

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): _____

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 _____ Insulin pen, pen needles, insulin cartridges

_____ Lancet device, lancets _____ Fast-acting source of glucose

_____ Urine ketone strips _____ Long-acting source of glucose

_____ Insulin pump and supplies _____ 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

THIS FORM MUST BE RENEWED AT THE BEGINNING OF EACH SCHOOL YEAR

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) _____

THIS FORM MUST BE RENEWED AT THE BEGINNING OF EACH SCHOOL YEAR