911***
3. Notify Parent
4. Stop insulin pump by:
   - ☐ Placing in "Suspend" or stop mode
   - ☐ Disconnecting at pigtail or clip
   - ☐ Cutting tubing
5. If pump was removed, send with EMS to hospital.

My signature provides authorization for the above orders. This authorization is valid for one year.

- ☐ **If changes are indicated, I will provide new written authorized orders (may be faxed).**
- ☐ **Dose/treatment changes may be relayed through parent.**

Dr. Signature: _____ **Date:** _____
Address: _____

☐ **I request that the school nurse provide me with a copy of the School Health Action Plan for this student.**