717 JORDAN PUBLIC SCHOOLS
500 Sunset Drive
Jordan, Minnesota 55352
952-492-6200 main | 952-492-4445 fax

DISTRICT NURSE
jordannurse@isd717.org

Diabetes Care Plan

To assist your child in maintaining optimum health, it is necessary for the school to have current information regarding his/her diagnosis of diabetes. Written doctor's orders and parental permission is required each school year for the nurse to test your child's blood glucose level and to administer insulin.

Please be aware that:

1. A nurse may not always be available. If the school nurse is not available in a situation in which blood glucose testing and/or insulin administration is needed, the parents, designated staff or emergency medical assistance (911) will be notified depending on the situation.
2. All diabetic supplies must be provided by the family including snacks and juice.
3. The parent must notify the school nurse of any changes in the child's blood glucose monitoring and/or insulin orders that may occur during the school year. New orders must be written and signed by the ordering physician.

Please complete the attached forms and return to the indicated school as soon as possible.

_____ **Jordan Elementary School**
Address: 815 Sunset Drive, Jordan, MN 55352
Fax: 952-492-4446

_____ **Jordan Middle School**
Address: 500 Sunset Drive, Jordan, MN 55352
Fax: 952-492-4450

_____ **Jordan High School**
Address: 600 Sunset Drive, Jordan, MN 55352
Fax: 952-492-4425

Please contact us with any questions. We look forward to working with you and your child this coming school year!

Darci Griffiths MSN, RN, LSN
District Nurse - JHS
952-492-4410
jordannurse@isd717.org
Fax: 952-492-4425

Jenn Passe, RMA
Jordan Middle School
952-492-4232
Fax: 952-492-4450

Jenna Hentges, RN
Jordan Elementary School
952-492-4278
Fax: 952-492-4446

Diabetic Care Plan - Independent School District 717

This plan should be completed by the student's personal diabetes health care team, including the parents/guardians. It should be reviewed with relevant school staff and copies should be kept in a place that can be accessed easily by the school nurse and authorized personnel.

Date of plan: _____This plan is valid for the current school year: _____-_____

Student information
Student's name: _____ Date of birth: _____
Date of diabetes diagnosis: _____❑Type 1 ❑Type 2 ❑Other: _____ Grade: _____ Teacher: _____

Contact information
Parent/guardian: _____
Telephone: Work: _____ Cell: _____
Email address: _____

Parent/guardian: _____
Telephone: Home: _____Cell:_____
Email address: _____

Student's physician/health care provider: _____
Address: _____
Telephone: _____

Other emergency contacts: _____
Relationship: _____
Telephone: Work: _____ Cell: _____

Glucose Monitoring

Fingerstick blood glucose monitoring:

Brand/model of blood glucose meter: _____

Target range of blood glucose:

Before meals: ❑ 90–130 mg/dL ❑ Other: _____

Check fingerstick blood glucose:

❑ Before breakfast	❑ After breakfast	❑ _____ Hours after breakfast
❑ 2 hours after a correction dose	❑ Before lunch	❑ After lunch
❑ _____ Hours after lunch	❑ Before dismissal	❑ Mid-morning
❑ Before PE	❑ After PE	❑ Other: _____

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

Preferred site of testing: ❑ Side of fingertip ❑ Other: _____

Note: The side of the fingertip should always be used to check blood glucose level if hypoglycemia is suspected.

Student's self-care blood glucose checking skills:

❑ Independently checks own blood glucose
❑ May check blood glucose with supervision
❑ Requires a school nurse or trained diabetes personnel to check blood glucose
❑ Uses a smartphone or other monitoring technology to track blood glucose value

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Continuous glucose monitor (CGM):

Brand/model:_____

- Alarms set for: Severe Low: _____ Low: _____ High: _____
- Predictive alarm: Low: _____ High: _____ Rate of change: Low: _____ High: _____
  Threshold suspend setting: _____
- CGM may be used for insulin calculation if glucose is between _____-_____ mg/dL ❑ Yes ❑ No
- CGM may be used for hypoglycemia management ❑ Yes ❑ No
- CGM may be used for hyperglycemia management ❑ Yes ❑ No

Additional information for student with CGM

- Insulin injections should be given at least three inches away from the CGM insertion site.
- Do not disconnect from the CGM for sports activities.
- If the adhesive is peeling, reinforce it with approved medical tape.
- If the CGM becomes dislodged, return everything. Do not throw any part away.
- Refer to the manufacturer's instructions on how to use the student's device.

Student's self-care CGM skills: (check box if student is able to perform without assistance)

❑ The student troubleshoots alarms and malfunctions.
❑ The student knows what to do and is able to deal with a HIGH alarm.
❑ The student knows what to do and is able to deal with a LOW alarm.
❑ The student can calibrate the CGM.
❑ The student knows what to do when the CGM indicates a rapid rise/fall in blood glucose.

Student's Name _____

The student should be escorted to the nurse if the CGM alarm goes off: ❑ Yes ❑ No
Other instructions for the school health team:_____

Diabetic Emergencies

Hypoglycemia treatment

Student's usual symptoms of hypoglycemia (list below):

_____

_____

_____ If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than _____ mg/dL, give _____. Recheck blood glucose in 15 minutes and repeat treatment if glucose level is less than ____ mg/dL.
Additional treatment:_____

If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movement):

- Position the student on his or her side to prevent choking.

Administer glucagon: _____

Injection: ❑ 1 mg ❑ ½ mg ❑ Other (dose) _____

- Route: ❑ Subcutaneous (SC) ❑ Intramuscular (IM)
- Site for glucagon injection: ❑ Buttocks ❑ Arm ❑ Thigh ❑ Other: _____

Nasal route: ❑ 3 mg ▪ Intranasal (IN)

- **Call 911** and the student's parents/guardians.
- If on an insulin pump, suspend the pump or disconnect. **Send the pump to the hospital.**

Hyperglycemia

Student's usual symptoms of hyperglycemia (list below):

_____

_____

_____

- Check Urine for ketones every ____ hours when blood glucose levels are above _____ mg/dL.
- For blood glucose greater than _____ mg/dL AND at least _____ hours since the last insulin dose, give a correction dose of insulin (see correction dose orders).
- Notify parents/guardians if blood glucose is over _____ mg/dL.
- **For insulin pump users:** see Additional Information for Students with Insulin Pump.
- Allow unrestricted access to the bathroom.
- Give extra water and/or non-sugar-containing drinks (not fruit juices): _____ ounces per hour

Additional treatment for ketones: _____
- If the student has symptoms of a hyperglycemia emergency, call 911 and contact parents.

Student's Name _____

Insulin therapy

Insulin delivery device: ❑ Syringe ❑ Insulin pen ❑ **Insulin pump**

Type of insulin therapy at school:
❑ **Adjustable (basal-bolus) insulin** ❑ **Fixed insulin therapy** ❑ **No insulin**

Adjustable (Basal-bolus) Insulin Therapy

Carbohydrate Coverage/Correction Dose: Name of insulin: _____

Carbohydrate Coverage:

- Insulin-to-carbohydrate ratio:
  Breakfast: ___unit of insulin per ____ grams of carbohydrate

  Lunch: _____ unit of insulin per _____ grams of carbohydrate

  Snack: _____unit of insulin per _____ grams of carbohydrate

Carbohydrate Dose Calculation Example
Total Grams of Carbohydrate to Be Eaten ÷ Insulin-to-Carbohydrate Ratio = __ Units of Insulin

❑ **Correction Dose:** Blood glucose correction factor (insulin sensitivity factor) = _____
Target blood glucose = _____mg/dL

Correction Dose Calculation Example
(Current Blood Glucose – Target Blood Glucose) ÷ Correction Factor = _____ Units of Insulin

❑ **Correction dose scale (use instead of calculation above to determine insulin correction dose):**

Blood glucose _____ to _____ mg/dL, give _____ units

Blood glucose _____ to _____ mg/dL, give _____ units

Blood glucose _____ to _____ mg/dL, give _____ units

Blood glucose _____ to _____ mg/dL, give _____ units

When to give insulin with Adjustable (basal-bolus) insulin:

Breakfast

- ❑ Carbohydrate coverage only
- ❑ Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.
- ❑ Other: _____

Lunch

- ❑ Carbohydrate coverage only
- ❑ Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.
- ❑ Other: _____

Snack

- ❑ No coverage for snack
- ❑ Carbohydrate coverage only
- ❑ Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.
- ❑ Correction dose only: For blood glucose greater than _____ mg/dL AND at least _____ hours since last insulin dose.
- ❑ Other: _____

Fixed Insulin Therapy Name of insulin:_____

❑ _____ Units of insulin given pre-breakfast daily

❑ _____ Units of insulin given pre-lunch daily

❑ _____ Units of insulin given pre-snack daily

❑ Other: _____

Basal Insulin Therapy Name of insulin: _____
To be given during school hours:

❑ Pre-breakfast dose: _____ units

❑ Pre-lunch dose: _____ units

❑ Pre-dinner dose: _____ units

Other diabetes medications:

Name: _____ Dose: _____ Route: _____ Times given: _____

Name: _____ Dose: _____ Route: _____ Times given: _____

Parents/Guardians authorization to adjust insulin dose:

❑ Yes ❑ No Parents' authorization should be obtained before administering a correction dose.

❑ Yes ❑ No Parents are authorized to increase or decrease correction dose scale within the following range: +/- _____ units of insulin.

❑ Yes ❑ No Parents are authorized to increase or decrease insulin-to-carbohydrate ratio within the following range: _____ units per prescribed grams of carbohydrate, +/- _____ grams of carbohydrate.

❑ Yes ❑ No Parents/guardians are authorized to increase or decrease fixed insulin dose within the following range: +/- _____ units of insulin.

Student's self-care insulin administration skills:

❑ Independently calculates and gives own injections. (does not need to see nurse)

❑ May calculate/give own injections with supervision.

❑ Requires school nurse or trained diabetes personnel to calculate dose and student can give their own injection with supervision.

❑ Requires school nurse or trained diabetes personnel to calculate dose and give the injection.

Student with an INSULIN PUMP

Brand/model of pump: _____ Type of insulin in pump:_____

Basal rates during school: Time: _____ Basal rate: _____
Time: _____ Basal rate: _____
Time: _____ Basal rate: _____
Time: _____ Basal rate: _____
Time: _____ Basal rate: _____

Other pump instructions:

_____

_____

Type of infusion set: _____
Appropriate infusion site(s): _____

❑ For blood glucose greater than _____ mg/dL that has not decreased within _____ hours after correction, consider pump failure or infusion site failure. Notify parents/guardians.
❑ For infusion site failure: Insert new infusion set and/or replace reservoir, or give insulin by syringe or pen.
❑ For suspected pump failure: Suspend or remove pump and give insulin by syringe or pen.

Physical Activity with Insulin Pump

❑ May disconnect from pump for sports activities: ❑ Yes, for _____ hours ❑ No
❑ Set a temporary basal rate: ❑ Yes, _____% temporary basal for _____ hours ❑ No
❑ Suspend pump use: ❑ Yes, for _____ hours ❑ No

Student's self-care pump skills Independent?

Counts carbohydrates ❑ Yes ❑ No
Calculates correct amount of insulin for carbs consumed ❑ Yes ❑ No
Administers correction bolus ❑ Yes ❑ No
Calculates and sets basal profiles ❑ Yes ❑ No
Calculates and sets temporary basal rate ❑ Yes ❑ No
Changes batteries ❑ Yes ❑ No
Disconnects pump ❑ Yes ❑ No
Reconnects pump to infusion set ❑ Yes

Student's Name _____

❑ No

Prepares reservoir, pod and/or tubing ❑ Yes

❑ No

Inserts infusion set ❑ Yes

❑ No

Troubleshoots alarms and malfunctions ❑ Yes

❑ No

Meal/Snack	Time	Carbohydrate Content (grams)
Breakfast	_____	_____ to _____
Mid-morning snack	_____	_____ to _____
Lunch	_____	_____ to _____
Mid-afternoon snack	_____	_____ to _____

Other times to give snacks and content/amount: _____

_____

Special Considerations

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event): _____

Parent/guardian substitution of food for meals, snacks and special events/parties permitted.
Special event/party food permitted: ❑ Parents'/Guardians' discretion ❑ Student discretion
Student's self-care nutrition skills:

- ❑ Independently counts carbohydrates
- ❑ May count carbohydrates with supervision
- ❑ Requires school nurse/trained diabetes personnel to count carbohydrates

Physical activity and sports

A quick-acting source of glucose such as
❑ glucose tabs and/or ❑ sugar-containing juice must be available at the site of phy-ed/sports.
Student should eat ❑ 15 grams ❑ 30 grams of carbohydrate ❑ other: _____
❑ before ❑ every 30 minutes during ❑ every 60 minutes during ❑ after vigorous activity
❑ other: _____

If most recent blood glucose is less than _____ mg/dL, student can participate in physical activity when blood glucose is corrected and above _____ mg/dL.

Avoid physical activity when blood glucose is greater than _____ mg/dL or if urine/blood ketones are moderate to large.
(See Administer Insulin for additional information for students on **insulin pumps**.)

Signatures: This Diabetes Medical Management Plan has been approved by

_____

Physician/Health Care Provider Signature **Date**

I, (parent/guardian) _____ give permission to the school nurse or another qualified healthcare professional or trained diabetes personnel of (school) _____ to perform and carry out the diabetes care tasks as outlined in (student)

Student's Name _____

_____ Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified healthcare professional to contact my child's physician/health care provider. Acknowledged and received by:

Student's Parent/Guardian Signature Date

School Nurse Date

Student may independently manage all diabetic cares and will seek assistance as needed.

Parent/Guardian Signature

Student's Name _____