New Albany-Floyd County Consolidated School Corporation
Health Services
2023-2024 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

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) _____

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