**New Albany-Floyd County Consolidated School Corporation School Health Services**

**2019-2020 School Year**

# Diabetes Management Plan: Page 1

***To be completed by prescribing Health Care Provider***

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_ School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_ Teacher: \_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- |
| **DIAGNOSIS:**  🞎 Type 1 Diabetes 🞎 Type 2 Diabetes 🞎 Hypoglycemia requiring monitoring  **Required blood sugar testing/monitoring at school:**  🞎 Trained personnel must perform blood sugar test  🞎 Trained personnel must supervise blood sugar test  🞎 Student can perform testing independently  **When should blood sugar monitoring be done?**  🞎 Before lunch 🞎 Before snack 🞎 Before standardized tests (ISTEP)  🞎 As needed to determine hypo- or hyperglycemia 🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Diet Requirements:**  🞎 No concentrated sweets diet (no sweet treats, chocolate milk)  🞎 Carbohydrate counting: -- carbs/meal (give range)  🞎 Regular diet/No restrictions  **Does student require a SCHEDULED snack during the school day?** 🞎 Yes 🞎 No   * If yes, what time? \_\_\_\_\_\_  |  | | --- | | **HYPERGLYCEMIA (HIGH BLOOD SUGAR)** |   **SIGNS & SYMPTOMS: ∙dry mouth ∙increased urination ∙tired ∙thirsty ∙sores or infections that won’t heal ∙hungry ∙sleepy ∙dry, itchy skin ∙headache**  **\*If symptoms persist🡪can lead to nausea, vomiting, stomach pain, fruity smelling breath**  HIGH BLOOD SUGAR LEVEL OF > \_\_\_\_\_\_ mg/dl REQUIRES THE FOLLOWING INTERVENTIONS:  🞎 Encourage extra liquids without sugar such as water. No extra juice or milk.  🞎 Allow frequent trips to restroom.  🞎 Give correction dose at: 🞎 meal time only,  🞎 *other than at meal time* if it has been **greater than \_\_\_\_\_ hours since last correction dose.**  🞎 any time it is recommended by pump.  🞎 Ketone monitoring. If ketones present, is additional insulin need at school? 🞎 Yes 🞎 No   * **If yes, SM \_\_\_\_ units, MOD \_\_\_\_ units, LG \_\_\_\_ units given no more than every \_\_\_ hrs**   🞎 Student should refrain from taking tests until blood sugar below \_\_\_\_\_\_\_ and PE until blood sugar below \_\_\_\_\_\_\_\_.  🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  | | --- | | **HYPOGLYCEMIA (LOW BLOOD SUGAR)** |   **SIGNS & SYMPTOMS: ∙hunger ∙staring ∙becoming very quiet ∙dizzy ∙crying ∙headache ∙clammy sweat**  **∙nervous ∙unable to think clearly ∙shaky ∙blurry vision ∙restless ∙weak ∙combative ∙unusually sleepy**  **∙pale ∙pounding heart ∙confused or disoriented ∙stumbling around ∙change in personality (mean/hateful)**  LOW BLOOD SUGAR LEVEL OF < \_\_\_\_\_\_ mg/dl REQUIRES THE FOLLOWING INTERVENTIONS:  🞎 **Give 15 grams of simple sugar and recheck in 15 min.** (ex. of simple sugar include 3-4 glucose tabs, 15 Skittles, 1 sm. tube glucose gel, 12 Sweet Tarts, 2-3 rolls Smarties)  🞎 **If blood sugar < \_\_\_\_\_\_mg/dl at recheck, then repeat simple sugar. Recheck again in 15 min.**  🞎 **Once blood sugar above \_\_\_\_\_\_\_ mg/dl, give 15 gram complex carbohydrate or lunch.** (ex. of complex carb include 4 peanut butter or cheese crackers, ½ sandwich, 1 sm. bag pretzels)  🞎 If low occurs at meal time check or before scheduled snack requiring insulin, give insulin after meal or snack. Only count carbs in meal or scheduled snack for carb insulin dose.  🞎 Call parent if the blood sugar does not rise above \_\_\_\_\_\_\_ mg/dl after 2 treatments with simple sugar.  🞎 Student should refrain from taking tests until blood sugar above \_\_\_\_\_\_\_ and PE until blood sugar above \_\_\_\_\_\_\_\_.  🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **EMERGENCY PLAN OF ACTION**  FOR UNCONSCIOUSNESS, SEIZURE, OR INABILITY TO SWALLOW DURING HYPOGLYCEMIA:  🞎 Give GLUCAGON \_\_\_\_\_\_\_ cc into the: 🞎 arm 🞎 thigh if kit provided by parent/guardian. Lay student on side.   1. Call 911 and school nurse. 2. Notify school personnel trained in CPR/First Aid to respond and initiate CPR if needed prior to EMS arrival. 3. Contact parent/guardian or emergency contact immediately. 4. If student arouses before EMS arrival, give sips of juice or regular soda and crackers. Do not give any food or liquids while unresponsive. 5. When student is transported via EMS, NAFCS staff must accompany student unless parent and/or emergency contact accompanies them. 6. If student requires emergency medical treatment while on the bus, driver/transportation will contact EMS. 7. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \*Please be aware that school nurses are not on site at all times. Non-nurse school personnel trained in diabetes care may be administering the medication. |

**New Albany-Floyd County Consolidated School Corporation School Health Services**

**2019-2020 School Year**

# Diabetes Management Plan: Page 2

***To be completed by prescribing Health Care Provider for (Student Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

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| --- | --- | --- | --- |
| **INSULIN TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ VIA : 🞎 PEN 🞎 PUMP 🞎SYRINGE & VIAL**  **Does this student require insulin during school?** 🞎 Yes 🞎 No  **Trained personnel must supervise insulin administration:** 🞎 Yes 🞎 No  **Can student administer insulin independently if needed at school?** 🞎 Yes 🞎 No  **Student can calculate own insulin dose:** 🞎 Yes 🞎 No  **Student has permission to carry insulin:** 🞎 With him/her during school day  🞎 To and from school  **INSULIN ORDERS:**  **Breakfast—\_\_\_ unit per \_\_\_\_ grams of carbohydrate (# carbs / \_\_\_\_\_ = insulin)**  **Insulin given: 🞎Before food 🞎After food 🞎Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Lunch—\_\_\_ unit per \_\_\_\_ grams of carbohydrate (# carbs / \_\_\_\_\_ = insulin)**  **Insulin given: 🞎Before food 🞎After food 🞎Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Scheduled snack—\_\_\_ unit per \_\_\_\_ grams of carbohydrate (# carbs / \_\_\_\_ = insulin)**  **Insulin given: 🞎Before food 🞎After food 🞎Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Class treat—\_\_\_ unit per \_\_\_\_ grams of carbohydrate (# carbs / \_\_\_\_ = insulin)**  **Insulin given: 🞎Before food 🞎After food 🞎Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**    **CORRECTION DOSE FOR HIGH BLOOD SUGAR: 🞎 N/A**  **If BS > \_\_\_\_\_mg/dl, give \_\_\_ unit per \_\_\_\_ mg/dl > \_\_\_\_ mg/dl**  **(i.e. BS -- \_\_\_\_\_ / \_\_\_\_\_\_ = correction dose)**  **🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **FOR STUDENTS WITH INSULIN PUMP: 🞎 N/A**  **🞎 Use pump settings for all insulin dosing unless pump failure occurs. Please follow meal and correction insulin orders above in event of pump failure.**  Type of pump: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current basal rates during school\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \*It is understood that programmed settings may change during school year.  🞎 Suspend pump for following circumstances: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **FOR STUDENTS WITH SLIDING SCALE: 🞎 N/A**  \_\_\_\_\_\_\_\_ Unit(s) if blood sugar is between \_\_\_\_\_ and \_\_\_\_\_  \_\_\_\_\_\_\_\_ Unit(s) if blood sugar is between \_\_\_\_\_ and \_\_\_\_\_  \_\_\_\_\_\_\_\_ Unit(s) if blood sugar is between \_\_\_\_\_ and \_\_\_\_\_ | **Parents must provide all necessary snacks and emergency supplies, including:**   |  |  | | --- | --- | | \_\_\_\_\_\_ Blood glucose meter, test strips, batteries  \_\_\_\_\_\_ Lancet device, lancets  \_\_\_\_\_\_ Urine ketone strips  \_\_\_\_\_\_ Insulin pump and supplies | \_\_\_\_\_\_ Insulin pen, pen needles, insulin cartridges  \_\_\_\_\_\_ Fast-acting source of glucose  \_\_\_\_\_\_ Long-acting source of glucose  \_\_\_\_\_\_ Glucagon emergency kit |   **Parent should be notified for the following circumstances: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Preferred method to contact parent during school day:**  🞎 Phone: 🞎 Home \_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Cell \_\_\_\_\_\_\_\_\_\_\_\_\_  🞎 Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞎 Written note sent home with student  🞎 Text: Cell number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **AUTHORIZATIONS**  **Prescribing Health Care Provider:**  The Diabetes Management Plan and medication orders have been developed and approved by:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Prescriber Printed Name Phone Fax  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Prescriber Signature Date  **Parent/Guardian:**  I give permission to the school nurse, trained diabetes personnel (Volunteer Health Aides), and other designated staff members to perform and carry out the diabetes care tasks as outlined in the Diabetes Management Plan. I understand that a school nurse is not always present at my child’s school and I give consent for other trained school personnel and Volunteer Health Aides to provide diabetes care to my child as needed according to this plan. I understand that, as provided under IC 34-30-14, a volunteer health aide is not liable for civil damages for assisting in the student’s care. I give permission for the school nurse and prescribing health care provider to exchange information regarding any necessary medication order clarifications, response to medication, and adverse effects. I also consent to the release of information contained in this Diabetes Management Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child’s health and safety.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Student’s Parent/Guardian Signature Date |

For school nurse use:

Personnel who are trained including the date of training:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*Please ensure ALL DIABETES CARE SUPPLIES are taken on all field trips.**

**Also, be sure to share this information with any substitute teacher.\*\*\***

**This plan has been reviewed and approved by:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Nurse’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Building Principal’s Signature Date

**Location of supplies:**

🞎 Health office

🞎 With student\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Classroom

🞎 Specials classrooms

🞎 Bus

🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Copies of HCAP given to/Date given:**

🞎Health Office ­­­­­­­\_\_\_\_\_\_\_ 🞎Teacher (Elem)\_\_\_\_\_\_\_ 🞎Principal\_\_\_\_\_\_\_🞎 Teacher of Record (Special Ed)\_\_\_\_\_\_\_ 🞎IEP(Special Ed) \_\_\_\_\_\_\_

🞎ESC (Special Ed)\_\_\_\_\_\_\_ 🞎Bus/Aide\_\_\_\_\_\_\_ 🞎Cafeteria (if diet orders)\_\_\_\_\_\_\_ 🞎All trained staff\_\_\_\_\_\_\_ 🞎Transportation (if care given on bus) \_\_\_\_\_\_