

**Muscogee County School System  
Student Health Services  
DIABETIC STUDENT HEALTH CARE PLAN**

Please bring or mail this health care plan to the school.  
**A new health care plan is required every school year.**

Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ School year: \_\_\_\_\_

School: \_\_\_\_\_ Teacher: \_\_\_\_\_ Grade/Team: \_\_\_\_\_

**Emergency Contacts**

Parent/Guardian/Contact	Relationship	Phone Number	Alternate Phone Number
<b>Diabetes Healthcare Provider:</b>		<b>Phone Number:</b>	

**Emergency Notification**

Notify parents of the following conditions:

- Loss of consciousness or seizure immediately after calling **911** and administering Glucagon
- Blood sugar in excess of \_\_\_\_\_ mg/dl
- Positive urine ketones
- Abdominal pain, nausea/vomiting, fever, diarrhea, altered breathing, or altered level of consciousness

**Student's Competence with Procedures** (Must be verified by parent and Clinic Staff)

- |  |  |
|--|--|
| <input type="checkbox"/> Blood glucose (BG) monitoring | <input type="checkbox"/> Independently operates insulin pump       |
| <input type="checkbox"/> Monitoring BG in classroom    | <input type="checkbox"/> Carry supplies for BG monitoring          |
| <input type="checkbox"/> Determining insulin dose      | <input type="checkbox"/> Carry supplies for insulin administration |
| <input type="checkbox"/> Measuring insulin dose        | <input type="checkbox"/> Self-treatment for mild low blood sugar   |
| <input type="checkbox"/> Injecting insulin             | <input type="checkbox"/> Determine own snack/meal content          |

**Blood Glucose Monitoring:**

Target range: \_\_\_\_\_ mg/dl to \_\_\_\_\_ mg/dl

- |   |  |
|---|--|
| <input type="checkbox"/> None required at this time | <input type="checkbox"/> Mid-afternoon                   |
| <input type="checkbox"/> Before Meals               | <input type="checkbox"/> 2 Hours Before Correction       |
| <input type="checkbox"/> Midmorning                 | <input type="checkbox"/> Before Dismissal                |
| <input type="checkbox"/> Before PE / Activity       | <input type="checkbox"/> PRN for Suspected Low / High BG |
| <input type="checkbox"/> After PE / Activity        |  |

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**Insulin Administration:**

None

Dose may be determined by:     Student     Parent     Clinic Staff

**Insulin Delivery System:**    Syringe     Pen     Pump (Complete Supplemental Authorization for insulin pump)

Insulin Type: \_\_\_\_\_

CHO:Insulin Ratio : \_\_\_\_\_ units per \_\_\_\_\_ grams CHO

Set dose of \_\_\_\_\_ units

**Correction Bolus Dose:** (Check only those which apply)

- Use the following formula: **BG** - \_\_\_\_\_ / \_\_\_\_\_ for BG > \_\_\_\_\_.
- Sliding Scale:
  - BG from \_\_\_\_\_ to \_\_\_\_\_ = \_\_\_\_\_ units
  - BG from \_\_\_\_\_ to \_\_\_\_\_ = \_\_\_\_\_ units
  - BG from \_\_\_\_\_ to \_\_\_\_\_ = \_\_\_\_\_ units
  - BG from \_\_\_\_\_ to \_\_\_\_\_ = \_\_\_\_\_ units
- Decrease correction dose by \_\_\_\_\_ units or \_\_\_\_\_% if PE/activity is anticipated < 1 hr. after correction dose
- Decrease correction dose by \_\_\_\_\_ units if given following a low blood glucose level
- Add CHO bolus to correction bolus for total insulin

**Management of Low Blood Glucose (Below \_\_\_\_\_ mg/dl):**

Mild: BG < \_\_\_\_\_

- Never leave student alone
- Give 15gm glucose and recheck in 10 minutes
- If BG<70, repeat treatment and recheck BG every 10 minutes x3
- Notify Parent/Guardian if not resolved
- Provide snack with CHO, fat, protein after treating/meal <1 hour

Describe specific signs of low BG:

- Shaking
- Fast Heartbeat
- Sweating
- Dizziness
- Anxiety
- Hunger
- Impaired Vision
- Weakness
- Fatigue
- Headache
- Irritability
- Shortness of Breath
- Other: \_\_\_\_\_

**Management of High Blood Glucose (Above \_\_\_\_\_ mg/dl):**

- Sugar-free fluids / frequent bathroom privileges
- If BG > \_\_\_\_\_, initiate insulin orders
- If BG > \_\_\_\_\_, check for ketones. Notify parent/guardian if ketones are present.
- May not need snack.
- Note and document changes in status
- Notify parent/guardian (Refer to page 1)

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**Describe specific signs of high BG:**

- |   |   |
|---|---|
| <input type="checkbox"/> Extreme Thirst     | <input type="checkbox"/> Nausea               |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Abdominal pain       |
| <input type="checkbox"/> Dry Skin           | <input type="checkbox"/> Confusion            |
| <input type="checkbox"/> Hunger             | <input type="checkbox"/> Sweet Odor to Breath |
| <input type="checkbox"/> Blurred Vision     | <input type="checkbox"/> Other: _____         |
| <input type="checkbox"/> Drowsiness         |   |

**Exercise:** (Staff must be informed, educated regarding management and have easy access to supplies/equipment)

- Student should NOT exercise if BG levels are < \_\_\_\_\_ mg/dl or > \_\_\_\_\_ mg/dl + ketones
- Eat \_\_\_\_\_gms CHO for vigorous exercise
  - Before
  - During
  - After Exercise
  - As Needed
- Student may discontinue insulin pump for \_\_\_\_\_ hours or decrease basal rate by \_\_\_\_\_

**Physician's Authorization**

My signature provides for the above orders. I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.

- If changes are indicated, I will provide new written authorized orders
- Dose/treatment changes may be relayed through parent/guardian.

**Physician's Name:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent Consent for Management of Diabetes at School**

I \_\_\_\_\_ (Parent/Guardian) hereby authorize the named Healthcare Provider who has attended to my child, to furnish to the School Health Services Nurse and/or School Clinic Staff any medical information and/or copies of records pertaining to my child's diabetes and for this information to be shared with pertinent school staff at my child's school. I understand that as of April 14, 2003, under the Health Insurance Portable and Accountability Act ("HIPAA") disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance in the Muscogee County School District. This authorization expires as of the last day of the school year.

I request designated school personnel to administer the medication and treatment orders as prescribed above. I agree to provide the necessary supplies and equipment and to notify the school nurse if there is a change in the student's diabetes management or health care provider.

I understand that it is my responsibility to notify the bus driver, school administration, teacher, clinic worker and school nurse of any and all health conditions for my child.

**Parent/Guardian's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_