Edina Public Schools Diabetes Management Plan for School

Please have physician complete this two page form.

Student's Name:_____Date of Birth:_____ (Student Photo)

School:_____ School Year: _____

Type of Diabetes: ❑ Type 1 ❑ Type 2 ❑ Other Date of Diagnosis:_____

Blood Glucose Monitoring

❑Meter type: _____ **Blood glucose target range: ____- ___mg/dl**

❑ Blood glucose monitoring prior to meals and snacks

❑ For suspected hypoglycemia ❑ At student's discretion excluding suspected hypoglycemia

❑ No blood glucose testing at school ❑ Supervision of testing/ results

❑ Permission to test independently ❑ Other _____

❑ Needs assistance with testing and blood glucose management

❑ Before or after physical education

❑ Restrict from participation in physical activity when blood glucose level is:_____mg/dl

Diabetes Medication

❑ No insulin at school. Current insulin at home: _____

❑ Oral diabetes medication at school: _____

Insulin at school: ❑Humalog ❑ Novolog ❑ Apidra ❑ Lantus ❑ Other: _____

Insulin delivery device: ❑ Syringe and vial ❑ Insulin pen ❑ Insulin pump

Insulin dose for school: _____

❑ Standard lunch time dose.

❑ Meal bolus: _____units of insulin per _____grams of carbohydrate.

❑ Correction for blood glucose: _____units of insulin for every_____mg/dl above_____mg/dl.

❑ Correction bolus can be given with meals or every 3 hours if blood glucose levels are high.

Correction Scale

Blood Glucose Value (mg/dl)	Units of Insulin
Less than 100	
100 - 150	
151 – 200	
201 – 250	
251 – 300	
301 – 350	
352 – 400	
More than 400	

Note: Insulin dose is a total of meal bolus and correction bolus.

❑ Parent / Guardian may adjust insulin doses within the following range: _____

Meal Plan

Carbohydrate choice = _____ Grams of carbohydrate

❑ Meal plan variable

❑ Meal plan prescribed (see below)

Snack Time: _____ # of carb choices = _____

Lunch Time: _____ # of carb choices = _____

❑ Extra food allowed: ❑ Parent / guardian's discretion ❑ Student's discretion

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Response to Diabetic Emergencies at School

Hypoglycemia: Blood Glucose less than _____mg/d**l**

- ❑ Self-treatment of mild lows ❑ Assistance for all lows
- ❑ Immediately treat with 15 gm of fast-acting carbohydrate (e.g.: 4 oz. juice, 3-4 glucose tabs, 6 oz regular soda, 3 tsp glucose gel)
- ❑ Recheck blood glucose in 15 minutes and repeat 15 gm of carbohydrate if blood glucose remains low.
- ❑ If more than 1 hour until next meal or snack student should have another 15 gm of carbohydrate.
- ❑ If child will be participating in additional exercise or activity before the next meal, provide another 15 gm of carbohydrate.
- ❑ If student is using an insulin pump, suspend pump until blood glucose is back in goal range.

Severe Hypoglycemia:

If the child is unconscious or having seizures due to low blood glucose immediately administer injection of:

Glucagon _____mg (glucagon emergency kit)

Hyperglycemia: Blood Glucose> _____mg/dl

- ❑ Check ketones when blood glucose ➤ _____ mg/dl or student is sick.
- ❑ Unlimited bathroom pass.
- ❑ Notify parent immediately of blood glucose ➤ _____ mg/dl or if student is vomiting
- ❑ Other_____

Field Trips

- ❑ Arrange for appropriate monitoring and access to medications, supplies, and fast acting carbohydrates on all field trips.

Physician/Licensed Prescriber Signature (required): _____Date: _____

Print Physician/Clinic Name: _____Phone: _____Fax: _____

All authorizations <u>expire</u> at the end of the school year or following the summer school session.

<u>Parent/Guardian Authorization</u>

1. I request that the above medication/s be given during school hours as ordered by my child's physician/licensed prescriber.
2. I will notify the school if medication is stopped.
3. I give permission for the medication/s to be given by school personnel as delegated, trained, and supervised by the school nurse.
4. Legally I may refuse to sign the Diabetes Medical Management form. If I refuse to sign, the district will not be able to administer the medication.
5. This consent me be removed at any time by sending a written notice to the licensed school nurse.

_____ _____

Parent/Guardian Signature Date

<u>Permission for Release of Information</u>

1. I give permission for the licensed school nurse to communicate, as needed, with school staff about my child's medical condition/s and the action of the medication/s.
2. I give permission for the licensed school nurse to contact my child's physician/licensed prescriber solely for the purpose of clarification or questions about the above listed medication/s or medical condition/s being treated by medication/s.

_____ _____

Parent/Guardian Signature Date

Licensed School Nurse: _____Date:_____

Health Associate:_____Date:_____

Adapted with Permission from National Association of School Nurses H.A.N.D.S.,[SM] 2008