Fayette County School Health Services

DIABETES HEALTH CARE PLAN

Please bring or mail this health care plan to the school or send to the secure FAX at 770-460-3928.

Student: _____ Date of Birth: _____ School Year: 20___ - 20___

School: _____ Homeroom Teacher: _____ Grade/Team: _____

EMERGENCY CONTACTS

Parent/Guardian/Contact	*Relationship*	*Phone Number*	*Email*
Diabetes Healthcare Provider:		***Phone Number:***	

EMERGENCY NOTIFICATION

Notify parents of the following conditions:

- ☐ Loss of consciousness or seizure immediately after calling 911 and administering Glucagon
- ☐ Blood sugar in excess of _____ mg/dl.
- ☐ Positive urine ketones.
- ☐ Abdominal pain, nausea/vomiting, fever, diarrhea, altered breathing, or altered level of consciousness.

STUDENT'S COMPETENCE WITH PROCEDURES *(Must be verified by parent and Clinic Staff)*

☐ Blood glucose (BG) monitoring	☐ Carry supplies for BG monitoring
☐ Determining insulin dose	☐ Carry supplies for insulin administration
☐ Measuring insulin	☐ Monitoring BG in classroom
☐ Injecting insulin	☐ Self treatment for mild low blood sugar
☐ Independently operates insulin pump	☐ Determine own snack/meal content

MEAL PLAN

	Time	*Location*	*CHO Content*		*Time*	*Location*	*CHO Content*
☐ Breakfast				☐ Mid-PM			
☐ Mid-AM				☐ Before PE			
☐ Lunch				☐ After PE			

Meal/snack will be considered mandatory. Content of meal/snack will be determined by:
☐ *Student* ☐ *Parent* ☐ *Clinic Staff* ☐ *Diabetes Healthcare Provider*

LOCATION OF SUPPLIES/EQUIPMENT: Parent to provide and restock supplies. *(Completed by Clinic Staff)*

Blood glucose equipment:	☐ Clinic	☐ With Student
Insulin administration supplies:	☐ Clinic	☐ With Student
Glucagon emergency kit:	☐ Clinic	☐ With Student
Fast acting carbohydrate:	☐ Clinic	☐ With Student
Snacks:	☐ Clinic	☐ With Student

I, this child's parent/guardian, hereby authorize the named Healthcare Provider who has attended to my child, to furnish to the School Health Services Coordinator and/or School Clinic Staff any medical information and/or copies of records pertaining to my child's diabetes and for this information to be shared with pertinent school staff at my child's school.. I understand that as of April 14, 2003, under the Health Insurance Portability and Accountability Act ("HIPAA") disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance in the Fayette County Schools. This authorization expires as of the last day of the school year.

Parent/Guardian's Signature: _____ Date: _____

Clinic Staff's Signature: _____ Date: _____

Implemented: August 2001
Revised: February 6, 2002; August 2003; August 2, 2004; September 9, 2005; February 20, 2006; April 13, 2012; May 15, 2012

DIABETES HEALTHCARE PROVIDER AUTHORIZATION *Diabetes Health Care Plan page 2*

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Student: _____ DOB: _____ Date: _____

BLOOD GLUCOSE MONITORING: (Target range: _____ mg/dl to _____ mg/dl)

☐ None required at this time	☐ Before PE/activity time	☐ 2 hours after correction
☐ Before meals	☐ After PE/activity time	☐ Before dismissal
☐ Midmorning	☐ Mid-afternoon	☐ PRN for suspected low/high BG

INSULIN ADMINISTRATION: ☐ None **Dose determined by: ☐ Student ☐ Parent ☐ Clinic Staff**

Insulin delivery system: ☐ **Syringe**
☐ **Pen**
☐ **Pump - Complete *Supplemental Authorization for Insulin Pump***

Insulin Type: _____ ☐ **CHO Insulin Ratio**: _____ **units per** _____ **gms. CHO**
☐ **Set dose of** _____ **units**

CORRECTION BOLUS DOSE: (Check only those which apply)

☐ Use the following formula: BG - _____ / _____ for BG > _____.

☐ Sliding Scale: BG from _____ to _____ = _____ units
BG from _____ to _____ = _____ units
BG from _____ to _____ = _____ units
BG from _____ to _____ = _____ units

☐ Decrease correction dose by _____ units or _____% if PE/activity is anticipated < 1 hour after correction dose.

☐ Decrease correction dose by _____ units if given following a low blood glucose level.

☐ Add CHO bolus to correction bolus for total insulin dose.

MANAGEMENT OF LOW BLOOD GLUCOSE: (below _____ mg/dl)

MILD: BG < _____	**SEVERE: Loss of consciousness or seizure**
☐ Never leave student alone.	☐ Call 911. Open airway. Turn to side.
☐ Give 15 gms glucose; recheck in 10 minutes.	☐ Glucagon injection _____ mg IM/SQ
☐ If BG < 70, retreat and recheck q 10 minutes x 3.	☐ Notify parent.
☐ Notify parent if not resolved.	
☐ Provide snack with CHO, fat, protein after treating/meal < 1 hour	

MANAGEMENT OF HIGH BLOOD GLUCOSE: (Above _____ mg/dl)

☐ Sugar-free fluids/frequent bathroom privileges.
☐ If BG is > _____, initiate insulin orders.
☐ If BG is > _____, check for ketones. Notify parent if ketones are present.
☐ May not need snack.
☐ Note and document changes in status on student's *Health Office Visit.*
☐ Notify parent (*Refer to Diabetes Health Care Plan page 1*)

EXERCISE: *Staff must be informed, educated regarding management and have easy access to supplies/equipment.*

Student should NOT exercise if BG levels are < _____ mg/dl or > _____ mg/dl + ketones.

☐ Eat _____ gms CHO for vigorous exercise ☐ Before ☐ During ☐ After exercise ☐ As needed
☐ Student may discontinue insulin pump for _____ hours or decrease basal rate by _____.

My signature provides authorization for the above orders. I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.

☐ *If changes are indicated, I will provide new written authorized orders.*
☐ *Dose/treatment changes may be relayed through parent.*

Physician's Signature: **_____** ***Date:*** **_____**

Physician's Name: _____Telephone Number: _____

IMPORTANT – PLEASE COMPLETE REVERSE SIDE AND SIGN FOR INSULIN PUMP

SUPPLEMENTAL AUTHORIZATION FOR INSULIN PUMP *Diabetes Health Care Plan page 3*

Student: _____ DOB: _____ Date: _____

PUMP RESOURCE PERSON: _____ PHONE NUMBER: _____

Blood Glucose Target Range: _____ Pump Insulin: ☐ Humalog ☐ Regular

Insulin Correction Factor for BG over Target: _____

Insulin CHO Ratios: _____

Student to receive insulin bolus for CHO intake ☐ Immediately before ☐ ____ minutes before eating ☐ After eating

Location of extra pump supplies _____

☐ **INDEPENDENT MANAGEMENT**

This student has been trained to independently perform routine pump management and to troubleshoot problems including but not limited to:

- *Giving boluses of insulin for both correction of blood glucose above target range and for food consumption.*
- *Changing of insulin infusion sets using universal precautions.*
- *Switching to injections should there be a pump malfunction. Parents will provide extra pump supplies.*

☐ **NON-INDEPENDENT MANAGEMENT: Child Lock On? ☐ Yes ☐ No**

Because of young age or other factors, this student cannot independently evaluate pump function nor independently change infusion sets.

- Insulin for meals and snacks will be given and verified as follows: _____
- Insulin for correction of BG > _____ will be given and verified as follows: _____

PARENT NOTIFICATION IN THE EVENT OF:

☐ Pump alarms/malfunctions
☐ Soreness or redness at site
☐ Detachment of dressing/infusion set
☐ Student must give insulin injection
☐ Corrective measures do not return BG to target range within _____ hours
☐ Student has to change site
☐ Leakage of insulin
☐ Other: _____

MANAGEMENT OF HIGH/VERY HIGH BLOOD GLUCOSE: *Refer to Healthcare Provider Authorization page 2*

MANAGEMENT OF LOW BLOOD GLUCOSE: *Refer to Healthcare Provider Authorization page 2, <u>but in addition:</u>*

- If low blood glucose recurs without explanation, notify parent/ diabetes healthcare provider for potential instructions to suspend pump.
- If seizure or unresponsiveness occurs:
  1. Give Glucagon and/or glucose gel (*Refer to Healthcare Provider Authorization page 2*)
  2. Call 911
  3. Notify Parents
  4. Stop insulin pump by: ☐ Placing in "Suspend" or stop mode
     ☐ Disconnecting at pigtail or clip
     ☐ Cutting tubing
  5. If pump was removed, send with EMS to hospital.

SPECIAL CONSIDERATIONS AND PRECAUTIONS (including school activities, sports and trips):

_____

My signature provides authorization for the above orders. I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.

☐ *If changes are indicated, I will provide new written authorized orders.*
☐ *Dose/treatment changes may be relayed through parent.*

***Physician's Signature:* _____ *Date:* _____**

Physician's Name: _____Telephone Number: _____