EAU CLAIRE AREA SCHOOL DISTRICT

CHILD/STUDENT PLAN/ORDERS FOR DIABETES MANAGEMENT
PART A – DIABETES CARE/SPECIALIZED HEALTHCARE PROCEDURE INSTRUCTIONS FORM

PHYSICIAN /LICENSED PRESCRIBER INSTRUCTIONS TO PARENT/GUARDIAN

Name of Child/Student _____ **Birthdate**_____

School Child/Student Attends_____ **Grade**_____

Child/Student's Condition/Diagnosis_____

BLOOD GLUCOSE TESTING (Check **ALL** that apply)

Target range of blood glucose: _____

Check blood glucose level:

☐Mid-morning ☐Before lunch ☐ ____ hours after lunch

☐____hours after a correction dose ☐Before Phy Ed ☐After Phy Ed ☐Before dismissal

☐As needed for signs/symptoms of low or high blood glucose and/or of illness

☐Other: _____

Student's blood glucose testing skills:

☐Will be done by student independently.

☐Will need assistance from a staff member/supervision.

☐Continuous Glucose Monitor (CGM): ☐ May use CGM to treat blood glucose levels ---**or** ---

☐ Confirm CGM results with blood glucose meter check before taking action, on sensor blood glucose level. If student has symptoms or signs of hypoglycemia, check fingertip blood glucose level regardless of CGM.

HYPOGLYCEMIA – LOW BLOOD GLUCOSE TREATMENT (Check **ALL** that apply)
If student is experiencing symptoms, TEST BLOOD GLUCOSE.

☐If blood glucose level is less than _____mg/dL, give a quick-acting glucose product equal to _____ grams of carbohydrate.

☐If blood glucose level is less than _____mg/dL, give a quick-acting glucose product equal to _____ grams of carbohydrate.

☐Recheck blood glucose in _____minutes and repeat treatment if blood glucose level is less than _____ mg/dL.

☐Call parent if__ has low blood sugars – per parent preference _____

☐If at meals or snacks student's blood glucose is less than their low parameter (see above) then: _____
_____

Additional treatments: _____

Student's hypoglycemia treatment skills:

☐Will be done by student independently.

☐Will need assistance from a staff member/supervision.

SEVERE HYPOGYLCEMIA – GLUCAGON (Check **ALL** that apply)

If student confused/unable to answer commands, unable to swallow, becomes unconscious or has a seizure due to suspected low blood glucose:

CALL 911

☐**Administer Glucagon injection as prescribed.**

***NOTE**: If child/student is to receive Glucagon, a "Child/Student Medication Management (Part A – Medication Instructions Form)" must be completed.

☐**Student does not have a prescription for emergency Glucagon**

If Applicable

☐**Disconnect insulin pump tubing**

☐**Suspend insulin pump/POD**

CALL PARENT/GUARDIAN

HYPERGLYCEMIA - HIGH BLOOD GLUCOSE TREATMENT (Check **ALL** that apply)
If student is experiencing symptoms, TEST BLOOD GLUCOSE.

☐For blood glucose greater than _____mg/dL AND at least _____hours since last insulin dose, give correction dose of insulin.

***NOTE**: If child/student is to receive insulin, a "Child/Student Medication Management (Part A -Medication Instructions Form)" must be completed.

☐If blood glucose is greater than _____mg/dL have student drink water.

☐Call parent blood glucose is greater than _____mg/dL & Ketones are present.

Additional treatments: _____

Student's hyperglycemia treatment skills:

☐Will be done by student independently.

☐Will need assistance from a staff member/supervision.

KETONE TESTING (Check **ALL** that apply)

☐Test ketones for blood glucose greater than _____mg/dL.

☐Test ketones if student is ill.

Students should not exercise if ketones are:
☐Trace ☐Small ☐Moderate ☐Large

Call parent/guardian if ketones are:
☐Trace ☐Small ☐Moderate ☐Large

☐If ketones are positive, have student drink water and retest blood glucose and ketones in ___hours.

☐Follow ketone sliding scale.

***NOTE**: If child/student is to receive insulin per ketone sliding scale "Child/Student Medication Management (Part A – Medication Instructions Form)" must be completed.

Student's ketone testing skills:

☐Will be done by student independently.

☐Will need assistance from a staff member verifying reading results.

☐Will not need ketone testing in school.

INSULIN THERAPY (Check **ALL** that apply)

Insulin delivery device: ☐syringe ☐insulin pen ☐insulin pump ☐Insulin pod

Insulin to be taken: ☐before eating ☐after eating

***Note:** If child/student will need insulin at school a "Child/Student Medication Management (Part A – Medication Instructions Form)" must be completed.

Student's insulin therapy skills:

☐Will be done by student independently.

☐Will need to be supervised but may self-administer.

☐Will need assistance from a staff member.

☐No insulin at school.

FOOD PLAN (Check **ALL** that apply)

☐Will bring daily morning snack to be eaten at_____.

☐Will bring daily afternoon snack to be eaten at_____.

☐On special occasions, student can eat same snack provided to classmates.

☐On special occasions, student will select alternate snack provided by parent

***NOTE: Parents, with the assistance of their children, will be responsible for packing a lunch from home or selecting appropriate food choices from school lunch menu. Parents will provide all snacks.**

Student's food plan skills:

☐Will be done by student independently.

☐Will need assistance from a staff member/supervision.

PHYSICAL ACTIVITY (Check **ALL** that apply) Refer to school orders from Children's of MN Diabetes Clinic

Physical activity treatment:

Check blood glucose before physical activity if physical activity is **greater than** _____ minutes.

☐If blood glucose is **less than** _____ mg/dL before _____ minutes of physical activity, give ____ grams carbs.

☐If blood glucose is **less than** _____ mg/dL before _____ minutes of physical activity, give ____ grams carbs.

☐If blood glucose is **less than** _____ mg/dL before physical activity, student should **not** participate until blood glucose is **greater than** _____mg/dL.

☐If blood glucose is **greater than** _____ mg/dL before physical activity, student should **not** participate until blood glucose is **less than** _____mg/dL.

Student's physical activity treatment skills:

☐Will be done by student independently.

☒Will need assistance from a staff member.

EAU CLAIRE AREA SCHOOL DISTRICT

CHILD/STUDENT PLAN FOR DIABETES MANAGEMENT

PART A – DIABETES CARE/SPECIALIZED HEALTHCARE PROCEDURE INSTRUCTIONS FORM

PHYSICIAN/LICENSED PRESCRIBER INSTRUCTIONS TO PARENT/GUARDIAN

Name of Child/Student _____ **Birthdate**_____

School Child/Student Attends_____ **Grade**_____

Child/Student's Condition/Diagnosis_____

For this condition/diagnosis, I have prescribed diabetic care/specialized healthcare procedure(s) as outlined in the pages of this "Child/Student Plan for Diabetes Management" form.

☐ THIS "CHILD/STUDENT PLAN FOR DIABETES MANAGEMENT" IS VALID FOR THE CURRENT SCHOOL YEAR AND THE SUMMER IMMEDIATELY FOLLOWING.

Or-

☐ THIS "CHILD/STUDENT PLAN FOR DIABETES MANAGEMENT" IS TO BE CONTINUED UNTIL

_____

(THE MAXIMUM TIME DIABETIC CARE PLAN ORDERS ARE VALID IS FOR ONE SCHOOL YEAR AND THE SUMMER IMMEDIATELY FOLLOWING.)

Additional directions/instructions_____

_____

_____

NOTE TO PARENT/GUARDIAN:

PLEASE CALL ME AT ANY TIME FOR QUESTIONS THAT YOU HAVE CONCERNING YOUR CHILD'S CONDITION/DIAGNOSIS, THE PLAN FOR DIABETES MANAGEMENT/SPECIALIZED HEALTHCARE PROCEDURE(S) PRESCRIBED OR REACTIONS TO THE PROCEDURE(S). IF YOUR CHILD WILL BE RECEIVING THE SPECIALIZED HEALTHCARE PROCEDURE(S) DURING THE DAY AT SCHOOL, THE DESIGNATED SCHOOL PERSONNEL CAN CALL ME AT ANY TIME WITH QUESTIONS OR CONCERNS RELATED TO THE STUDENT'S CONDITION/DIAGNOSIS OR THE SPECIALIZED HEALTHCARE PROCEDURE(S).

I WILL HAVE TO COMPLETE A NEW "PLAN FOR DIABETES MANAGEMENT (PART A – DIABETES CARE/SPECIALIZED HEALTHCARE PROCEDURE INSTRUCTIONS FORM)" WHEN THERE ARE CHANGES IN THE DIABETES CARE OR SPECIALIZED HEALTHCARE PROCEDURES FOR THIS CHILD/STUDENT.

Physician/Licensed Prescriber Signature_____ Date_____

Physician/Licensed Prescriber Printed Name_____ Phone_____

Physician/Licensed Prescriber Address_____ Fax No. _____

EAU CLAIRE AREA SCHOOL DISTRICT

CHILD/STUDENT PLAN FOR DIABETES MANAGEMENT

PART B – DIABETES CARE/SPECIALIZED HEALTHCARE PROCEDURE CONSENT FORM

PARENT/GUARDIAN CONSENT

Name of Child/Student _____ **Birthdate**_____

School Child/Student Attends_____ **Grade**_____

Child/Student's Condition/Diagnosis_____

I agree to:

- Follow the instructions of my Child's physician/practitioner ("licensed prescriber") and grant permission for unlicensed assistive school personnel to administer diabetes care to my Child according to the instructions written by the licensed prescriber in the "Child/Student Plan for Diabetes Management: Part A - Diabetes Care/Specialized Healthcare Procedures Instructions Form" (ATTACHED PART A FORM) and the Child/Student Medication Management: Part A - Medication Instructions Form (ATTACHED PART A FORM) and grant permission for school personnel to communicate with my child's licensed prescriber whenever necessary.
- Give consent for the free exchange of any necessary information between the licensed prescriber and school personnel.
- Hold the District, its employees and agents who are acting within the scope of their duties, and the licensed prescriber and its employees harmless in any and all claims arising from the administration of or exchange of information regarding the medications and diabetes care procedures noted on the attached Part A Form at school or at school related events.
- Notify the school **in writing** at the termination of this request or when there is ANY change in the licensed prescriber diabetes management instructions. I understand that the licensed prescriber diabetes management instructions and my consent are in force only for the current school year**.**

I agree and accept my responsibilities regarding school provision of diabetes medication and care to my Child, that is, to:

1. Notify the school of my Child's needs.
2. Complete this "Child/Student Plan for Diabetes Management Consent Form" (Part B of Child/Student Plan for Diabetes Management), which grants the school permission to administer diabetes care to my Child, and to communicate directly with the licensed prescriber. This "Child /Student Plan for Diabetes Management Form" is valid only for the current school year.
3. Deliver the licensed prescriber written instructions (Part A), this parental authorization (Part B), and the initial supply of needed supplies to the school.
4. Obtain additional written instructions from the licensed prescriber and deliver them to the school each time there is a change in instructions for diabetes care procedures.
5. Assume full responsibility for the safe delivery of supplies to appropriate school personnel.
6. Notify the school, in writing, if the diabetic care is discontinued during the school year.

MY SIGNATURE INDICATES THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

Parent/Guardian Signature_____ **Date**_____

Parent/Guardian Printed Name_____ **Phone**_____

Parent/Guardian Printed Address_____ **Fax**_____