CARMEL CLAY SCHOOLS
5201 E. Main St. · Carmel, IN 46033 · (317) 844-9961

DIABETIC ACTION PLAN

Pages 2-7 of this plan are to be completed by a parent.

Pages 8-11 of this plan are to be completed by the health care provider.

Please note that the health care provider may choose to submit their own version of an action plan in lieu of pages 8-11.

Please note that both the parent and health care provider portions of the plan must be submitted in order to have a full action plan on file for your student.

If you have questions about this action plan, please contact your school nurse.

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PARENT CONTACT INFORMATION FOR STUDENT WITH DIABETES

Student name: _____

Grade: _____ School year: _____ Rides bus: YES _____ NO _____

Parent/guardian #1 name: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Parent/guardian #2 name: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Emergency contact name: _____ Relationship: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Health care provider name: _____

Address: _____

Phone: _____ Hospital preference: _____

I give permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact my care provider if necessary and for this form to be faxed/emailed to my child's school or be shared with school staff per FERPA guidelines. I assume full responsibility for providing the school with prescribed medications and delivery/monitoring devices.

Parent signature: _____ **Date**: _____

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PARENT INFORMATION FORM FOR STUDENT WITH DIABETES

Student name: _____ Age diabetes was diagnosed: _____

1. What type of insulin does your child use? _____

2. Insulin delivery system (circle): **pump** **insulin pen** **insulin vial/syringes**

3. What time of day does your child routinely check their blood sugar (circle): **lunch** **other: _____**

4. My child's daily diabetic management will be done in the Health Center (circle): **YES** ***NO**

***** If "NO" (daily diabetic management ***will not*** be done in the Health Center), all area below in #5 should be circled "NO" for assistance needed.

5. Does your child need assistance with the following tasks?

Task	**Needs assistance**	
Performing glucose check?	YES	NO
Determine correct amount of insulin?	YES	NO
Drawing up correct amount of insulin?	YES	NO
Giving own injections?	YES	NO
Counting carbohydrates correctly?	YES	NO
Giving own bolus via pump?	YES	NO
Calculating and setting basal rates?	YES	NO
Disconnecting pump?	YES	NO
Reconnecting pump at infusion site?	YES	NO
Preparing reservoir and tubing?	YES	NO
Inserting infusion set?	YES	NO
Troubleshooting alarms and malfunctions?	YES	NO

6. Glucagon should be stored in the Health Center. Please deliver glucagon to the school nurse by the first day of school.

7. Does your child participate in extracurricular activities (circle): ***YES** **NO**

***** If "YES", please complete the two extracurricular forms in this pack and return to the school nurse prior to the start of the activity.

8. If applicable, would you be available to attend field trips with your child? **YES** **NO**

9. Please contact student's counselor at the beginning of the school year for accommodations needed for diabetic management (i.e. snack, glucose monitoring) during standardized testing (i.e. SAT, ISTEP).

Parent signature: _____ **Date**: _____

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CONTINGENCY PLANNING FOR STUDENT WITH DIABETES

Student name: _____

Grade: _____ Building: _____

Carmel Clay Schools employs a registered nurse to staff each building. Occasionally the building nurse is not available to work on her scheduled day. In this instance, every effort is made to find a substitute nurse to cover for the building nurse. In rare instances, a substitute nurse is not available. In such cases, every building has a non-medical staff member designated to assist students in the Health Center. If this should occur on a day while your child is in attendance at school, please formulate a plan in conjunction with the school nurse and mark appropriate actions from the options below.

_____ Parent will be notified if non-medical staff will be managing care of student.

_____ Non-medical staff will call a CCS registered nurse for assistance.

_____ Parent is available to assist with care of student by phone.

_____ Parent is able to assist with care of student by coming to school as needed during the day.

_____ The following additional staff have been trained to assist with care of student: _____

_____

_____

Additional plans for care of the student when a nurse is not available will be:

1.

2.

3.

Parent signature: _____ **Date**: _____

Nurse signature: _____ **Date**: _____

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EXTRACURRICULAR PLAN FOR STUDENT WITH DIABETES

Student name: _____

Grade: _____ Building: _____

In order to plan appropriate care for your child, before or after school hours, when a school nurse is not available, please choose one of the following options.

_____ I, as the parent/guardian of the above student, will be responsible for informing any adult that is responsible for my child at an extracurricular activity. I will inform the adult in writing and instruct them as needed in the care of my child during the extracurricular activity.

_____ I, as the parent/guardian of the above student, will be responsible for informing the school nurse, by complete the Extracurricular Activity Information Form, whenever my child is participating in a before or after school-related activity. When this option is checked, the school nurse will send a copy of the Extracurricular Activity Information Form to the adult listed as being in charge of the activity. Any additional instruction required will be the responsibility of the parent/guardian.

Parent signature: _____ **Date**: _____

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EXTRACURRICULAR PLAN FOR STUDENT WITH DIABETES

Student name: _____ School year: _____

Grade: _____ Building: _____

Extracurricular activity: _____

Adult in charge of activity: _____

Contact information for adult in charge of activity: _____

Days attending activity: _____

Times of activity: _____

Will the student require transportation on a school bus during this activity? YES _____ NO _____

Description of care needed	**Can child do independently?**
1. Blood glucose checks	YES _____ NO _____
2. Treatment of blood glucose	YES _____ NO _____

Symptoms to look for when blood glucose may be out of range: _____

_____

Emergency treatment steps:

1.

2.

3.

Parent/guardian #1 name: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Parent/guardian #2 name: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Parent signature: _____ **Date**: _____

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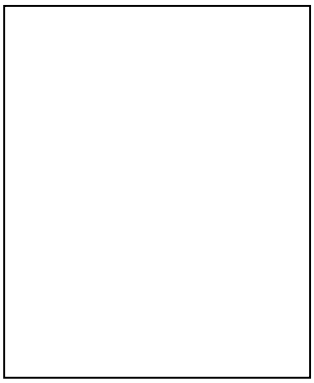
MEDICAL ALERT FOR BUS DRIVER

PLEASE KEEP CONFIDENTIAL



(Student Photo)

Student name: _____ School year: _____ Bus # _____

This student has Type 1 Diabetes.

- Type 1 diabetes is a chronic medical condition that affects how the body normally gets energy from food. Type 1 diabetes results when a person's pancreas stops making the insulin hormone. When insulin production ceases, the body cannot get the energy it needs from the foods that are eaten.

- Please watch for signs and symptoms of high or low blood sugar. (A behavior change could be a symptom of high or low blood sugar.)

    1. **High blood sugar: thirst, urination, fatigue, headache, nausea**
    2. **Low blood sugar: pale, weak, headache, dizzy, sweaty, whiney**

- If the student feels "low" while on the bus, please allow the student to drink juice or eat a snack. (Low blood sugar could occur in the morning or afternoon while on the bus.) Please DO NOT give food, candy, etc., otherwise.

- If the student has a seizure or becomes unconscious, call 911.

- Please contact the school nurse for further information and/or questions regarding this student.

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Dear Health Care Provider,

In order to provide optimal health care for _____, a diabetic student enrolled in Carmel Clay Schools, I have enclosed some information for your review.

Carmel Clay Schools is concerned about the health and safety of all our students, and to this end, provides a full-time registered nurse at each of our buildings. It is the recommendation of Carmel Clay Schools that all routine diabetic testing and insulin bolus/injections take place in the nursing clinic. However, the determination of the location and supervision for diabetic care is individually determined in the best interest of each child on a case by case basis. If any class time is missed for diabetic health care, provisions will be made to allow the student to make up the missed work without penalty.

Carmel Clay Schools does allow diabetic students to carry all diabetic supplies needed to test and treat for symptoms of an out of range blood glucose level at any time or place during the school day with written permission from their parents and their health care provider.

Please review and complete the following forms and return them to the school as soon as possible. Carmel Clay Schools encourages a cooperative effort and open communication between the student's parents, health care provider, and school personnel. Please feel free to contact the school nurse if you have any questions or concerns.

Sincerely,

_____ Date: _____

Carmel Clay School Nurse

Carmel High School · 520 E. Main Street, Carmel, IN 46032 · Phone: 846-7721 · Fax: 571-4066

Carmel Middle School · 300 S. Guilford Road, Carmel, IN 46032 · Phone: 846-7331 · Fax: 571-4067

Clay Middle School · 5150 E. 126th Street, Carmel, IN 46033 · Phone: 844-7251 · Fax: 571-4020

Creekside Middle School · 3525 W. 126th Street, Carmel, IN 46032 · Phone: 733-6420 · Fax: 733-6422

Carmel Elementary · 101 4th Ave. S.E., Carmel, IN 46032 · Phone: 844-0168 · Fax: 571-4024

Cherry Tree Elementary · 13989 Hazel Dell Pkwy., Carmel, IN 46033 · Phone: 846-3086 · Fax: 571-4053

College Wood Elementary · 12415 Shelborne Road, Carmel, IN 46032 · Phone: 733-6430 · Fax: 733-6445

Forest Dale Elementary · 10721 Lakeshore Drive W., Carmel, IN 46033 · Phone: 844-4948 · Fax: 571-4031

Mohawk Trails Elementary · 4242 E. 126th Street, Carmel, IN 46033 · Phone: 844-1158 · Fax: 571-4034

Orchard Park Elementary · 10404 Orchard Park S. Dr., Indianapolis, IN 46280 · Phone: 848-1918 · Fax: 571-4043

Prairie Trace Elementary · 14200 N. River Road, Carmel, IN 46033 · Phone: 571-7925 · Fax: 571-7926

Smoky Row Elementary · 900 W. 136th Street, Carmel, IN 46032 · Phone: 571-4084 · Fax: 571-4088

Town Meadow Elementary · 10850 Towne Road, Carmel, IN 46032 · Phone: 733-2645 · Fax: 733-2655

West Clay Elementary · 3495 W. 126th Street, Carmel, IN 46032 · Phone: 733-6500 · Fax: 733-6501

Woodbrook Elementary · 4311 E. 116th Street, Carmel, IN 46033 · Phone: 846-4225 · Fax: 571-4037

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DIABETES MEDICAL MANAGEMENT PLAN

To be completed by Health Care Provider

Student name: _____

1. Target blood glucose range: _____

2. Daily glucose testing is required at the following times: _____

3. Type of insulin used: _____

4. Insulin/carbohydrate ratio: _____

5. Formula for calculating insulin dosage at lunch: _____

6. Formula for calculating corrective insulin dosage: _____

Treatment of hypoglycemia:

Blood glucose is _____ to _____ → _____

Blood glucose is _____ to _____ → _____

Blood glucose is _____ to _____ → _____

Blood glucose is _____ to _____ → _____

Retest in _____ and retreat as above.

Other instructions: _____

In addition to the treatment plan for hypoglycemia, is a daily snack required?

Yes _____ No _____ at the following time: _____

Amount of snack required: _____

Glucose check before snack? Yes _____ No _____

Blood glucose over _____ then correct before snack

Health Care Provider signature: _____ **Date**: _____

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DIABETES MEDICAL MANAGEMENT PLAN

Student name: _____

Treatment of hyperglycemia:

Blood glucose is _____ to _____ → _____

Blood glucose is _____ to _____ → _____

Blood glucose is _____ to _____ → _____

Blood glucose is _____ to _____ → _____

Retest in _____ and retreat as above.

Other instructions: _____

Can supplemental insulin be given within 2 hours of last insulin administration? (circle) YES NO

Urine should be checked for ketones when blood glucose is above _____

Treatment for ketones: _____

Student should not exercise if:
- Blood glucose is above: _____
- Ketones are: (circle) trace small moderate large

Emergency treatment: glucagon shall be provided by a parent and kept in the Health Center.

Glucagon should be given if the student is unconscious, having a seizure, or unable to swallow. Give glucagon, call 911, and notify parents.

Order for glucagon is as follows (dose, route): _____

These medical orders have been approved by:

Health Care Provider signature: _____ **Date**: _____

Carmel Clay Schools acknowledges that the above medical orders may change throughout the school year. When changes are required, written communication must occur between the health care provider and the school nurse. Please provide the necessary information below in case of questions about the diabetic management plan.

Printed physician name: _____

Phone number: _____ Fax: _____

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PHYSICIAN CERTIFICATION TO AUTHORIZE STUDENT SELF-ADMINISTRATION OF DIABETES TREATMENT AT SCHOOL

Student name: _____

Diabetic management supplies should be kept in the Health Center and/or in the classroom. It is the parents' responsibility to make sure that these supplies are adequate in quantity and not expired. This includes:

Blood glucose meter
Control solution
Extra batteries for meter
Extra batteries for pump
Glucagon emergency kit
Glucose gel/cake icing gel
Insulin vial or pen
Ketone strips (blood or urine)
Lancet device
Lancets
Low blood sugar treatments
Medical ID (i.e. bracelet, necklace)
Pump infusion set replacement
Snacks
Syringes
Test strips
Water bottle

Carmel Clay Schools will allow the students to carry and self-administer emergency treatment and/or medication if you provide the following certification.

I certify that:

1. The above student has diabetes for which I have prescribed medication/treatment.

2. I have instructed the student on how to self-administer this medication/treatment.

Health Care Provider signature: _____ **Date**: _____

* NOTE – It is the recommendation of Carmel Clay Schools that the student inform a school employee, especially the school nurse, whenever self-administration of the above medication/treatment has occurred.