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:** ___________________