Andover Public Schools
DEPARTMENT OF HEALTH SERVICES

Medical Management for Diabetes
To be signed by physician (may have input from parents and school nurse)

Diabetes Care Plan for _____ School _____ Effective Date: _____
(Name of Pupil)
Date of Birth: _____ Age of Onset: _____. Grade: _____ Homeroom Teacher: _____

_____

Contact Information:

Parent/guardian #1(call first): _____.

Telephone – Home: _____ Work: _____ Cell Phone: _____

Parent/guardian #2: _____

Telephone – Home: _____ Work: _____ Cell Phone: _____

Emergency Contact (if unable to contact parent): _____ Relationship: _____

Telephone – Home: _____ Work: _____ Cell Phone: _____

_____Pupil's Doctor/Health Care Provider: _____ Phone: _____

_____

Nurse Educator: _____ Phone: _____

Hospital Choice: _____ **Known Allergies**: _____

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Blood Glucose Target range is _____

****

Blood Glucose Monitoring

Type of blood glucose meter student uses: _____

Times to test: If Finger stick put F, if CGM put C, if not testing put N for no. (CGM Type _____)

___ mid-morning ___ before exercise/PE ___ when student exhibits symptoms of hyperglycemia

___ pre-lunch ___ after exercise ___ when student exhibits symptoms of hypoglycemia

___ mid-afternoon ___ other (explain):_____

_____.

Times to Compare CGM to Finger stick: _____Hypo/hyper-glycemia _____Before Meals/Snacks (insulin)

Can student perform own blood glucose tests? _____ Yes _____ No Exceptions: _____

_____

When should CGM be calibrated at school: _____

For Students with Insulin Pumps:

Type of pump: _____

Insulin/carbohydrate ratio: _____

Correction factor: _____

Is student competent regarding pump? ___Yes ___No

Can student effectively troubleshoot problems (e.g. ketosis, pump malfunction)? ___Yes ___No

Note:_____

Suspend pump for: _____minutes for glucose < _____ / suspend before PE for _____minutes for glucose < _____. May disconnect pump for contact sports___ Yes ___No

Comments: _____

_____

Insulin - Routine (supplemental orders below)

BREAKFAST – give:

_____before meal _____after meal

_____units **OR**

_____units/_____grams of carbohydrates

Type: _____

LUNCH – give:

_____before meal _____after meal

_____units **OR**

_____units/_____grams of carbohydrates

Type: _____

****

Parents may change insulin / carbohydrate ratio by _____

Can student give own injections?___ Yes ___ No Can student determine correct amount of insulin?___ Yes ___ No

Can student draw correct dose of insulin? ___ Yes ___ No Other Notes:_____

Home insulin: Type _____ Dose _____ Frequency _____

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For Hypoglycemia

Common symptoms: _____

Glucagon ordered? _____ No _____ Yes _____ 1 unit (1mg) _____ 1/2 unit (1/2 mg) : give if student is unconscious, having a seizure, or unable to swallow.

- **Give Glucagon** (as ordered).
- **Call 911**

- **Notify parent or emergency contact (see page 1)**
- **Notify physician if unable to reach parent or emergency contact (see page 1)**

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Blood glucose below 30 mg and conscious treat with:_____

If blood glucose 31-69 mg treat with: _____

Recheck Blood Glucose 15 minutes following oral treatment. If blood glucose is still below 70, may repeat oral treatment and recheck blood glucose again in 15 minutes.

*** If blood glucose is still below 70 or ____,** repeat oral treatment and notify a parent or emergency contact who may pick up the pupil and care for student until blood glucose has been above 90 for at least 1½ hrs.

*** If blood glucose is above 70 or ____,** follow with a protein snack. Pupil may return to class if no longer experiencing any symptoms of hypoglycemia._____

<u>For Hyperglycemia</u> :

Always encourage water for glucose > _____.

Check ketones if glucose is > or = _____.

No exercise / recess / PE if glucose is > or = _____ and / or _____ ketones.

Send home for glucose level of _____ and / or _____ ketones.

(Andover Health Services protocol includes if blood glucose is 400 or above, with or without ketones, that has been treated once in the health office, this student should be sent home. The student may return to school if under 300 after home treatment for an hour – as verified by school nurse. If the glucose is 500 or above the student should be sent home to be treated until under 300 for at least an hour without ketones before returning to school.)

When supplemental insulin is given at school:

Administer supplemental insulin when Blood Sugar is > _____ . May hold if student just participated or is immediately scheduled to participate in strenuous prolonged physical activity YES NO and glucose is within the following range _____.

Correction Factor Calculation:

Calculate insulin needed as follows; Blood glucose - Target number =_____ Divided by correction factor of _____. BG – TN / CF = units to be given.

Can administration of supplemental insulin be repeated? No / Yes If yes, frequency _____.

Indications and amount: _____

Other: _____

After supplemental insulin, recheck in 60 minutes. If level is still elevated, parent or parent-designees will be notified to pick pupil up from school and care for student until level is below 300 or _____.

****

Special instructions for elementary students who may have daily snack times, and parties:

_____

Supplies to be kept at school: _____

_____

_____

Parent comments/concerns:_____

_____

XXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXX

_____

Signatures: **May write any additional orders/comments on back**

Approved by: _____ _____

(Physician's Signature) (date)

_____ _____

(Physician printed name) (Phone #)

Acknowledged/received by: _____ _____

(Parent/Guardian) (date)

USD 385 – Andover Public Schools

Health Services

Medication Administration Release Form

I hereby certify that _____ has previously had at least one dose of the prescribed medication listed and did not have an adverse reaction. I request this medication(s) to be administered at school as prescribed by the physician. I understand that any school employee who administers this prescription to my child in accordance with written instructions from the physician or dentist (and USD #385 Board of Education Policy) shall not be liable for damages as a result of an adverse drug reaction suffered by the pupil, because of administering such a drug or because of a mislabeled or altered product. I hereby authorize USD #385 Department of Health Services personnel to exchange information regarding dispensing and monitoring of this medication with _____, the attending physician or dentist, or with the pharmacy as identified on the label of the prescribed medication container. All prescription medications must be PICKED UP from the Health Office by a parent or guardian on or before the last day of school.

_____ _____

Printed Name of Parent/Legal Guardian Signature of Parent/Legal Guardian

_____ _____

Date Telephone Number

NOTE: The as-labeled non expired medication must be brought to school in the original container appropriately labeled by the pharmacy, or physician, stating the name of the medication, the dosage and times to be administered.

Building: _____ Teacher/Grade_____/_____

Student's Name_____ Birth Date:_____

Medication:_____ Diagnosis:_____

Route:_____ Dosage:_____

Time to administer at school:_____ Special Instructions for Administration: _____.

_____

Requested Starting Date of treatment: _____ Duration (End Date):_____

Physician's Printed Name	Physician's Signature

Date	Telephone Number	Fax Number