Community Education & Recreation Department
A Division of Mankato Area Public Schools

INDIVIDUAL HEALTH CARE/EMERGENCY PLAN FOR CHILD WITH DIABETES

HEALTH CARE PROVIDER AND PARENT PLEASE COMPLETE THIS FORM AND RETURN TO YOUR CHILD'S CER PROGRAM

TO BE RENEWED EACH PROGRAM SESSION

(If you need assistance completing this form, contact the Program Coordinator)

Child's Name: _____ Birth Date: _____

Program Site: _____ Grade: _____ Session: _____

Type of Diabetes: ___Type 1 ___Type 2 ___Other Date of Diagnosis: _____

Diabetes Medication: ___Oral Medication ___Insulin Vial and Syringe ___Insulin Pen ___Insulin Pump ___None

Insulin at During Program Hours (list types): _____

I. BLOOD GLUCOSE MONITORING

Target range: _____ - _____ mg / dl

Parent to be notified for blood glucose less than _____ greater than _____.

(Check all that apply)

___Before breakfast Time:
___Before a.m. snack Time:
___Before lunch Time:
___Before p.m. snack Time:
___Before outdoor play
___Before gym play
___Other BG testing Time:
___Continuous glucose monitoring

(Check all that apply)

____Trained personnel must perform
____Trained personnel must supervise
____Child can perform independently
____Child can recognize & treat hypoglycemia
____Child can recognize & treat hyperglycemia

**Note: It is the parent's responsibility to train CER program staff*

II. FOR CHILD WITH INSULIN PUMP

Type of pump: _____ Type of insulin in pump: _____

- Child needs assistance checking insulin dosage ____ yes ____ no
- Child can self-manage insulin pump ____ yes ____ no
- **CER personnel will not be responsible for changing pump settings, filling insulin cartridges or changing infusion sites and tubing. The parent/guardian will be contacted to make any changes.**
- Parent/guardian may direct staff to suspend or disconnect pump.
- Correction scale (use with fast-acting insulin before meals/snacks/other): ___yes ___no

III. FOR CHILD WITH INSULIN PEN / SYRINGE OR IF INSULIN PUMP MALFUNCTIONS

Type of insulin given at during CER program hours: _____

Time(s): ____Before lunch ____After lunch ____ Other: _____

Dose determined by: ***(Check all that apply)***

____Standard lunchtime dose: _____.
____Insulin / carbohydrate ratio: _____ unit(s) per _____ gms
____Correction calculation to be used for pen / syringe

_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl
_____ units if ketones are moderate or large

- Child can determine correct amount of insulin ____ yes ____ no
- Child can draw correct amount of insulin ____ yes ____ no
- Child can inject own insulin ____ yes ____ no

IV. EMERGENCY CARE PLAN

1. **LOW BLOOD GLUCOSE:** Child must be treated when blood sugar is below _____.

   Symptoms: Please circle all that apply:

   Hunger, confusion, shakiness, sweating, paleness, headache, crying, sleepiness or other behavioral changes. List additional symptoms:_____

   Treatment: With any level of low blood glucose ***never*** leave child unattended.
   - Test blood glucose. If blood glucose monitor is not available, treat child immediately per symptoms.
   - If blood glucose is below _____, give 15 gms of a fast-acting carbohydrate such as sugared juice, 3 to 4 glucose tablets, or other 15 gm carb: _____
   - Wait 15 minutes. Recheck blood glucose. Continue until BG is _____ or more.
   - If child is conscious but unable to drink fluids, give one tube (15 gms) glucose gel (if provided by parents/guardian). Place between cheek and gum with head elevated.
   - Follow with snack or lunch when blood glucose rises above _____ or when symptoms improve.
   - Call parent/guardian if gel used or symptoms continue.

2. **SEVERE LOW BLOOD GLUCOSE:** Indicated when blood sugar is below _____.

   Symptoms: Unresponsive or unconscious or having seizure activity

   Emergency treatment:
   - **Call 911 and parent * Stay with student * Roll student on side and protect from injury.**
   - **If conscious, attempt to administer 1 tube (15 gms) of glucose gel (*if provided*) in child's cheek pouch closest to ground and massage cheek.**
   - **If child is unconscious or unresponsive, do not put anything to eat or drink in child's mouth.**

3. **HIGH BLOOD GLUCOSE**: Child must be treated when blood sugar is above _____.

   Symptoms: Please circle all that apply:

   Extreme thirst, headache, abdominal pain, nausea, vomiting, frequent urination

   Treatment:
   - Offer drinks that do not contain carbohydrates (i.e. water, sugar-free soda, Crystal Light). Encourage child to carry water bottle.
   - Do not allow exercise if blood glucose above _____.
   - Recheck blood glucose in one hour and report results to parent/guardian.
   - Parent will provide ketone testing equipment _____ yes _____ no
   - Test ketones for blood glucose greater than _____. Report ketones above _____ to parent/guardian.
   - Contact parent/guardian regarding persistent high blood glucose.
   - If symptoms persist and child's consciousness is impaired, call 911.

Emergency Contacts *(List in order of who to call first)*

Name: _____ Relationship: _____ Daytime Phone: _____ Cell: _____

Name: _____ Relationship: _____ Daytime Phone: _____ Cell: _____

Name: _____ Relationship: _____ Daytime Phone: _____ Cell: _____

Child's Name_____

V. SNACKS DURING CER PROGRAM

____ Insulin bolus to be given at time carb snack is consumed if it has been at least three hours after last dose of insulin.

____ Insulin bolus to cover afternoon snack can be predetermined and given with lunch bolus if snack consumed within 1½ hours of insulin administration.

____ Child is to use a "free carb" or predetermined snack as provided by parent.

____ Carb choice determined by blood glucose with pump determining need for insulin bolus.

____ Will not eat snacks provided at by CER Program.

VI. CHILD TRANSPORTATION CONSIDERATIONS FOR FIELD TRIPS

If a low blood glucose episode occurs 30 minutes or less prior to departure, the designated staff will:

____ Call parent to inform of low blood glucose episode (regardless if blood glucose returns to normal).

____ Allow child to ride the bus if blood glucose returns to normal.

____ Call parent to pick up child **(child will not be sent on the bus with a low blood glucose).**

____ Other _____

If child is totally independent in diabetes management, it is the child's responsibility to alert staff of high or low blood glucose occurring 30 minutes or less before any field trips.

VI. PHYSICIAN/LICENSED PRESCRIBER AUTHORIZATION

- **Glucagon will be not be given during CER program as a trained nurse is not available.**
- My signature below provides authorization of the above procedures for the current CER program session.
- If changes are indicated, I will provide new written authorization.
- Child is ready to perform and self-manage diabetes care and procedures as outlined in this "Individual Health Care/Emergency Plan for Child with Diabetes". _____Yes _____No
  (Parent/guardian and Program Coordinator must verify competency as well)
- Parent may adjust insulin doses as directed. _____Yes _____No

PHYSICIAN/LICENSED PRESCRIBER SIGNATURE: _____ DATE:_____

PRINT NAME:_____ PHONE #:_____

CLINIC:_____ FAX #: _____

(See reverse side for Parent Authorization)

Child's Name_____

Parent / Guardian- Please sign either VII or VIII

VII. PARENT / GUARDIAN AUTHORIZATION

1. I will be responsible for maintaining necessary supplies, including glucose meter kit (including all blood testing supplies), Ketostix, glucose tablets, glucose gel, pre-packaged snacks, etc.
2. I will provide the insulin in the original, unopened, and labeled vial or pen with my child's name.
3. I give permission for the CER Program Coordinator/designee to give insulin during CER program hours, including field trips as ordered by my child's health care provider.
4. I give permission for the CER Program Coordinator/designee to consult with my child's health care provider regarding diabetes and my child's Individual Health/Emergency Plan.
5. I give permission for the CER Program Coordinator/designee to communicate with the appropriate CER program staff about my child's Individual Health/Emergency Plan.
6. I will provide an updated Consent for Diabetes Medical Management form from the health care provider if there are any changes.
7. I release the CER Program Coordinator/designee from any liability in relation to the management of diabetes at school.

Parent/Guardian Signature: _____Date: _____

~ OR ~

VIII. PARENT / GUARDIAN AUTHORIZATION FOR CHILD SELF-MANAGEMENT

If the health care provider indicates that student can self-manage diabetes, the Program Coordinator will meet with him/her & parent/guardian to assess child's knowledge and skill(s) to safely manage diabetes during CER program hours.

1. I request that my child self-manage his/her diabetes and be responsible for all necessary supplies, blood glucose testing, carbohydrate calculations / meal and snack planning, insulin dosage and administration as ordered by the health care provider.
2. I give permission for the CER program coordinator/designee to consult with my child's health care provider regarding diabetes and my child's Individual Health/Emergency Plan.
3. I give permission for the CER program coordinator/designee to communicate with the appropriate CER program staff about my child's Individual Health/Emergency Plan.
4. I will provide an updated Consent for Diabetes Medical Management form from the health care provider if there are any changes.
5. I will contact the CER program coordinator if any of the above information changes.

Parent/Guardian Signature: _____Date: _____