

SCHOOL DIABETES ORDERS – Pump:

NAME :

GRADE:

SCHOOL:

Start date: _____ for 2023-2024 school year. *Licensed Healthcare Provider (LHP) to Complete Annually*

LOW GLUCOSE (BG) MANAGEMENT

1. If BG is below 70 or SG < 80 with a downward arrow or student having symptoms, give _____ grams fast-acting carbohydrates per 504.
2. Recheck BG in 15 minutes and repeat carbohydrate treatment if BG still < 80 or if student continues to be symptomatic.
3. Once BG is > 80, may follow with 5-15 gram carb snack, or meal if time. Do not include low treatment in meal carbs.

If unconscious, unresponsive, difficulty swallowing, or evidence of seizure: Phone 911 immediately. Do NOT give anything by mouth.

☐ If nurse or PDA is available, administer Glucagon _____ mg SQ or IM -or- ☐ Baqsimi 3mg/nasal spray by nurse/designee.

HIGH GLUCOSE (BG) MANAGEMENT

1. Correction with Insulin

☐ If glucose is over 200 for 2 hours after last bolus or carbohydrate intake, student should receive correction bolus of insulin per insulin orders; pump will account for insulin on board (IOB).

☐ Never correct for high blood glucose other than at mealtime, unless consultation with student's LHP (Licensed Healthcare Provider) or as set up by 504 plan.

2. Ketones: Test urine/blood ketones if ☐ Glucose > 300 X 2hrs, or ☐ Never. Call guardian if having moderate/large ketones.
3. No exercise if having nausea or abdominal pain, or if ketones are tested and found positive (moderate or large).
4. Encourage student to drink plenty of water and provide rest if needed.

BLOOD GLUCOSE (BG) TESTING / SENSOR GLUCOSE (SG) VIA CONTINUOUS GLUCOSE MONITOR (CGM)

Use of sensor Glucose allowed for extra testing.

Glucose to be tested: ☐ Before meals and for symptoms of low or high glucose, or as set up by the 504 plan.

Extra glucose testing: ☐ before PE ☐ before going home unless pick up by guardian.

Glucose at which guardian should be notified: Low < 70 mg/dL after 2 treatments, or High > 300 mg/dL X 2 hours.

Notify guardian if repeated hypoglycemia, abdominal pain, nausea/vomiting, fever, hypoglycemic before going home, or if there is a refusal of care by the student. Hyperglycemia alone is not medically justified for sending student home in absence of symptoms.

INSULIN ADMINISTRATION at Mealtime/Snacks ☐ Apidra ☐ Humalog ☐ Novolog ☐ Fiasp ☐ Lyumjev

Insulin to Carb Ratio: 1 unit per _____ grams Carb

Glucose Correction Factor: 1 unit per _____ mg/dL > _____

Insulin bolusing to be given: ☐ before, or ☐ after meal

☐ Insulin injection should be used for pump malfunction

☐ Guardian authorized to adjust insulin for carbs, glucose level, activity

☐ after meal bolusing when before meal BG < 80 mg/dL

☐ Licensed medical personnel authorized to adjust the insulin dose by +/- 0 to 5 units after consultation with guardian

STUDENT'S SELF-CARE

1. Independent Diabetes Management - Student will ☐ perform all diabetes task independent of adult supervision. Guardian will work together with student to make dose adjustments as needed.

2. Student Needs Supervision - Specific supervision plan ☐ subject to parent, student, nurse and HCP approval and/or assessment, with ongoing re-evaluation, as identified in the IHP and 504 plan.

If patient wears Dexcom or FreeStyle Libre CGM insulin dose per orders based on SG reading per FDA. Test BG if no number, no arrow trend, or if symptoms/expectations do not correlate with SG reading.

If patient wears Medtronic CGM; Insulin per orders based on BG reading only per FDA.

DISASTER PLAN & ORDERS

Guardian is responsible for providing and maintaining "disaster kit" and to notify school nurse. In case of disaster:

Use above glucose correction scale + carb ratio coverage for disaster insulin dosing every 3hrs as indicated by BG levels and carbs.

Electronically signed by: _____

Fax: 509-474-2241 Phone: 509-474-2880

I authorize the exchange of medical information about my child's diabetes management between the LHP and the school nurse.

Parent Signature: _____

Print Name: _____

Date: _____

School Nurse Signature: _____

Print Name: _____

Date: _____

DIABETES INDIVIDUALIZED HEALTHCARE PLAN AND 504 ACCOMMODATION PLAN

Parent/Guardian and School Nurse to Complete Annually Together

Name _____ Birthdate _____ Grade _____
Last First MI Legal name (if different)

Start Date: _____ End Date: ☐ Last day of school ☐ other: _____

Brief History

Age of onset:	Results and date of Hemoglobin A1C test:
Date(s) of recent hospitalizations:	Related social/emotional factors:
Concurrent illness or disability (including medications):	

Substantial limitation in major life activities

All students with diabetes are substantially limited in the function of their endocrine system. Additional major life activities affected:

☐ Eating ☐ Caring for oneself ☐ Thinking ☐ Communicating ☐ Learning ☐ Other: _____

ACCOMMODATIONS

Daily Diabetes Routine

Daily snacks (time): _____

Recess times: _____

Blood glucose testing: Time/s: _____

Insulin dosing: Time/s: _____

Location/s: _____

Location/s: _____

Breakfast eaten at ☐ home ☐ school (time): _____

PE days/times: _____

Lunch eaten at (time): _____ Location/s: _____

District food services department will provide carbohydrate content information for meals provided by the district. Meals will never be withheld because of nonpayment of fees or disciplinary action.

Student will be allowed unrestricted access to water, meal/snack, and use of the restroom.

Classroom work and tests

Educators working with the student will be informed when the student has a blood glucose level (less than ____ or over ____) that may affect their cognitive and/or physical ability by: ☐ Written note ☐ Student verbally ☐ Other (specify) _____

- If the student is affected by high or low blood glucose levels at the time of regular testing, the student will be permitted to take the test at another time without penalty.
- If the student needs to take breaks to use the water fountain or bathroom, check blood glucose, or to treat hypoglycemia or hyperglycemia during a test or other activity, the student will be given extra time to finish the test or other activity without penalty.
- The student shall be given instruction to help him/her make up any classroom instruction missed due to diabetes care without penalty.
- The student shall not be penalized for absences required for medical appointments and/or for illness. The parent will provide documentation from the treating health care professional if otherwise required by school policy

Communication

- The school nurse, and other staff will keep the student's diabetes confidential, except to the extent that the student decides to openly communicate about it with others.
- Encouragement is essential. The student be treated in a way that encourages the student to eat snacks on time and to progress toward self-care with their diabetes management skills.
- The teacher, school nurse, or other school staff will provide reasonable notice to parent/guardian when there will be a change in planned activities such as exercise, playground time, field trips, parties, or lunch schedule, so that the lunch, snack plan, and insulin dosage can be adjusted accordingly.
- Each substitute teacher and substitute school nurse will be provided with written instructions regarding the student's diabetes care and a list of all school nurses and trained staff at the school.
- Communication from staff members to parents will be completed by: ☐ Written note ☐ Student verbally ☐ Other (specify): _____

Classroom parties: Food treats will be handled as follows:

- ☐ Student will eat treat ☐ Replace with parent/guardian supplied alternative ☐ Other _____
☐ Schedule extra insulin per prearranged plan.

Parent Designated Adult (PDA): Is a PDA present for your child? ☐ Yes (If Yes, PDA Documentation Required) ☐ No

After-school activities/school-sponsored events: _____

Note: Student will be permitted to participate in all school-sponsored activities without restriction and with all accommodations and modifications indicated in this plan.

Field trips: All diabetes supplies are taken and care is provided by: ☐ Licensed nurse ☐ PDA ☐ Other _____

Note: In the unplanned event where these options are unavailable, the student may remain at school and be provided a comparable experience or stay home when applicable.

Transportation: ☐ Takes the bus (Bus # _____) ☐ Walks ☐ Transported by parent/guardian

On-bus care is provided by: ☐ Licensed nurse ☐ PDA ☐ Other _____

Student will not be transported on school bus with BG < _____ or > _____ within 15 minutes of departure. Parent/guardian will be called to transport the student.

Additional accommodations:

Student uses and carries electronic device(s) for diabetic management: ☐ Yes ☐ No

If yes, please describe what is used: _____

EXTRA SUPPLIES (PROVIDED BY PARENT/GUARDIAN) AND LOCATION KEPT (including disaster supplies):

1.
2.
3.
4.
5.
6.

CONTACT INFORMATION

Parent/Guardian 1	Parent/Guardian 2
Name:	Name:
Home Phone:	Home Phone:
Work Phone:	Work Phone:
Other:	Other:

ADDITIONAL EMERGENCY CONTACTS:

1.	Relationship:	Phone:
2.	Relationship:	Phone:

LICENSED HEALTHCARE PROVIDER:

Name:	Phone:	Fax:
Location/Address:		

SIGNATURES:

Parent/Guardian:	Date:
Student:	Date:
School Nurse:	Date:

LIBERTY SCHOOL DISTRICT
HISTORY/QUESTIONNAIRE FOR STUDENTS WITH DIABETES

Name _____ Birthdate _____ Grade _____
Last First MI Legal name (if different)

1. At what age was your child diagnosed with diabetes? _____ ☐ Type 1 ☐ Type 2 ☐ Other _____
2. Has your child been hospitalized for diabetes? ☐ No ☐ Yes If yes, when: _____
3. Does your child have other health concerns or take other medications? ☐ Yes ☐ No
If yes, please list: _____
4. What insulin method of delivery does your child use? ☐ Vial/syringe ☐ Pen (type) _____ ☐ Pump (type) _____
 - Insulin administration: ☐ Requires assistance ☐ Requires supervision ☐ Independent
5. What form of glucagon is prescribed for your child? ☐ Injectable (type) _____ ☐ Intranasal
 - Has glucagon ever been given for severe low blood sugar? ☐ No ☐ Yes If yes, when: _____
6. What glucose monitoring device does your child use? ☐ meter ☐ CGM (brand/model) _____
 - Blood glucose monitoring: ☐ Requires assistance ☐ Requires supervision ☐ Independent
 - Ability to recognize signs of low and high blood sugar: ☐ Requires assistance ☐ Independent
7. How often does your child typically experience **low** blood sugar?
☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____
8. My child typically experiences low blood sugar:
☐ Morning ☐ Before lunch ☐ Afternoon ☐ Evening ☐ After Exercise ☐ Other _____
9. My child's symptoms of low blood sugar are: _____
10. How often does your child typically experience **high** blood sugar?
☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____
11. My child typically experiences high blood sugar:
☐ Morning ☐ Before lunch ☐ Afternoon ☐ Evening ☐ After Exercise ☐ Other _____
12. My child's symptoms of high blood sugar are: _____
13. Do you have concerns about your child being in school related to diabetes? _____
14. Does your child have concerns about being in school related to diabetes? _____
15. Will your child eat school meals? ☐ Breakfast ☐ Lunch ☐ no, meals will be provided from home
 - Carbohydrate counting: ☐ Requires assistance ☐ Requires supervision ☐ Independent
16. Any other information do you want us to know to best help your child in school? _____
17. How would your child prefer to share information about diabetes with classmates? _____

Parent signature _____

Phone _____

Date _____