School Lunch Time: _______________

New Albany-Floyd County Consolidated School Corporation School Health Services
2020-2021 School Year

Diabetes Management Plan: Page 1

To be completed by prescribing Health Care Provider

Student Name: ________________________________ Date of Birth: ___________ School: ____________________________ Grade: ___ Teacher: ____________

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.

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

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
______ 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

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