

FOX CHAPEL AREA SCHOOL DISTRICT
Individualized Health/Emergency Care Plan For Diabetes

Student's Name _____ Grade _____ Age _____ HR _____ School Year _____

Type 1 Insulin Dependent Diabetes

Diabetes is a disorder in the body's ability to use blood sugar (glucose) and is usually a result of the pancreas not producing enough insulin. The result is too much sugar in the blood. Treatment consists of daily injections of insulin, food management, and exercise. Diabetes is not contagious. The priority for a child with diabetes is to lead a normal life. While the fact that they have diabetes should not be hidden, the student does not want to be singled out. With careful management, diabetes can be well controlled and allow children to lead healthy, active, fun-filled lives.

LOW BLOOD SUGAR (HYPOGLYCEMIA)

The emergency situation you are most likely to encounter in the school setting is low blood sugar. It occurs most commonly when blood sugar levels fall below 70 mg/dl. Most students are aware when their blood sugar is low but sometimes it can occur suddenly and if not treated promptly, it can be an emergency.

Causes: Too much insulin, extra exercise, a missed snack, or less food at a meal than usual.

Prevention: Eat meals/snacks at specified time - especially during periods of exercise, recognize and treat symptoms

SIGNS OF HYPOGLYCEMIA (LOW BLOOD SUGAR) REACTION:

- | | | |
|----------------------------|---------------------|-----------------------------|
| • Hunger | • Irritability | • Personality changes |
| • Headache | • Pale, moist skin | • Crying |
| • Tiredness | • Confusion | • Uncooperative |
| • Nausea/stomachache | • Slurred Speech | • Combative |
| • Inability to concentrate | • Poor coordination | • Other (specific to child) |
| • Day-dreaming | • Sweating (clammy) | _____ |
| • Weakness/dizziness | • Shakiness | _____ |

If the above symptoms are ignored or go unrecognized, loss of consciousness or seizures may result. These serious side effects, however, rarely occur.

NEVER SEND STUDENT TO NURSE ALONE WHEN HAVING SYMPTOMS!

Type of treatment for symptoms of low blood sugar should be based on the student's level of consciousness: (When possible check blood glucose)

1. IF THE STUDENT IS CONSCIOUS AND ABLE TO SWALLOW-give one of the following:

- ◆ *Fruit Juice (1/2 to 1 cup)
- ◆ Glucose Tablets (2-4)
- ◆ Regular soda (6 oz)
- ◆ Glucose Gel (squirt in side of mouth and massage)
- ◆ _____ (student preference)

After the administration of the item listed above, the student's symptoms should improve within 15 minutes. If not, repeat treatment. Student should not be left alone until symptoms are completely gone.

Once symptoms subside, give a small snack like crackers or milk to prevent reoccurrence of the symptoms if the next meal or snack is not within 1/2 hour.

***Note to school personnel:** Juice is the preferred treatment because it is quickly absorbed and fast acting. Do not hesitate to give to student-it will not harm them. If you do not have a can of apple juice (or crackers) please see the school nurse. This juice must be readily available. Please write down where you will keep it for substitute personnel. Juice will be kept: _____.

2. IF THE STUDENT BEGINS TO LOSE CONSCIOUSNESS, IS UNABLE TO SWALLOW OR

IS HAVING A SEIZURE: the school nurse or designated person(s) _____ MUST **ADMINISTER GLUCAGON INJECTION IMMEDIATELY.**

- Emergency kit with Glucagon is kept: _____
- **CALL 911 (ACTIVATE EMS)**
- Notify parent or guardian

Does your child wear a medic alert tag? ___Yes ___No

Will student always carry a form of sugar on them? ___Yes ___No

If Yes, where _____

HIGH BLOOD SUGAR (Hyperglycemia): Occurs when blood sugar levels get too high. Symptoms (such as excessive thirst, fatigue, weakness, increased trips to bathroom and blurred vision) typically develop gradually, over a period of days.

If blood sugar is over _____ at school, please do the following: _____

BLOOD GLUCOSE TESTING

Blood sugar testing involves pricking a finger, placing a drop of blood on a test strip, using a glucometer, and recording the results. The information is then recorded and insulin doses adjusted based on test results.

This procedure is typically done in the nurse's office.

• **Testing Times**

- Before Lunch
- Before exercise
- After exercise
- Before snacks
- Symptoms of high/low glucose
- Other: _____

REGULAR MEALS AND SNACK TIMES

- Allow the student to follow his or her routine inconspicuously. When the child needs a snack, to test blood sugar, or to take insulin, help by allowing the necessary time and not calling attention to these special actions.
- All school personnel will permit the student to eat a snack in the classroom or wherever the child is (Including, but not limited to gym, field trips and school bus)

Will student eat a scheduled snack in school? Yes No

Eat snack before or after exercise/gym class? Yes No

If Yes, list times of snack: _____ Will student need a reminder to eat snack? yes no

WATER AND BATHROOM ACCESS

- The student shall be permitted to have immediate access to water by keeping a water bottle with them, and by permitting the student to use the drinking fountain without restriction
- The student shall be permitted to use the bathroom without restriction

SCHOOL PARTIES AND SPECIAL EVENTS

Student may consume any classroom food or drink without restriction

Student may only consume food ***pre-approved by parent**

*Teacher must obtain parent permission for snack to be approved

Student will consume ONLY the food/drink sent in by parent

Other: _____

BUS TRAVEL

Student is permitted to drink/eat food on the bus at any time

Please indicate any other necessary arrangements or care needed on bus: _____

FIELD TRIPS Please Indicate any special arrangements needed on field trips:

CAFETERIA Indicate any special arrangements necessary during meals in cafeteria:

***PHYSICAL EDUCATION (GYM)**

- Low blood sugars may occur during exercise, and a source of instant sugar (juice) should be nearby. Often a snack is eaten before gym and the child may be delayed in getting started. Exercise is very important for children with diabetes. Typically, exercise is not scheduled before a meal. It is important to schedule gym class at an appropriate time during the day.

- ***Parents:** Please contact the school before the first day to check on your child's gym schedule

OTHER

Please address any other issues, guidelines or special precautions that you feel are important to your child's safety and care during the school day. Please include any **FOOD ALLERGIES** or **SPECIAL DIETARY NEEDS**.

***AFTER SCHOOL ACTIVITIES**

- **Parents:** Please make sure your child has a juice and snack with them at all times.
- **Parents:** If your child needs an additional snack or juice, please contact the school nurse.

SUPPLIES AND EQUIPMENT

Parents are to provide the following necessary supplies and equipment:

1. **Emergency Low Blood Sugar Kit(s):**
 - Glucagon
 - Glucose Gel
 - Juice
 - Glucose Tablets
 - Prepackaged snacks
 - Other: _____

*** Please indicate where you would like the kits to be kept:** (i.e. Nurses office, classroom, bus, etc.):

2. High Blood Glucose Supplies
 - Ketone Test strips/bottle
 - Water Bottle or drink indicated for highs
3. Insulin Supplies: Insulin, syringes and extra pump supplies
 1. Regular Snacks /Juice
 2. Glucometer: meter, testing strips, lancing device, lancet

The information in this Care Plan is a supplement to more detailed information, instructions and physicians orders, which are kept in the Nurse's office. Including but not limited to: Guidelines for Managing the Student with Diabetes and Physicians Orders for Management of Insulin.

Parent Consent for Management of Diabetes at School

We (I), the undersigned, the parent(s)/guardian(s) of the above named pupil, request that the above Health Care Plan service for Management of Diabetes in school be administered to our (my) child.

I will:

1. Provide the necessary supplies and equipment
2. Notify the school nurse if there is a change in pupil health status
3. Notify the school nurse immediately and provide new physicians consent for any changes

I authorize the school nurse to communicate with the physician when necessary.

For the safety and well being of your child we MUST be able, to reach a parent at all times.

My signature below indicates that I have read and completed the above information and give my permission for this Individualized Health Plan to be released to all school personnel.

→ **Parent/Guardian Signature** _____ **Date** _____

Physician Authorization For Diabetes Management In School

My signature below provides authorization for the above written orders and also for Guidelines for Managing the Student with Diabetes (colored flip cards). This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization upon request.

→ **Physician Name** _____ **Physician Signature** _____ **Date** _____

FOX CHAPEL AREA SCHOOL DISTRICT

**TYPE 1 INSULIN DEPENDENT DIABETES
PHYSICIAN ORDERS FORM**

Student's Name _____
Last First Grade

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons or permitted to medicate herself/himself (as outlined below) also by me and my physician. We agree to hold the school, its offices, agents and employees harmless in administering the medication pursuant to the physician's written instructions. We further agree to notify you promptly when it is no longer necessary to administer this medication.

X _____
Parent/Guardian Signature Date

The following is to be completed by PHYSICIAN:

SCHEDULED AND EMERGENCY MEDICATIONS

1. If Insulin to be given at school, please indicate:

Brand name and Type: _____ Form _____ Time _____

Dose _____ /or

Sliding Scale as follows:

Blood Glucose from	_____	to	_____	=	_____	Units
	_____	to	_____	=	_____	Units
	_____	to	_____	=	_____	Units
	_____	to	_____	=	_____	Units
	_____	to	_____	=	_____	Units
	_____	to	_____	=	_____	Units

Other Information:

2. Glucagon Injection

Brand name and Type: _____ Form: Injection Time: PRN

Dose _____

Indicated For: Loss of consciousness, seizure, inability to swallow or:

Other Information:

Date: _____ Physician's Signature _____

Note: Prescription medication must be in the original prescription labeled container.

**PARENT/GUARDIAN
REQUEST TO ADMINISTER MEDICATION IN SCHOOL**

Name _____ Grade _____ Room _____ School _____

Please administer prescribed medication to our child according the Physician Medication Instructions.

As a parent/guardian of _____, we hereby release the Fox Chapel Area School District and all its employees from all liability for damages our child may suffer as a result of this request.

Date _____

Signature of Parent/Guardian _____

PHYSICIAN'S MEDICATION INSTRUCTIONS

The parent/guardian has requested that medication be administered during the school day. If you feel it essential that the medications(s) be administered during the school day, we require completion of the information below.

Diagnosis _____

Medication	Dosage	Administration	Time
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Medication	Dosage	Administration	Time
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Self-administration with adult supervision: Yes _____ No _____

Possible side effects _____

Curtailment of school activity (sports, shop, labs, driver's ed., etc.) _____

Duration: From _____ / _____ / _____ to _____ / _____ / _____
Month Day Year Month Day Year

Other medications student is taking outside school hours _____

Comments _____

Date _____ Physician's Signature _____ Telephone Number _____

FOX CHAPEL AREA SCHOOL DISTRICT
GUIDELINES FOR ADMINISTERING MEDICATION

Medication should be given at home. Should the need arise for a student to be given medication during school hours, these procedures must be followed:

1. Written instructions signed by a physician with the diagnosis, medication, dosage, length of time to be given, possible side effects, and parent signature is required for all types of medication. Forms are available from the Certified School Nurse.
2. It is the parent's responsibility to maintain an adequate supply of medication throughout the school year.
3. **Medications must be brought to the School Nurse by the parent/guardian in the prescription-labeled container that must remain at school.**
4. If the School Nurse is not available, the building Principal or Acting Principal will accept and sign for medication.
5. Over-the-counter medication such as Advil, Tylenol, cough drops, will not be administered to Kindergarten- 8th grade unless prescribed by a physician.
6. The Certified School Nurse will review all new medication requests.
7. The first dose of a new medication: *It is the parent's responsibility to give the first dose when the child is able to stay at home to ascertain the child's reaction to the medication.*
8. Medications will be discarded one week following termination date or conclusion of the school year, unless return is requested by the parent. **Medication will be returned to the parent or an adult designee only.**

Field Trip Medication

1. Children with serious, life threatening or potentially life threatening medical conditions may request that medications be given on a field trip. No other medication will be permitted. Any parent who has a child needing medication in such a situation should contact the Certified School Nurse.

NOTE: According to the American Academy of Pediatrics, life threatening conditions may include but are not limited to, conditions such as: Asthma, diabetes, seizure disorders, hormonal disorders or severe allergy.

2. Parents of students who receive routine medication during school hours may choose to have the child not receive his/her medication on the day of the field trip. Otherwise, the parent may accompany the child on the field trip or make other arrangements with the Principal.

**NO MEDICATION WILL BE ADMINISTERED AT SCHOOL UNLESS ALL
REQUIREMENTS OF THE MEDICATION POLICY ARE MET**