

New Albany-Floyd County Consolidated School Corporation School Health Services  
2021-2022 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

2021-2022 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

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