Student Photo Here

INDIVIDUAL HEALTH CARE/EMERGENCY PLAN FOR STUDENT WITH DIABETES

PHYSICAN AND PARENT PLEASE COMPLETE THIS FORM AND RETURN TO YOUR CHILD'S SCHOOL

TO BE RENEWED EACH SCHOOL YEAR

(If you need assistance completing this form, contact the school nurse)

Student Name: _____ Birth Date: _____

School: _____ Grade: _____ School Year: _____

Emergency Contact information:

	Name/Relationship	***Home #***	***Work #***	***Cell #***
1.	Parent/Guardian:			
2.				
3.				
4.	Diabetes Care Provider	Phone #		Fax #
5.	Diabetes Nurse Educator	Phone #		Fax#

I. BLOOD GLUCOSE MONITORING

Blood glucose target range: _____ - _____ mg / dl

Required Blood Glucose testing:
(Check all that apply)

- ☐ Trained personnel must perform
- ☐ Trained personnel must supervise
- ☐ Student can self manage
- ☐ Student can recognize & treat hypoglycemia
- ☐ Student can recognize & treat hyperglycemia

Times to do blood glucose testing:
(Check all that apply)

- ☐ Before lunch
- ☐ Before snack
- ☐ Before physical exercise
- ☐ As needed

List other: _____

Parent to be notified for blood glucose less than _____ greater than _____.

II. FOR STUDENT WITH INSULIN PEN OR SYRINGE

Type of insulin given at school: _____

Time(s): ____Before lunch ____After lunch ____ Other: _____

Dose determined by: ***(Check all that apply)***

☐ Standard lunchtime dose: _____.

☐ Insulin / carbohydrate ratio: _____ unit(s) per _____ gms

☐ Correction calculation to be used for pen / syringe:

_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl

- Student can determine correct amount of insulin ☐ yes ☐ no
- Student can draw correct amount of insulin ☐ yes ☐ no
- Student can inject own insulin ☐ yes ☐ no

☐ Health file

Student Name_____

III. FOR STUDENT WITH INSULIN PUMP

Type of pump: _____Type of insulin in pump: _____

Insulin sensitivity : _____

Insulin / carbohydrate ratio: _____ unit(s) insulin per _____ gms

Blood glucose correction: _____ unit(s) for each _____ mg/dl over _____

- Student needs assistance checking insulin dosage ☐ yes ☐ no
- Student can self-manage insulin pump ☐ yes ☐ no
- **School personnel will not be responsible for changing pump settings, filling insulin cartridges or changing infusion sites and tubing. The parent/guardian will be contacted to make any changes.**

IV. SNACKS AT SCHOOL

Morning/afternoon snack times may or may not be offered by your student's school. Please complete sections **a** through **c** if using an insulin pen/syringe and sections **c** through **e** if using an insulin pump.

a. ☐ Student is to use a "free carb" or predetermined snack.

b. ☐ Snack choice is determined by blood glucose **without** giving insulin bolus.

_____Bg _____gm carb snack

_____Bg _____gm carb snack

_____Bg _____gm carb snack

c. On special occasions student may participate when food is being provided for students in their classroom. ☐ Yes ***or*** ☐ No

☐ Insulin bolus to be given at time carb snack is consumed

☐ Insulin bolus to cover afternoon snack can be predetermined and given with lunch bolus if snack consumed within 1 ½ hours of insulin administration.

d. ☐ Student is to use a "free carb" or predetermined snack.

e. ☐ Carb choice determined by blood glucose with pump determining need for insulin bolus.

V. EMERGENCY CARE PLAN

HIGH BLOOD GLUCOSE: Student must be treated when blood sugar is above _____.

Symptoms: Please circle all that apply:

Extreme thirst, headache, abdominal pain, nausea, vomiting, frequent urination

Additional symptoms: _____

Treatment:

- Drink 8-16 oz. of water every hour (student encouraged to carry water bottle).
- Use restroom as often as needed.
- **Do not allow exercise if blood glucose above _____.**
- **Recheck blood glucose in one hour and report results to school nurse.**
- **Parent will provide ketone testing equipment ☐ yes ☐ no**
  - **Check ketones if blood glucose above _____.**
  - **Report ketones above _____to parent.**

MILD LOW BLOOD GLUCOSE:

Symptoms: Please circle all that apply:

Hunger, irritability, shakiness, sweating, paleness, uncooperative, crying or other behavioral changes

Additional symptoms:_____

Treatment: With any level of low blood glucose ***never*** leave student unattended. If treated outside the classroom, **a responsible person should accompany the student to the Health Service Office** for further assistance.

- Test blood glucose. If blood glucose monitor is not available, treat student immediately per symptoms.
- If blood glucose is below _____, give 4 oz. of juice or 6 oz. (1/2 can) or regular sugar soft drink or 3-4 glucose tablets.
- Wait 15 minutes. Recheck blood glucose. Re-treat as above if still below _____.
- Follow with snack or lunch when blood glucose rises above _____ or when symptoms improve.
- If symptoms continue call school nurse and parent/guardian.

MODERATE LOW BLOOD GLUCOSE:

Symptoms: Please circle all that apply:

Hunger, irritability, shakiness, sleepiness, sweating, paleness, uncooperative, crying, behavior changes, combative, disoriented or incoherent

Additional symptoms:_____

Treatment: If student is conscious yet unable to effectively drink the fluids offered:

- Administer 1 tube (15 gms) of glucose gel. Place between cheek and gum with head elevated. Encourage student to swallow.
- Call school nurse and parent/guardian.
- Recheck blood glucose in 15 minutes. If still below _____, re-treat as above.
- Follow with snack or lunch when blood glucose rises above _____ or when symptoms improve.

SEVERE LOW BLOOD GLUCOSE:

Symptoms: Seizures or loss of consciousness

Emergency treatment:

- **Call 911 and parent (notify the office) * Stay with student * Roll student on side & protect from injury**
- **Do not put anything to eat or drink in student's mouth.**
- **Attempt to administer 1 tube (15 gms) of glucose gel in student's cheek pouch closest to ground & massage cheek.**

VI. PHYSICIAN AUTHORIZATION

- **Glucagon will be given if ordered by physician, provided by parent, and trained nurse is available.**
  Glucagon is recommended at school ☐ Yes ☐ No
  Glucagon: Dosage _____ Route_____
- My signature below provides authorization of the above procedures for the current school year.
- If changes are indicated, I will provide new written authorization (may be faxed).
- Student is ready to perform and manage diabetes care and procedures as outlined in this "Individual Health Care/Emergency Plan for Students with Diabetes". ☐ yes ☐ no (Parent/guardian and School Nurse must verify competency as well)

Physician signature: _____ Date: _____

Printed Physician name: _____

Clinic/Office address: _____ Phone #_____

Student Name_____

Parent / Guardian- Please sign either VII or VIII

VII. PARENT / GUARDIAN AUTHORIZATION

1. I will be responsible for maintaining necessary supplies, including glucose, snacks, testing kit and insulin.
2. I will contact the school nurse in advance of school field trips my child will be participating in.
3. I request that the insulin listed above be given during school hours (no after school activities) as ordered by my child's physician.
4. I give permission for the school nurse to consult with my child's physician with regard to diabetes, insulin and emergency plan.
5. I give permission for the school nurse to communicate with the appropriate school staff about the action and side effects of the insulin.
6. I will provide a new consent form from the physician if changes occur with any portion of this medical management. I understand I will need to carry out the cares at school until new physician authorization is obtained (may be faxed.)
7. I will provide the insulin in the original bottle or pen that is labeled with my child's name.
8. I release the school nurse or designee from any liability in relation to the administration of the insulin at school.
9. **I understand if my child rides the school bus and/or participates in before or after school activities, it is my responsibility to inform the staff/bus company of my child's diabetes plan.**

Parent/Guardian Signature: _____Date: _____

School Nurse Signature: _____Date: _____

OR

VIII. PARENT / GUARDIAN AUTHORIZATION FOR STUDENT SELF-MANAGEMENT

If physician indicates that student can self-manage diabetes, the Licensed School Nurse will meet with him/her to assess student's knowledge and skill(s) to safely manage diabetes during school hours.

1. I request that my child self-manage his/her diabetes and be responsible for all necessary supplies and equipment, blood glucose testing, carbohydrate calculations / meal plans, insulin dosage and administration as ordered by child's physician.
2. I will contact the school nurse if any of the above information changes.
3. **I understand that my child will inform all staff, including principals, teachers, coaches, and bus drivers, of his/her diabetes plan and building location of blood glucose testing.**

Parent/Guardian Signature: _____ Date:_____

School Nurse Signature: _____Date: _____