

Fox Chapel Area School District
Individualized Health Care Plan - Diabetes

Student Information

Student Name: _____

Grade: _____

Age: _____

Homeroom: _____

School Year: _____

Overview

Type 1 insulin-dependent diabetes is a disorder affecting the body's ability to use blood sugar (glucose). The result is too much sugar in the blood. Treatment generally consists of insulin, food management, and exercise. The goal is for the student to lead a normal, healthy, active school life. With careful management, diabetes can be well-controlled and allow children to lead healthy, active, fun-filled lives.

Low Blood Sugar (Hypoglycemia)

Low blood sugar commonly occurs when blood glucose falls below 70 mg/dL and should be treated promptly. Most students are aware when their blood sugar is low, but it can drop suddenly and, if not treated properly, can be an emergency.

Possible Causes

- Too much insulin
- Extra exercise
- Missed snack
- Less food than usual at a meal

Prevention

Eat meals/snacks on schedule, especially during exercise, and recognize and treat symptoms promptly.

Signs and Symptoms

- Hunger
- Headache
- Tiredness
- Nausea/stomachache
- Difficulty concentrating
- Daydreaming

- Weakness/dizziness
- Shakiness
- Irritability
- Pale, moist skin
- Confusion
- Slurred speech
- Poor coordination
- Sweating (clammy)
- Personality changes
- Crying
- Uncooperative behavior
- Combative behavior
- Other (specific to student): _____

If the above symptoms are ignored or go unrecognized, loss of consciousness or seizures may result. These serious side effects, however, rarely occur. **Never send a student to the nurse alone when they are experiencing symptoms.**

Treatment

If the student is conscious and able to swallow, provide ONE of the following:

- Fruit juice (1/2 cup–1 cup)
- Glucose tablets (2–4)
- Regular soda (6 oz.)
- Glucose gel
- Student-preferred fast-acting carbohydrate: _____

If symptoms do not improve within 15 minutes, repeat treatment. The student should not be left alone until the symptoms are completely gone. Once symptoms improve, provide a snack such as crackers or milk if the next meal is more than 30 minutes away.

Juice is the preferred treatment because it is quickly absorbed and fast-acting. The juice must be readily available. Please write down where you will keep it so that substitute personnel can access it.

Juice will be kept: _____

If student loses consciousness, cannot swallow, or has a seizure:

- Administer glucagon immediately (school nurse/designated personnel). The emergency glucagon kit is available _____.
- Call 911
- Notify parent/guardian

Does the child wear a medic alert tag: ☐ Yes ☐ No

Does the student carry sugar: ☐ Yes ☐ No If yes, where? _____

High Blood Sugar (Hyperglycemia)

Hyperglycemia occurs when blood sugar levels get too high. Symptoms may include excessive thirst, fatigue, weakness, frequent urination, and blurred vision.

If blood sugar is over _____ at school, follow these instructions:

Blood Glucose Testing

Blood sugar testing involves pricking a finger, placing a drop of blood on a test strip, using a glucometer, and recording the results. The information is then recorded and insulin doses adjusted based on test results. This procedure is typically done in the nurse's office.

Testing Times:

☐ Before lunch

☐ Before snacks

☐ Before exercise

☐ After exercise

☐ Symptoms of high/low glucose

☐ Other: _____

Meals and Snacks

Allow the student to follow their routine discreetly and permit snacks, blood glucose testing, or insulin administration as needed.

Scheduled snack in school: ☐ Yes ☐ No

Snack before/after exercise: ☐ Yes ☐ No

Snack time(s): _____ Reminder needed: ☐ Yes ☐ No

Water and Bathroom Access

Student should have unrestricted access to water and restroom facilities.

School Parties and Special Events

☐ May consume any classroom food/drink without restriction

☐ Only food pre-approved by parent/guardian

☐ Only food/drink provided by parent

☐ Other: _____

Bus Travel / Field Trips / Cafeteria / Physical Education / Other

The student will be permitted to drink/eat food on the bus at any time. Special arrangements for bus travel:

Special arrangements for field trips:

Special arrangements in cafeteria:

Low blood sugar may occur during exercise, and a source of instant sugar (juice) should be nearby. Special instructions for physical education:

Please address any other issues, guidelines, or special precautions that you feel are important to your child's safety and care during the school day. Please include **food allergies** or **special dietary needs**.

After-School Activities

Parents/guardians: Please make sure your child has a snack and juice with them at all times. If your child needs an additional snack or juice, please contact the school nurse.

Supplies and Equipment

Parents/guardians are to provide the following necessary supplies and equipment:

1. Emergency low blood sugar kit: glucagon, glucose gel, juice, glucose tablets, prepackaged snacks, etc. Please indicate where you would like the kits to be kept (i.e. nurse's office, classroom, bus, etc.): _____
2. High blood glucose supplies, including ketone test strips/bottle and a water bottle or drink indicated for highs
3. Insulin supplies, including insulin, syringes, and extra pump supplies
4. Regular snacks and juice
5. Glucometer, testing strips, lancing device, and lancet

Parent/Guardian Consent for Management of Diabetes at School

The information in this care plan is a supplement to more detailed information, instructions, and physician's orders, which are kept in the nurse's office. Including but not limited to Guidelines for Managing the Student With Diabetes and Physician's Orders for Management of Insulin.

We (I), the undersigned, the parent(s)/guardian (s) of the above-named pupil, request that the above health care plan service for the management of diabetes in school be administered to our (my) child.

1. Provide the necessary supplies and equipment
2. Notify the nurse if there is a change in pupil health status
3. Notify the school nurse immediately and provide new physician's consent for any changes.

I authorize the school nurse to communicate with the physician when necessary.

For the safety and well-being of your child, we must be able to reach a parent/guardian at all times.

My signature below indicates that I have read and completed the above information and give my permission for the individualized health plan to be released to all school personnel.

Parent/Guardian Signature: _____

Date: _____

Physician Authorization for Diabetes Management in School

My signature below authorizes the above-written orders and the Guidelines for Managing the Student With Diabetes (colored flip cards). This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization upon request.

Physician Name: _____

Physician Signature: _____

Date: _____

Type 1 Insulin Dependent Diabetes Physician Orders Form

Student's Name (Last Name, First Name): _____

Grade: _____

I request that my child be assisted in taking the medicine (s) described below at school by authorized personnel or permitted to medicate themselves (as outlined below), also by my physician and me. We agree to hold the school, its offices, agents, and employees harmless in administering the medication pursuant to the physician's written instructions. We further agree to notify you promptly when it is no longer necessary to administer this medication.

Parent/Guardian Signature _____

Date: _____

The following is to be completed by a physician:

Insulin

If insulin is to be given at school, please indicate:

Brand name and type: _____

Form: _____

Time(s): _____

Dose/sliding scale: _____

Additional instructions: _____

Glucagon Injection

Brand name and type: _____

Form: Injection

Time(s): PRN (as needed)

Dose: _____

Indicated for: Loss of consciousness, seizure, inability to swallow or:

Additional instructions: _____

Date: _____

Physician's Signature: _____

Note: Prescription medicine must be in the original prescription-labeled container.