HINSDALE

Hinsdale Central
High School
a partnership in
lifelong learning

Contact Information
55th & Grant Streets
Hinsdale, Illinois 60521

p 630.570.8000
f 630.887.1362
www.hinsdale86.org

Dear Parent or Guardian,

Enclosed is a copy of your child's *Individual Health Care Plan* (IHCP), a *Medication Authorization Form*, and a sample physician *Diabetes Orders* form for the upcoming school year. Please review the plan and forms carefully, consulting your physician or diabetes nurse as appropriate. Amend the *Individual Health Care Plan* (IHCP) if needed. Sign and return it along with the *Medication Authorization Form* to Health Services as soon as possible. Also, send a completed copy of your physician's *Diabetes Medical Management Plan* and/or *Diabetes Orders* or use the sample *Diabetes Orders* form enclosed. Please make sure that your child's Insulin type and Glucagon (if ordered) is added to the school Medication Authorization Form.

Please return the plan and forms by July 1st of the upcoming school year to ensure that a plan is in place for your child prior to the beginning of the school year. Please contact us with any questions.

Sincerely,

Central Health Office
centralhealth@hinsdale86.org
Phone 630-570-8595
Fax 630-570-8599

****Emergency names and phone numbers are on Health Office card****

Diabetes Orders

Place Child's Photo Here

Student's Name_____ **DOB**_____
School_____
Physician_____ **Effective Date**_____

Type of insulin: (circle one) Rapid or Short Acting: Apidra/Humalog/Novolog/Regular
Intermediate or Long-acting given at home: (cirlce one) NPH/Lantus/Levemir
Insulin to carbohydrate ratio (I:CR):_____**units/**_____**grams or Fixed insulin lunch dose**_____
Parent may adjust I:CR by +/- 1 to 5 grams Yes/No (circle one)
Correction Factor (CF) (insulin sensitivity): **CF:** _____ **units per** _____**mg/dl over** _____ **mg/dl**
(Correction Factor Formula: Student's BG minus Target BG ÷ correction factor = insulin dose)

Usual Insulin Dose Range_____. **Target blood glucose range:** 70-110 pre-meal. **Other:**_____

Insulin Pump: (if applicable)
Type: _____
Basal Rates: Time: Rate (units per hr)
12:00 am =_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Blood Glucose Monitoring (in classroom if possible) or Location_____

Before am snack _____
Before lunch _____
Before exercise _____
After exercise _____
Signs of low or high blood sugar _____
Other _____

Child is able to:
(Circle all that apply)
Test own glucose Yes/No
Determine insulin dose Yes/No
Draw up insulin Yes/No
Administer insulin dose Yes/No
Manage/troubleshoot pump Yes/No

Exercise and Sports
Student **should not** exercise if blood glucose is
BG is below _____mg/dl or
above _____mg/dl
Snack before exercise Yes/No
Snack after exercise Yes/No

Meals/ Snacks:
Breakfast_____
A.M. Snack _____
Lunch _____
P.M. Snack _____
Food in class, e.g. party _____

Supplies to be provided by parents: Blood Glucose Monitor and all monitoring supplies, Insulin and administration supplies, Glucagon emergency kit, snack foods, fast-acting glucose source, Ketone testing supplies, Insulin pump supplies if appropriate.

High blood glucose Management/Preventing Diabetic Ketoacidosis
If BG is above 250 mg/dl, wash hands and recheck. If still above 250:
→**If less than 2 hrs since last dose of Apidra, Humalog or Novolog,* recheck at 2 hrs after the last dose and continue as below.**
→**If 2 hrs or more since the last dose of Apidra, Humalog, or Novolog* give a correction dose using the correction factor formula.**
→ Check urine for ketones. If positive, drink 6-8 oz liquid with no calories every 30 minutes (e.g. water, diet soda)
→ **If moderate or large ketones at any time, call parent.**
→ Check BG and ketones every 2 hrs and give correction dose until BG reaches target range and ketones clear.
→ If BG and ketones are not decreasing after 4 hrs, call parent.
Additional Instructions for Insulin Pump Users:
→ If ketones are negative, check pump and site. If okay, give correction bolus by pump.
→ If ketones are positive, give correction bolus by syringe (not by pump) and have student change infusion set/site if able or call parent.
→ If initial correction bolus was given by pump, recheck BG in 1 hr. If BG has not decreased, give correction bolus by syringe and have student change infusion set/site if supplies are available or call parent.
→ Check BG and ketones every 2 hrs and give correction dose until BG reaches target range and ketones clear, by syringe until site is changed.
*If taking Regular, NPH or NPH mix insulin, call parent for direction.

Low blood glucose (hypoglycemia)
Some symptoms of low BG:
→Sweating →Hunger
→Headache →Dizziness
→Drowsiness →Confusion
→Trembling →Palpitations
→Blurred vision →Speech Impairment
Hypoglycemia protocol: the rule of 15
If blood glucose is less than 70 mg/dl or symptomatic (70 to 100 mg/dl)
→Eat/drink 15 grams of carbohydrate
→Check BG again in 15 minutes; if not above 70 mg/dl repeat treatment
→Check BG again in 15 minutes; if not above 70mg/dl repeat treatment and contact parent.
These items have 15 grams of carbohydrate:
→ 3 Glucose tablets → 4 oz of juice or soda (not diet)
→ 6-7 hard candies such as lifesavers
→1 tablespoon of table sugar or honey

Rx:
Glucagon: If child becomes unconscious, unable to cooperate, or has a seizure, give glucagon 0.5/1.0 mg subcutaneously. (Please circle dose) Call 911 and parents. Do not force eating or drinking. Turn on side.

☐ I hereby certify that the above information is complete and I have provided the school with all information that they will need to reasonably care for and monitor my child's health related to his/her diabetes. I give permission for the school to talk to my doctor, nurse practitioner, and/or physician's assistant and/or nurse.

☐ Above I hereby certify that my child can monitor and manage his/her care without supervision from school staff except in emergencies.
Signature and dates: Parents_____ Student _____ Date _____

Physician_____ Date _____ School Representative and Title_____ 4/19/07

Hinsdale Central High School

MEDICATION AUTHORIZATION FORM

PHONE 630-570-8595 FAX 630-570-8599

Student Name: _____ Class/ID: _____ / _____

TO BE COMPLETED BY THE PHYSICIAN: (please print)

All medication (prescription or nonprescription, including generic Tylenol and ibuprofen) requires authorization **each school year.** It is the parent's responsibility to update student health information in the event of any change.

Please note**: Only **generic** Tylenol, Advil, or Motrin will be dispensed in the Health Office. If non generic is ordered, parent must supply the medication. **If medication below is not advised, delete or amend as needed.

Medication *Required* during School	**Dosage/Route**	**Time and Frequency**
Generic Tylenol	325-650 mg po	every 4-6 hours as needed
Ibuprofen	200-400 mg po	every 4-6 hours as needed

Other Medication *Required* during School	**Dosage**	**Time and Frequency**
Glucagon 1 mg SQ if child is unable to tolerate PO fluids		

Insulin type; _____

Diagnosis requiring medication(s): _____

Intended effect/Possible side effects: _____

Other medication student is taking: _____

Medication student may carry and self-administer: **Inhaler, insulin or Epi-Pen** (circle if applicable). Please contact the school nurse at 630-570-8595 for details.

Self-Administered Medication: such as medication for asthma, diabetes, or severe allergy: I or a member of my staff has instructed the above student in the proper administration of the self-administered medication. He/she understands the need for the medication, the appropriate response, and the necessity to report to school personnel any unusual side effects or lack of appropriate response. The student is capable of using this medication independently.

Physician's Signature _____ **Date** _____

Physician's Name _____ **Phone**_____ **Fax**_____

Parent/Guardian's Authorization By signing below:

I hereby acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Hinsdale Township High School District 86 and it employees and agents, on my behalf and stead, to administer or attempt to administer to my child (or allow my child to self-administer) the lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than the school nurse, and specifically consent to such practices. I further acknowledge and agree that, when lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition I agree to hold harmless and indemnify the School District, its employees and agents, either jointly or severally, from any and all claims, damages, and causes of action or injuries, except a claim based on willful and wanton conduct, incurred or resulting from the administration or self-administration of medication.

Parent/Guardian's Signature _____ Date _____

Address _____ Phone _____