# INDIVIDUAL HEALTH CARE/EMERGENCY PLAN FOR CHILD WITH DIABETES

Child's Name: _____ Birth Date: _____

Program Name/Site: _____ Grade: _____

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 During Program Hours (list types): _____

## BLOOD GLUCOSE MONITORING

Target range: _____ - _____ mg / dl

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

**Please check all that apply:**

- ❑ Before breakfast Time: _____
- ❑ Before a.m. snack Time: _____
- ❑ Before lunch Time: _____
- ❑ Before p.m. snack Time: _____
- ❑ Before outdoor play Time: _____
- ❑ Before gym play Time: _____
- ❑ Other BG testing Time: _____
- ❑ Continuous glucose monitoring

**Please 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 CE program staff**

## 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**
- **CE 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**

**OVER**

**Child's Name:** _____

**FOR CHILD WITH INSULIN PEN / SYRINGE OR IF INSULIN PUMP MALFUNCTIONS**

Type of insulin given during CE program hours: _____

Time(s): ❑ Before lunch ❑ After lunch ❑ Other: _____

1. **Dose determined by: (Please 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**

**EMERGENCY CARE PLAN**

1. **LOW BLOOD GLUCOSE:** Child must be treated when blood sugar is below _____.
2. **Symptoms**: (**Please check all that apply)**

   ❑ hunger ❑ confusion ❑ shakiness ❑ sweating ❑ paleness ❑ headache

   ❑ crying ❑ sleepiness or other behavioral changes

   List additional symptoms: _____

3. **Treatment:** With any level of low blood glucose ***never*** leave the child unattended.

- ❖ Test blood glucose. If blood glucose monitor is not available, treat the child immediately per symptoms.
- ❖ If blood glucose is below _____, give15 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 is used or symptoms continue.

**OVER**

4. **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 the ground and massage cheek.
- ➔ If child is unconscious or unresponsive, do not put anything to eat or drink in the child's mouth.

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

❖ **Symptoms: (Please check all that apply):**

❑ extreme thirst ❑ headache ❑ nausea ❑ vomiting

❑ frequent urination ❑ abdominal pain

❖ **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 the child's consciousness is impaired, call 911.

6. **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: _____

**OVER**

**Child's Name:** _____

## SNACKS DURING CE PROGRAM

- ☐ Insulin bolus to be given at time carb snack is consumed if it has been at least three hours after the last dose of insulin.
- ☐ Insulin bolus to cover afternoon snack can be predetermined and given with lunch bolus if the 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 by CE Program.

## 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.*

## PHYSICIAN/LICENSED PRESCRIBER AUTHORIZATION

- ❖ **Glucagon will be not be given during CE program as a trained nurse is not available.**
- ❖ My signature below provides authorization of the above procedures for the current CE 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 #: _____

**OVER**

**Child's Name:** _____

## PARENT/GUARDIAN- PLEASE SIGN ONE OF THE OPTIONS BELOW

**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 CE Program Coordinator/designee to give insulin during CE program hours, including field trips as ordered by my child's health care provider.
4. I give permission for the CE 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 CE Program Coordinator/designee to communicate with the appropriate CE 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 CE Program Coordinator/designee from any liability in relation to the management of diabetes at school.

**Parent/Guardian Signature:** _____ **Date:** _____

**OR**

**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 CE 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 CE 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 CE program coordinator/designee to communicate with the appropriate CE 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 CE program coordinator if any of the above information changes.

**Parent/Guardian Signature:** _____ **Date:** _____