SCS
SCOTT COUNTY SCHOOLS

Dear Parent/Guardian:

According to our health records, your **child has a diagnosis of diabetes that will require a Diabetes** Medical Management Plan at school.

Enclosed are the Scott County Schools **Guidelines for the management of student with Diabetes** and forms that will need to be completed **and returned to the School Nurse. We must have the** medication form along with the Glucagon **so that staff may administer it in case of an emergency.**

The information on these forms **will help us determine how best to help your child during the** school day and will be distributed to **appropriate school personnel on a need-to-know basis and** may include bus drivers, substitute teachers, **cafeteria staff, and others who work with your** student daily.

To help your child, please let us **know of any changes in your child's medical condition or emergency daytime phone numbers.**

The following forms need to be **completed and returned to your child's school at the start of the** school year.

- Administration of Medication **Forms for Glucagon and Insulin (parent and physician)**
- Diabetes Individualized Health Plan/Emergency Plan (parent and school nurse)
- Diabetes Medical Management **Plan** (provided by physician)

Please contact the School Nurse if you **have any questions.**

We are looking forward to a great year **with your student!**

Scott County School District Nurse

Billy Parker, Superintendent
2168 Frankfort Road | Georgetown, Kentucky 40324 | 502-863-3663 | www.scott.kyschools.us
Equal Opportunity Employer

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SCOTT COUNTY SCHOOLS

Management of Students with Diabetes Guidelines

PARENT/GUARDIAN RESPONSIBILITIES: Parents/guardians are integral to planning, care, and coordination of care for all students with diabetes. School nurses should involve the student's parent/guardian to the fullest extent possible. It is important for school nurses and parents/guardians to work collaboratively to provide for the health and safety of these students. Parents/guardians are responsible to:

- Inform the school nurse or other school health services staff that their student has diabetes
- Provide the school with emergency contact information that is accurate and updated as needed
- Provide the school with complete, accurate, and up-to-date medical information related to the student's diabetes
- Provide the appropriately completed written diabetes medical management plan/health care provider order form
- Provide timely communication to the school nurse regarding any changes in insulin pump settings
- Provide written authorization for sharing of information between the school and the student's diabetes care provider
- Provide any other health care provider orders
- Supply non-expired routine and emergency medications and medication administration and dosing devices/equipment as needed throughout the school year including: ♣ Insulin and insulin administration supplies; ♣ Blood glucose meter, test strips, lancets; ♣ Urine/blood ketone test strips; ♣ Glucagon kit; ♣ Batteries for meter and pump if applicable; ♣ Pump and pump supplies if appropriate; ♣ Fast acting sugar (and any needed measuring/dosing devices) as ordered by the health care provider; and ♣ Any other needed supplies to provide care according to provider orders
- Perform blood glucose monitor control testing or provide control solution to the school;
- Provide appropriate snacks and beverages (including a refillable water bottle if possible) for during school and for after-school time as needed
- Provide the school and the school nurse with up-to-date and timely information regarding the student's participation in school sponsored after-school activities (e.g., clubs, sports, academic supports/tutoring, make-up work) to allow a reasonable amount of time to arrange staffing for addressing the student's diabetes care needs;
- Work with the school team to develop the plan of care and the 504 plan to the best of their ability;
- Work with the school nurse to develop and implement a plan for increased diabetes care self-management, as appropriate, in collaboration with the student's health care provider;
- Provide the recommended and preferred medical identification bracelet/necklace indicating student has diabetes.

STUDENT RESPONSIBILITIES: Coordinating and managing the care of students with a diagnosis of diabetes requires the school nurse to communicate to the student their role in the planning process. Student participation in planning and responsibilities must be developmentally appropriate and may include, but are not limited to:

- Provide accurate, timely and up-to-date information regarding after-school activities to allow a reasonable amount of time to plan for staffing to meet the student's diabetes care needs
- Follow diabetes management plan/IHP
- Communicate with the school nurse or other designated school staff regarding symptoms of hypoglycemia or hyperglycemia and other illnesses which may impact diabetes management
- Communicate accurate information regarding carbohydrate intake;
- Act responsibly when possessing and self-administering medications, specifically, not to misuse medication
- Dispose of sharps appropriately; use standard precautions as instructed by the school nurse;
- Collaborate with the school nurse, parent/guardian and health care provider in care planning (as capable to do so)
- Provide timely communication to the school nurse regarding changes in pump settings
- Provide self-management or participate in learning self-management

SCHOOL RESPONSIBILITIES: School administrators should work closely with school nurses and other school staff to plan and coordinate the care for these students. The school administrator and school nurse collaborate to gather, maintain, and review school-wide information required to meet the student's needs. The school should provide the following:

- Sharps containers
- Appropriate storage for insulin and syringes
- Access to medication, blood glucose monitoring and ketone testing equipment, and snacks
- Meal and snack accommodations (if applicable) in compliance with USDA requirements
- Adequate staffing to administer insulin and glucagon according to the student's diabetes management plan, individualized health plan, and emergency plan
- Appropriate staff to provide or support the needed diabetes care during school sponsored events and field trips based on the student's DMMP/health care provider orders and nursing assessment.

SCHOOL ADMINISTRATOR RESPONSIBILITIES School administrators must be aware of students with a diagnosis of diabetes, and should work with the school nurse to support the implementation of a team approach to the health care needs of all students including those with diabetes. School nurses should provide aggregate data to the school administrator on the number of students with diabetes in the student population, and any needed accommodations. School administrator responsibilities are to:

- Support the school nurse as the leader of the school health services team
- Ensure the education and safety of the student
- Review data provided by the school nurse regarding students with diabetes and needed accommodations
- Support the school nurse's training, outreach, education, and awareness activities, which include, but are not limited to: ♣ Training school staff (e.g., coaches, teachers, cafeteria workers, bus drivers) to recognize signs and symptoms of hyperglycemia and hypoglycemia, to use emergency medications as indicated in students' emergency plan according to local policy; ♣ Planning for implementation of student DMMP/health care provider orders, IHP and emergency plans during school sponsored events; ♣ Providing outreach and education for parents/guardians, other caregivers, and the general school community; ♣ Ensuring classroom teachers, including substitute teachers, have access to emergency plans; ♣ Making routine medications and testing equipment as accessible as possible to minimize disruption to education and avoid treatment delay; and ♣ Making emergency medications, fast acting carbohydrates, and water as accessible as possible to avoid treatment delay; ♣ Supporting the school nurse's efforts to promote adherence to the parent/guardian and student responsibilities
- Support the school nurse's recommendations regarding school health services staffing necessary to administer insulin and glucagon according to the student's DMMP/health care provider orders, IHP, and emergency plan
- Support the school nurse's decision to identify and train appropriate school staff on the school system policy to ensure trained school staff is available to respond in an emergency including administration of emergency medications
- Support the school nurse's decision to identify and train appropriate school staff on the school system policy and applicable federal and state laws and regulations to ensure trained school staff is available to assist in the implementation of the student's IHPs when needed and when appropriate as determined by the school nurse
- Support implementation of the student's Section 504 plan, IEP or other written accommodation plan and other state or federal laws related to needed accommodations
- Support the participation of students with diabetes on field trips, during after-school activities, and other school sponsored events by providing needed diabetes management care in accordance with the student's DMMP/health care provider orders, IHP, Section 504 plan or IEP (if applicable), and emergency plan.

SCOTT COUNTY SCHOOLS

Diabetic Emergency Care Plan

(photo)

Student's Name: _____ DOB_____ Date of Plan_____

School_____ Grade/Teacher_____ Car Rider____ Bus Rider____ Bus Number_____

Age at Diagnosis_____ Other Health Concerns_____Medications_____

Insulin: Yes__ No__ Glucagon: Yes__ No__ Pump: Yes__ No__ Glucose Monitor: Yes__ No__

Emergency Contact Information

Parent 1/Guardian: _____

Email Address: _____ Home Phone: _____

Work Phone: _____ Mobile: _____

Parent 2/Guardian: _____

Email Address: _____ Home Phone: _____

Work Phone: _____ Mobile: _____

Health Care Provider: _____

Phone Number: _____

School Nurse: _____

Contact Number(s): _____

Trained Diabetes Personnel: _____

Contact Number(s): _____

Other Information: _____

_____

_____

_____

Kitty Parker, Superintendent
2168 Frankfort Road | Georgetown, Kentucky 40324 | 502-863-3663 | www.scott.kyschools.us
Equal Opportunity Employer

Student's Name_____

Hypoglycemia (low blood sugar)

Causes of Hypoglycemia	Onset of Hypoglycemia
• Too much insulin • Missing or delaying meals or snacks • Not eating enough food (carbohydrates) • Getting extra, intense, or unplanned physical activity • Being ill, particularly with gastrointestinal illness	• Sudden—symptoms may progress rapidly

Hypoglycemia Symptoms	
Circle student's usual symptoms.	
Mild to Moderate	**Severe**
• Shaky or jittery • Sweaty • Hungry • Pale • Headache • Blurry vision • Sleepy • Dizzy • Lightheaded • Confused • Disoriented • Uncoordinated • Irritable or nervous • Argumentative • Combative • Changed personality • Changed behavior • Inability to concentrate • Weak • Lethargic • Other: _____	• Inability to eat or drink • Unconscious • Unresponsive • Seizure activity or convulsions (jerking movements)

Actions for Treating Hypoglycemia	
Notify school nurse or trained diabetes personnel as soon as you observe symptoms. If possible, check blood glucose (sugar) at side of finger. Treat for hypoglycemia if blood glucose level is less than _____ mg/dL. WHEN IN DOUBT, ALWAYS TREAT FOR HYPOGLYCEMIA AS SPECIFIED BELOW.	
Treatment for Mild to Moderate Hypoglycemia	**Treatment for Severe Hypoglycemia**
☐ Provide quick-acting glucose (sugar) product equal to _____ grams of carbohydrates. Examples of 15 grams of carbohydrates are listed below: • 4 glucose tablets • 1 tube of glucose gel • 4 ounces of fruit juice (not low-calorie or reduced sugar) • 4-6 ounces (½ can) of soda (not low-calorie or reduced sugar) • _____ ☐ Wait 15 minutes. ☐ Recheck blood glucose level. ☐ Repeat quick-acting glucose product if blood glucose level is less than _____ mg/dL. ☐ Contact the student's parents/guardians. ☐ Once the student's blood glucose returns to normal, check the blood glucose level 1 hour later.	☐ Position the student on his or her side. ☐ Do not attempt to give anything by mouth. ☐ Administer glucagon: _____mg at _____site. ☐ While treating, have another person call 911 (Emergency Medical Services). ☐ Contact the student's parents/guardians. ☐ Stay with the student until Emergency Medical Services arrive. ☐ Notify student's health care provider.

Student's Name_____

Hyperglycemia (high blood sugar)

Causes of Hyperglycemia	Onset of Hyperglycemia
• Too little insulin or other blood glucose-lowering medications • Insulin pump or infusion set malfunction • Food intake that has not been covered adequately by insulin • Decreased physical activity • Illness • Infection • Injury • Severe physical or emotional stress	• Over several hours or days

Hyperglycemia Symptoms	Hyperglycemia Emergency Symptoms: Diabetic ketoacidosis (DKA), which is associated with hyperglycemia, ketosis, and dehydration
Circle student's usual signs and symptoms	
• Increased thirst and/or dry mouth • Frequent or increased urination • Change in appetite and nausea • Blurry vision • Fatigue • Other: _____	• Dry mouth, extreme thirst, and dehydration • Nausea and vomiting • Severe abdominal pain • Fruity breath • Heavy breathing or shortness of breath • Chest pain • Increasing sleepiness or lethargy • Depressed level of consciousness

Actions for Treating Hyperglycemia	
Notify school nurse or trained diabetes personnel as soon as you observe symptoms.	
Treatment for Hyperglycemia	**Treatment for Hyperglycemia Emergency**
☐ Check the blood glucose level. ☐ Check urine or blood for ketones if blood glucose levels are greater than _____ mg/dL. ☐ Calculate the Insulin Correction Dose needed as specified in the DMMP. ☐ Administer supplemental insulin dose: _____. (If student uses a pump, see instructions below.) ☐ Give extra water or non-sugar-containing drinks (not fruit juices): _____ ounces per hour. ☐ Allow free and unrestricted access to the restroom. ☐ Recheck blood glucose every 2 hours to determine if decreasing to target range of _____ mg/dL. ☐ Restrict participation in physical activity if blood glucose is greater than_____ mg/dL and if ketones are moderate to large. ☐ Notify parents/guardians if blood glucose is greater than _____mg/dL or if ketones are present.	☐ Call parents/guardians, student's health care provider, and 911 (Emergency Medical Services) right away. ☐ Stay with the student until Emergency Medical Services arrive.

Individualized Health Care Plan (IHP)

Student: _____

School: _____

Grade: _____ School Year: _____

IHP Completed by: _____ Date: _____

IHP Review Dates: _____

Nursing Assessment Review Dates: _____

Nursing Assessment Completed by: _____ Date: _____

Nursing Diagnosis	Sample Interventions and Activities	Date Implemented	Sample Outcome Indicator	Date Evaluated
Managing Potential Diabetes Emergencies (risk for unstable blood glucose)	Establish and document student's routine for maintaining blood glucose within goal range including while at school: • Where to check blood glucose: ☐ Classroom ☐ Health room ☐ Other: _____ • When to check blood glucose: ☐ Before breakfast ☐ Mid-morning ☐ Before lunch ☐ After lunch ☐ Before snack ☐ Before PE ☐ After PE ☐ 2 hours after correction dose ☐ Before dismissal ☐ As needed ☐ Other: _____ • Student's self-care skills: ☐ Independent ☐ Supervision ☐ Full assistance • Brand/model of BG meter: _____ • Brand/model of CGM: _____		**Blood glucose remains in goal range** Percentage of time 0% 25% 50% 75% 100%	

NDEP National Diabetes Education Program
A program of the National Institutes of Health and the Centers for Disease Control and Prevention

Nursing Diagnosis (continued)	Sample Interventions and Activities (continued)	Date Implemented (continued)	Sample Outcome Indicator (continued)	Date Evaluated (continued)
Supporting the Independent Student (effective therapeutic regimen management)	**Hypoglycemia Management** **STUDENT WILL:** • Check blood glucose when hypoglycemia suspected • Treat hypoglycemia (follow Emergency Care Plans for Hypoglycemia and Hyperglycemia) • Take action following hypoglycemia episode • Keep quick-acting glucose product to treat on spot • Type: _____ • Routinely monitor hypoglycemia trends r/t class schedule (e.g., time of PE, scheduled lunch, recess) and insulin dosing • Report to and consult with parents/ guardians, school nurse, HCP, and school personnel as appropriate		**Monitors blood glucose and appropriately responds to results** Percentage of time 0% 25% 50% 75% 100%	
Supporting Positive Coping Skills (readiness for enhanced coping)	**Create Positive School Environment** • Ensure confidentiality • Discuss with parents/guardians and student preferences about how school can support student's coping skills • Collaborate with parents/guardians and school personnel to meet student's coping needs • Collaborate with school personnel to create accepting and understanding environment		**Demonstrates positive coping** Percentage of time 0% 25% 50% 75% 100%	

Permission Form for Prescribed or Over-the-Counter Medication

School: _____ Date form received by the School: _____

Student's Name: _____ **Grade:** _____ **Homeroom/Classroom:** _____

Student's Age: _____ **Date of Birth:** _____

TO BE COMPLETED BY THE PHYSICIAN OR HEALTH CARE PROVIDER FOR PRESCRIPTION AND NON-PRESCRIPTION (OVER-THE-COUNTER "OTC") MEDICATION

Name of medication: _____ Reason for medication: _____

Form of medication/treatment: ☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

Describe schedule and dose to be given at school: _____

Starting Date: ☐ date form received ☐ Other, as specified: _____

Stopping Date: ☐ for episodic/emergency events only ☐ end of school year ☐ Other date/duration: _____

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other _____

Restrictions and/or important side effects: ☐ No restrictions/side effects ☐ Yes. Please describe:

_____

NOTE: ***In the event the Principal/designee is notified of the possibility of an adverse or extreme reaction to a medication, s/he shall inform the student's teacher(s) of such a possibility before the student begins the medication schedule.***

Pursuant to KRS 158.832 to 158.836, Scott County Schools permits a student to possess and self-administer medications for asthma, diabetes, or anaphylaxis at school and at school-related function upon completion of the following information by the parent/guardian and the student's physician and waiver of liability by the parent/guardian.

Student has been instructed in self-administering the medication to be completed for asthmatic, diabetic, or severe allergic reactions (anaphylaxis) ONLY: ☐No ☐Supervision Required ☐ Supervision Not Required

Student must carry this medication on his/her person: ☐No ☐Yes

Please indicate additional information: ☐ On the back side of this form ☐ As an attachment

_____ _____

Physician/Health Care Provider Signature ***Date***

_____ _____

Signature of Parent/Guardian ***Date***

Name of Physician/Health Care Provider: _____

Address: _____

Phone #: _____ **Fax #:** _____

To the school: Please report concerns about medications or the student's condition to the above physician/health care provider.

SCHOOL PERSONNEL: PLEASE ENSURE PAGE 2 OF THIS FORM IS ALSO COMPLETED.

Permission Form for Prescribed or Over-the-Counter Medication

FOR ALL MEDICATIONS

I give permission for _____ to receive the above medication(s) at school according
Student's Name
to standard school policy and expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration of the above medication unless such is the result of negligence or misconduct on behalf of the school or its employees. For on-going medications, I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable orders from a physician or health care provider to be followed.

Date: _____ *Signature:* _____ *Relationship:* _____

Home Phone: _____ *Work Phone* _____ *Emergency Phone* _____

TO BE COMPLETED BY SCHOOL PERSONNEL

I/we acknowledge receipt of the foregoing statement and authorization.

Administrator/designee _____ Date _____