See the following pages for forms used by the District for individualized health plans for students:

Exhibit A: Guidelines for Student Self-Management of Diabetes at School — 2 pages

Exhibit B: Diabetes Management and Treatment Plan — 4 pages

Exhibit C: Principal Designee for Unlicensed Diabetic Care Assistant — 1 page

Exhibit D: Physician's Authorization for Student Self-Management of Diabetes — 1 page

Exhibit E: Transportation Plan with Emergency Preparedness for Student with Diabetes — 1 page

Exhibit F: District Use and Electronic Access to Student Diabetes Data at Parent's Request – 1 page

EXHIBIT A

SPRING BRANCH INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES

GUIDELINES FOR STUDENT SELF-MANAGEMENT OF DIABETES AT SCHOOL

The District is fully committed to supporting its diabetic students who desire to carry their supplies and self-manage their diabetes while at school or school events. It is important that parents communicate with the school nurse, teachers, and staff throughout the school year regarding the student's diabetes care. The school nurse is available to assist both the diabetic student and parent/guardian as needed.

The safety of all District students is a primary concern of District staff. For the safety of the diabetic student as well as others, the following guidelines have been developed.

Please read and review with your student the guidelines listed below. Your signatures on this form indicate that you have read and will follow this important course of action. Return this form to your school nurse.

- Both parents and physician's signatures are required on the Diabetic Management and Treatment Plan (DMTP), and must be on file in the school nurse's office before the student will be permitted to carry diabetic supplies at school. The DMTP must be renewed at the beginning of every school year.
- Changes, revisions, or updates to the DMTP may be done when medically necessary with the written, signed request from the parents and physician. Periodic re-view of the plan will be done by the school nurse, student, and parents to ensure compliance.
- The parent/student must supply all diabetic equipment. The school does not stock reserve supplies. Parents will provide the school nurse with a secondary supply of emergency equipment (e.g., glucometer, lancets, and Glucagon) in the event the student becomes ill and personal equipment is not available.
- Students will not share their equipment with other students. Stolen or missing supplies should be immediately reported to the school nurse. Spring Branch ISD is not liable for lost, stolen, or damaged supplies.
- Students are required to carry and properly use a personal sharps disposal container, and should care for puncture sites and blood in such a way that others are not inadvertently exposed to the blood products.
- Diabetic supplies will be properly stored and kept in the student's direct possession at all times so that other students cannot easily access them. Except when equipment is in the possession of a staff member, supplies will not be kept in personal lockers or desks. Equipment will be stored in a safe manner so other students and staff are not exposed to sharps or blood and supplies are not damaged or lost.
- Snacks will not be shared with peers at any time and should only be an appropriate form of carbohydrate as identified in the DMTP.

- Students are expected to test and treat symptoms in class in the least disruptive manner possible. A nearby staff member should be notified immediately if a student becomes ill or feels he or she may need assistance. Please do not hesitate to ask for assistance.

These guidelines apply to all school-related activities. Due to the potential risk of harm to self or others that could arise from mismanagement, infractions of these guidelines may be referred for disciplinary action.

Parent Signature Date

Student Signature Date

EXHIBIT B

SPRING BRANCH INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES
DIABETES MANAGEMENT AND TREATMENT PLAN

Annual Health Service Prescription—Physician/Parent Authorization for Diabetic Care

*This form is to be renewed annually: DATE OF PLAN _____

A school nurse or a nonhealth-care professional designee of the principal may administer prescribed in-school medication or procedures.

Student _____ Birth Date _____

TO BE COMPLETED BY PHYSICIAN:

Please respond to the following based on your records and knowledge of the student:

1. **PROCEDURES:** (Parent to provide supplies for procedures):
   Test blood glucose before lunch and as needed for signs/symptoms of hypoglycemia.
   Test urine ketones when blood glucose is hyperglycemic, and/or child is ill.

2. **MEDICATION:** (Child may _____ may not _____ prepare/administer insulin injection).
   Rapid Acting Insulin (Regular/Humolog/Novalog) given subcutaneously prior to lunch time (<u>within 30 minutes prior to lunch</u>)

   Based on the following guidelines:

   a. Fixed dose:_____ units plus insulin correction scale; *OR*

   b. Insulin to Carbohydrate Ratio: 1 unit insulin per _____ grams carbohydrate plus insulin correction scale

   <u>Insulin Correction Scale</u>

   Blood glucose below _____ = no additional insulin

   Blood glucose from _____ to _____ = _____ unit(s) of insulin subcutaneously

   Blood glucose from _____ to _____ = _____ unit(s) of insulin subcutaneously

   Blood glucose from _____ to _____ = _____ unit(s) of insulin subcutaneously

   Blood glucose over _____= _____ unit(s) of insulin subcutaneously

   Notify parent if blood glucose is over _____

   c. Oral diabetes medication: _____ Dose _____ Time _____

   d. Student is to eat lunch following pre-lunch blood test and required medication.

   e. Parent/family have been instructed in diabetes self-management. Parents may _____ may not _____ adjust pre-lunch insulin dosage by up to ten percent every four to five days as indicated by glucose trends. **Parents will communicate changes to school personnel.**

3. **PRECAUTIONS:**

Refer to the physician's orders for Guidelines for Responding to Blood Glucose Test Results on the following page.

a. **Hypoglycemia:** Signs of hypoglycemia include trembling, sweating, shaking, pale, weak, dizzy, sleepy, lethargic, confusion, coma, or seizure.

b. **Hyperglycemia:** Signs include frequency of urination, excessive thirst, and positive urinary ketones.

4. **MEAL PLAN:**

a. The *Constant Carbohydrate Diet* emphasizes consistency in the number of grams of carbohydrates eaten from day to day at each meal or snack. Proteins and fats are "free foods" in that they have minimal effect of the blood glucose level. The child and parent can choose the carbohydrate product that they wish to use for meals or snacks. **Parents will communicate meal plan changes to school personnel.**

Breakfast _____ grams at _____ (time)

Mid AM Snack _____ grams at _____ (time)

Lunch _____ grams at _____ (time)

Mid PM Snack _____ grams at _____ (time)

b. The *Insulin to Carbohydrate Ratio Meal Plan* allows a variable amount of carbohydrate to be eaten at any meal or snack, but requires appropriate insulin to balance the carbohydrate. The ratio is listed above at #2–b.

Does this student have an insulin pump? Yes ☐ No ☐ If yes, please attach student's pump guidelines.

FOR DIABETIC SELF-CARE ONLY

Does this student have physician permission to provide self-care? Yes ☐ No ☐

This student has been provided instruction/supervision in recognizing signs/symptoms of hypoglycemia and is capable of doing self-glucose monitoring and his/her own insulin pump care, including using universal precautions and proper disposal of sharps?

Yes ☐ No ☐

☐ This student requires the supervision of a designated adult.

☐ This student requires the assistance of a designated adult.

Physician portion continued on following page

GUIDELINES FOR RESPONDING TO BLOOD GLUCOSE TEST RESULTS

1. If glucose is BELOW_____
   a. Give child 15 grams of carbohydrate, i.e.,
      6 lifesavers 6 ounces regular soda
      4 ounces of juice 3–4 glucose tabs
   b. Allow child to rest for 10–15 minutes, and retest glucose
   c. If glucose is above _____, allow student to proceed with scheduled meal, class or snack.
   d. If symptoms persist (or blood glucose remains below _____) repeat A and B.
   e. If symptoms still persist, notify parent and keep the child in the clinic.
2. If blood glucose is BELOW _____ and the child is unconscious or seizing
   a. Call Emergency Medical Services (911)
   b. Rub a small amount of glucose gel (or cake frosting) on child's gums and oral mucosa
   c. If available, inject Glucagon _____ mg. Subcutaneously
   d. Notify parent.

3. If blood glucose if FROM _____ to _____: Follow usual meal plan and activities (unless otherwise directed by insulin correction scale for insulin administration)

4. If blood glucose is OVER _____:
   a. If within 30 minutes prior to lunch, nurse or unlicensed diabetes care assistant to be called if student is unable to administer correction dose of insulin per student's sliding scale orders.
   b. Student checks urine ketones.

      <u>If ketones are negative or small</u>: encourage water until ketones are negative.

      <u>If ketones are negative or small</u>:
      - Student should remain in clinic for monitoring.
      - Notify parent for pick-up.
      - Give 1–2 glasses of water every hour.
      - If student remains at school, retest glucose and ketones every 2–3 hours or until ketones are negative.

   c. Student not to participate in physical education or other forms of exercise if blood sugar is above 250 and ketones are present.

d. If student develops nausea/vomiting, rapid breathing, and/or fruity odor to the breath, call 911, the nurse, and the parents.

Physician signature _____ Date _____

Clinic/facility _____ Phone _____ Fax _____

Diabetes Nurse Educator: Name _____ Phone _____

Clinical Dietician: Name _____ Phone _____

TO BE COMPLETED BY THE PARENT:

We (I) the undersigned, the parents/guardians of _____ request that the above Diabetes Management and Treatment Plan be implemented for our (my) child. Delivery of this form to the school nurse constitutes my participation in developing this plan, and is my consent to implement this plan. I will notify the school immediately if the health status of my child changes, if I change physicians or emergency contact information, or if the procedure is canceled or changes in any way. Information concerning my child's diabetes health management may be shared with/obtained from the diabetes health care providers.

Signature _____ Relationship _____

Date _____ Phone _____ (Home) _____ (Work)

EXHIBIT C

SPRING BRANCH INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES
PRINCIPAL DESIGNEE FOR UNLICENSED DIABETIC CARE ASSISTANT

School Name: _____ School Year: _____

In accordance with Health and Safety Code 168, I have designated the following people to monitor diabetic care in the school setting. This designation is in coordination with Spring Branch ISD diabetes care guidelines, which recommends at least one principal designee per campus. All District health services nurses and health services assistants are also authorized to monitor diabetes care as outlined in Health and Safety Code 168.

All principal designees must successfully complete training that includes but is not limited to:

- An understanding of the definition of diabetes, its components and consequences.
- Recognizing the symptoms of hypoglycemia and hyperglycemia.
- Understanding the details of a student's Diabetes Management and Treatment Plan (DMTP).
- Understanding the proper action to take if the blood glucose levels of a student with diabetes are outside the target ranges indicated by the DMTP.
- Demonstration of proper finger or arm-stick to check blood glucose levels, checking urine ketone levels, and recording of these tests.
- Demonstration of proper calculation and administration of insulin and glucagon if needed, and the recording of this administration.
- Recognizing complications that require seeking emergency assistance.
- Understanding the recommended schedules and food intake for meals and snacks for the diabetic student, the effect of physical activity on blood glucose levels, and the proper actions to take if a student's schedule is disrupted.

The following person(s) have been identified on campus as diabetes care assistant(s):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

_____ _____
Principal's Signature Date

EXHIBIT D

SPRING BRANCH INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES
PHYSICIAN'S AUTHORIZATION FOR STUDENT SELF-MANAGEMENT OF DIABETES

Appropriate candidates for diabetes self-management should be responsible individuals who are able to:

- Treat low blood sugars quickly and appropriately
- Record blood glucoses, urine ketones, and insulin doses
- Report blood glucose variations to school staff

_____ and family have been instructed in the proper
(Name of Student)

self-management of diabetes including:

- Blood glucose testing
- Insulin administration, storage, and care
- Emergency treatment, including the use of fast acting carbohydrates and Glucagon
- Proper disposal of sharps and blood-soiled items

I have completed and attached a Diabetes Management and Treatment Plan (DMTP), which includes physician directives for:

- Blood glucose testing
- Urine ketone testing
- Appropriate response to abnormal blood sugar levels
- Identification of and appropriate response to emergency conditions
- Diabetic medications including insulin (if applicable at school) and Glucagon

☐ In my professional opinion, this student should be allowed to carry diabetes supplies, including lancets and syringes, on his or her person, as well as to self-administer and manage diabetes testing and treatment while at school or school-related events. The student is capable of appropriate disposal of sharps (needles and lancets) in accordance with the safety standards established by the District.

☐ In my professional opinion, this student should not be allowed to carry diabetic-related equipment on his or her person while at school or school-related events.

Physician signature:_____ Date:_____

Printed physician's name:_____

Physician's phone number:_____

I agree with the physician's recommendations as noted above and have informed my child.

Parent's signature_____ Date:_____

Printed parent's name:_____

EXHIBIT E

SPRING BRANCH INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES

TRANSPORTATION PLAN WITH EMERGENCY PREPAREDNESS
FOR STUDENT WITH DIABETES

Confidentiality of this plan must be ensured.

Student's Name: _____ Grade: ___ Sex: ___ Age: _____ Birth date: _____

Home Address: _____ School: _____ School Phone: _____

EMERGENCY CONTACT INFORMATION:

Parent/Guardian: _____ Telephone: _____ Alt. Telephone: _____

Parent/Guardian: _____ Telephone: _____ Alt. Telephone: _____

Other Contact: _____ Telephone: _____ Alt. Telephone: _____

Physician: _____ Telephone: _____ Alt. Telephone: _____

Health need(s): **Diabetic equipment student may carry on his or her person:**
Other Specifics of DMTP:

Student's specific signs of hypoglycemia (low blood sugar):
Actions to take for hypoglycemia (low blood sugar):
Other important emergency precautions and actions:

Name: Transportation Personnel	Signature: Transportation Personnel	Date

School Nurse	Diabetes Care Assistant	Date	Reviewed

EXHIBIT F

SPRING BRANCH INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES

DISTRICT USE AND ELECTRONIC ACCESS TO STUDENT DIABETES DATA AT PARENT'S REQUEST

Parent Name: _____
Student Name: _____
School Name: _____
Device/Application Name: _____

I, (PARENT NAME), have requested that the nurse at (SCHOOL NAME) have access to electronic information transmitted from (DEVICE NAME, E.G. DEXCOM), which is a technology application on my child's phone. My child, (CHILD NAME), has diabetes and the use of (DEVICE NAME) allows for a blood glucose reading without regular finger pricks and may provide data alerts regarding my child's blood glucose level. Because of these health benefits, I want the school nurse to have access to my child's glucose data sent to a designated District device. In order for the school nurse to access my child's glucose data through (DEVICE NAME), I agree to the following:

1. I understand that the school nurse attends to many other children and that simply because he/she has access to my child's glucose readings, it is still my responsibility to inform my child that when he/she feels ill he/she must to go to the nurse.
2. I understand that the nurse does not have a proactive duty to seek my child out for medical care resulting from any device data alert.
3. I understand that the school nurse can only use a District device to access my child's medical data and that the District device is *only* for use during regular school hours. I understand that the school nurse has no obligation to my child outside of regular school hours.
4. I understand that (DEVICE NAME) may store my child's medical information in its own technology cloud and that the District has no responsibility to store my child's medical information received from (DEVICE NAME), and that the District has no duty to protect or repair or provide maintenance on anything related to or resulting from (DEVICE NAME).
5. I understand that I have to provide the applicable login information for the school nurse to use (DEVICE NAME) and that if the device logs the school nurse out of the account, the school nurse cannot login on his/her own, and I must provide assistance.

_____
Parent Signature Date