KISD HEALTH SERVICES

Diabetes Individualized Health Care Plan

Parent/Guardian:

Please complete and return the attached forms for your child as soon as possible. As well as your child's Physicians Diabetic Management Plan. This information will be shared with those whom come in contact with your child during the school year.

Please check the front and back of each form carefully. Please complete each section and sign where indicated. Please verify whether you would like to discuss your child's IHP.

If you have any questions or concerns please contact your Campus Nurse.

Thank You for your cooperation in this matter.

KISD Nursing Staff

KAUFMAN ISD Diabetes Medical Management Plan

Effective Dates:____

This plan should be completed by the student's personal health care team and parents/guardian. It should be reviewed with relevant school staff and copies should be kept in a place that is easily accessed by the school nurse, trained diabetes personnel, and other authorized personnel.

Student's Name:____________________ Date of Birth:_____________ Date of Diabetes Diagnosis:_________________ Grade: _______________Homeroom Teacher:_____________
Physical Condition: Diabetes Type 1____________________ Diabetes Type 2_____________

Contact Information
Mother/Guardian:____
Address:____

Telephone: Home_______________ Work______________________ Cell____________________
Father/Guardian:____
Address:____
Telephone: Home ___________________________Work__________________ Cell_____________

Student's Doctor/Health Care Provider Name:_____________________________________
Address: ____
Telephone:____

Other Emergency Contacts Name:____
Relationship:____
Telephone:______________________________ Home
____________________Work____ Cell

Notify parents/guardian or emergency contact in the following situations:____
____
____
____
___

MY CHILD RIDES A BUS: YES [ ] #_______ NO [ ]

Hypoglycemia (Low Blood Sugar) Usual symptoms of hypoglycemia:

Treatment of hypoglycemia:____

Glucagon should be given if the student is unconscious, having a seizure(convulsion), or unable to swallow. Route , Dosage , site for glucagon injection:____
arm, thigh, other. If glucagon is required, administer it promptly. Then, call 911(or other emergency assistance) and the parents/guardian.

Hyperglycemia (High Blood Sugar) Usual symptoms of hyperglycemia:

Treatment of hyperglycemia:

Urine should be checked for ketones when blood glucose levels are above__________ _ mg/d.
Treatment for ketones: ____

Supplies to be kept at School

Blood glucose meter, blood glucose test strips, batteries for meter Insulin pump and supplies Lancet device, lancets, gloves, etc. Insulin pen, pen needles, insulin cartridges Urine ketone strips Fast-acting source of glucose Insulin vitals and syringes Carbohydrate containing snack Glucagon emergency kit

Signatures____

This Diabetes Medical Management Plan has been approved by:

Student's Physician/Health Care Provider Date

I give permission to the school nurse, trained diabetes personnel, and other designated staff members of____
________________________________School to perform and carry out the diabetes care tasks as outlined by_______________________________________Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical 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.

Acknowledged and received by:

Parent/Guardian Date____

KISD Campus Nurse Date____

Kaufman Independent School District

Diabetic Individualized Health Care Plan

Children with Diabetes need a strong network for the many hours they spend in school and school related activities. Your campus Nurse will work with you, your child and their physician in providing and coordinating diabetes care at school.

In addition to the school Nurse, under HB 984, each school also must train other employees to serve as (UDCA) Unlicensed Diabetic Care Assistant who can provide diabetes management and care services if a nurse is not available when a student needs such services. Each school in which a student with diabetes is enrolled has a trained staff member to provide such services.

Please check the appropriate boxes below to indicate your election whether to allow:

An (UDCAJ Unlicensed Diabetic Care Assistant to provide Services to your child:

[ ] YES Agreement for Services: I authorize an Unlicensed Diabetic Care Assistant to provide diabetes

management and care services to my child at school. I understand that 'an Unlicensed Diabetic Care Assistant is immune from liability for civil damages under section 22.0511of the Texas Education Code. [ ] NO I DO NOT authorize an Unlicensed Diabetic Care Assistant to provide diabetes management and care

services to my child at school. I understand that in the event the school Nurse is not available, I the Parent/Guardian will be responsible for administration of the diabetic care for my child.

Self-care: If YES, paperwork MUST be completed and returned to the school Nurse as soon as possible:

[ ] YES My child CAN manage his/her diabetes independently and will NOT seek assistance for his/her

diabetes care while at school. I understand the school Nurse will provide emergency care as needed. This information will be shared with school district personnel as needed.

Acknowledged and received by:____

Student's Parent/Guardian Date____

KISD Campus Nurse Date____