INDIVIDUAL HEALTH CARE/EMERGENCY PLAN FOR STUDENT WITH DIABETES

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

TO BE RENEWED EACH SCHOOL YEAR

(If you need assistance completing this form, contact the Licensed School Nurse)

Student Name: _____ Birth Date: _____

School: _____ Grade: _____ Teacher: _____ School Year: _____

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 School (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 recess Time:
___Before lunch Time:
___Before phy ed Time: Day:_____
___After phy ed Time: Day:_____
___Before dismissal Time:
___Other BG testing Time:
___Continuous glucose monitoring

(Check all that apply)

____Trained personnel must perform
____Trained personnel must supervise
____Student can perform independently
____Student can recognize & treat hypoglycemia
____Student can recognize & treat hyperglycemia
____Student has permission to carry device in school for the purpose of checking continuous glucose monitor

II. FOR STUDENT WITH INSULIN PUMP

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

- Student needs assistance checking insulin dosage ____ yes ____ no
- Student can self-manage insulin pump ____ yes ____ no
- **School 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 STUDENT WITH INSULIN PEN / SYRINGE OR IF INSULIN PUMP MALFUNCTIONS

Type of insulin given at school: _____

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

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

Student Name_____

IV. EMERGENCY CARE PLAN

1. **LOW BLOOD GLUCOSE:** Student 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 student unattended. If treated outside the classroom, **a responsible person should accompany the student to the Health Service Office** for further assistance.

   - Test blood glucose. If blood glucose monitor is not available, treat student 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 student is conscious but unable to drink fluids, give one tube (15 gms) glucose gel. Place between cheek and gum with head elevated.
   - Follow with snack or lunch when blood glucose rises above _____ or when symptoms improve.
   - Call Licensed School Nurse/designee and 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 (notify the office) * Stay with student * Roll student on side and protect from injury.**
   - **If conscious, attempt to administer 1 tube (15 gms) of glucose gel in student's cheek pouch closest to ground and massage cheek.**
   - **If student is unconscious or unresponsive, do not put anything to eat or drink in student's mouth.**
   - **Administer Glucagon if consent form is received from physician/licensed prescriber, signed by parent/guardian and Licensed School Nurse, and a nurse is available to administer.**

3. **HIGH BLOOD GLUCOSE**: Student 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 student to carry water bottle.
   - Do not allow exercise if blood glucose above _____.
   - Recheck blood glucose in one hour and report results to the Licensed School Nurse/designee.
   - Parent will provide ketone testing equipment _____ yes _____ no
   - Test ketones for blood glucose greater than _____. Report ketones above _____ to parent/guardian.
   - Contact Licensed School Nurse and parent/guardian regarding persistent high blood glucose.
   - If symptoms persist and student'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: _____

Student Name_____

V. SNACKS AT SCHOOL

____ 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.
____ Student 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 school.

VI. STUDENT TRANSPORTATION CONSIDERATIONS

STUDENTS WHO RIDE THE BUS:

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 home if blood glucose returns to normal.
____ Call parent to pick up child **(student will not be sent on the bus with a low blood glucose).**
____ Other _____

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

STUDENTS WHO DRIVE TO SCHOOL (HIGH SCHOOL ONLY):

If a low blood glucose episode occurs 30 minutes or less prior to departure, the **student** will:
____ Treat mild hypoglycemia, wait 15 minutes and retest. If blood glucose returns to normal, student will drive home.
____ Call parent to inform of low blood glucose episode.
____ Call parent to pick up child if blood glucose does not return to normal. **(students with low blood glucose or high blood glucose with a large amount of ketones will not be allowed to drive home)**
____ Other _____

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

VII. PHYSICIAN/LICENSED PRESCRIBER AUTHORIZATION

- **Glucagon will be given if ordered by physician/licensed prescriber, provided by parent, and trained nurse is available.**
  Glucagon is recommended at school ____Yes ____ No
  Glucagon: Dosage _____ Route_____
- My signature below provides authorization of the above procedures for the current school year.
- If changes are indicated, I will provide new written authorization.
- Student is ready to perform and self-manage diabetes care and procedures as outlined in this "Individual Health Care/Emergency Plan for Students with Diabetes". _____Yes _____No (Parent/guardian and Licensed School Nurse 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)

Student Name_____

Parent / Guardian- Please sign either VIII or IX

VIII. 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, Glucagon (if ordered by physician/licensed prescriber and provided by parent/guardian), 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 Licensed School Nurse/designee to give insulin during school hours, including field trips (no after school activities) as ordered by my child's health care provider.
4. I give permission for the Licensed School Nurse/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 Licensed School Nurse/designee to communicate with the appropriate school staff about my child's Individual Health/Emergency Plan.
6. I will provide an Updated Consent for Diabetes Medical Management During School Hours form from the health care provider if there are any changes.
7. I release the Licensed School Nurse/designee from any liability in relation to the management of diabetes at school.
8. **I understand that if my child rides the school bus and/or participates in before or after school activities it is my responsibility to inform the staff/bus company of my child's diabetes and plan.**

Parent/Guardian Signature: _____Date: _____

Licensed School Nurse Signature: _____ Date: _____

~ OR ~

IX. PARENT / GUARDIAN AUTHORIZATION FOR STUDENT SELF-MANAGEMENT

If the health care provider indicates that student can self-manage diabetes, the Licensed School Nurse will meet with him/her to assess students' knowledge and skill(s) to safely manage diabetes during school 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 Licensed School Nurse/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 Licensed School Nurse/designee to communicate with the appropriate school staff about my child's Individual Health/Emergency Plan.
4. I will provide an Updated Consent for Diabetes Medical Management During School Hours form from the health care provider if there are any changes.
5. I will contact the Licensed School Nurse if any of the above information changes.
6. **I understand that if my child rides the school bus and/or participates in before or after school activities, it is my responsibility to inform the staff/bus company of my child's diabetes and plan.**

Parent/Guardian Signature: _____Date: _____

Licensed School Nurse Signature: _____ Date: _____