

DIABETES EMERGENCY CARE PLAN

Student Name: _____ Date: _____

Birthdate: _____ Student ID #: _____ Grade/Room: _____

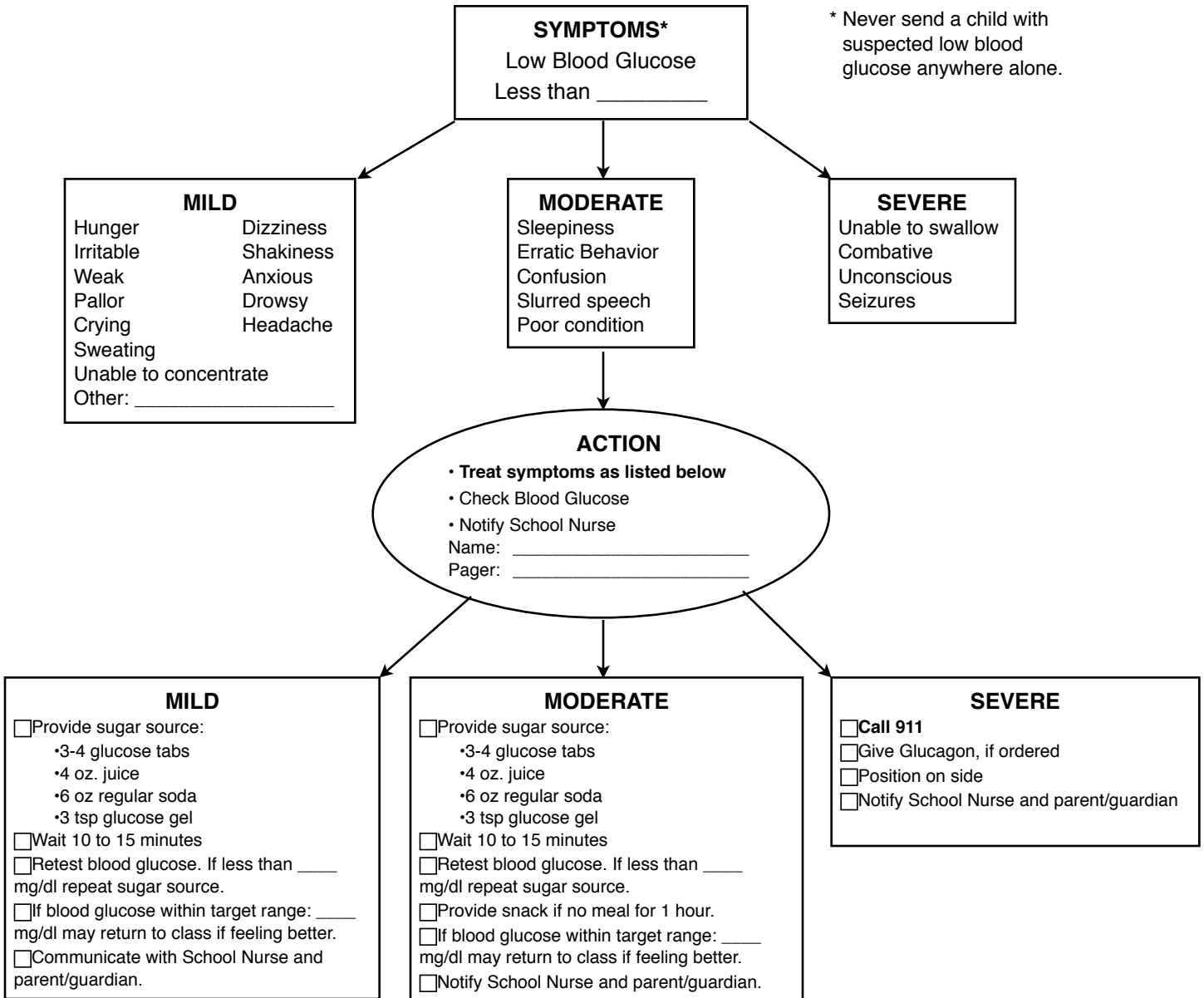
Parent/Guardian Name: _____ Phone: (_____) _____

Emergency Contact: _____ Phone: (_____) _____

Emergency Contact: _____ Phone: (_____) _____

Health Care Provider: _____ Phone: (_____) _____

Hospital in Case of Emergency: _____ Emergency Supplies Located: _____



School Nurse Signature: _____ Copy given to: _____

Date: _____ Date: _____



DIABETES QUESTIONNAIRE

Student: _____

DOB: _____

Student ID #: _____

Please complete and return to the School Nurse.

The following information is helpful in determining any special needs.

School year: _____

| | | | |
|--|---------------|-------------|-------------|
| Person to contact: | Relationship: | Work Phone: | Home Phone: |
| 1. _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ |
| Preferred Communication method: <input type="checkbox"/> Phone <input type="checkbox"/> Written <input type="checkbox"/> In Person <input type="checkbox"/> Email: _____ | | | |
| Health Care Provider: | Clinic: | Phone: | |
| _____ | _____ | _____ | |
| Hospital: | Phone: | | |
| _____ | _____ | | |

Student's age at diagnosis of diabetes _____

Does this student wear a medical alert bracelet/necklace? Yes No

Will this student need routine snacks at school? A.M. P.M. as needed
 (Snacks will need to be provided by the family.)

What would you like done about birthday treats and/or party snacks?

Should this student's blood sugar be tested at school? Yes No

What time should this student's blood sugar be monitored? A.M. P.M. as needed
 (Authorization by a health care provider is required.)

Does this student know how to test his/her own blood sugar? Yes No

Will this student need to test his/her urine for ketones at school? Yes No

Will this student need to test his/her blood for ketones at school? Yes No

What blood sugar level is considered low for this student? below _____

How often does this student typically experience low blood sugar? Daily Weekly Monthly
 Other

This student (blood sugar) typically experiences low blood sugar :
 mid A.M. before lunch afternoon after exercise other _____

Please check your student's usual signs/symptoms of low blood sugar.

- | | | |
|--|---|---|
| <input type="checkbox"/> hunger or "butterfly feeling" | <input type="checkbox"/> irritable | <input type="checkbox"/> difficulty with speech |
| <input type="checkbox"/> shaky/trembling | <input type="checkbox"/> weak/drowsy | <input type="checkbox"/> difficulty with coordination |
| <input type="checkbox"/> dizzy | <input type="checkbox"/> inappropriate crying or laughing | <input type="checkbox"/> confused/disoriented |
| <input type="checkbox"/> sweaty | <input type="checkbox"/> severe headache | <input type="checkbox"/> loss of consciousness |
| <input type="checkbox"/> rapid heartbeat | <input type="checkbox"/> impaired vision | <input type="checkbox"/> seizure activity |
| <input type="checkbox"/> pale | <input type="checkbox"/> anxious | <input type="checkbox"/> other |

Does he/she recognize these signs/symptoms? Yes No

In the past year, how often has this student been treated for severe low blood sugar?

In a health care provider's office In the emergency room Overnight in the hospital

In the past year, how often has this student been treated for severe high blood sugar or diabetic ketoacidosis?

In a health care provider's office In the emergency room Overnight in the hospital

Continued



DIABETES QUESTIONNAIRE (cont.)

What do you usually do to treat low blood sugar at home? Please be specific and state exact amount of food, beverage, glucagon, etc. (All must be provided by the family if needed at school.)

Please indicate your child's level for the following:

| Skill | Does alone | Does with help | Done by adult | Comments |
|--------------------------------|------------|----------------|---------------|----------|
| Picks/pokes blood glucose site | | | | |
| Reads meter and records | | | | |
| Counts carbs for meals/snack | | | | |
| Can interpret sliding scale | | | | |
| Selects insulin injection site | | | | |
| Measures insulin | | | | |
| Administers insulin | | | | |
| Measures ketones | | | | |
| Pump skills | | | | |

Medication taken on a regular basis:

| Name | By (mouth, injection, etc.) | Dose | Time of Day |
|-------|-----------------------------|-------|-------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Insulin taken on a regular basis:

| Name | Type | Units | Time of Day | Delivery Method (Pen, syringe, pump) |
|-------|-------|-------|-------------|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Does your child use an insulin to carbohydrate ratio for insulin adjustments? Yes: No: Ratio: _____

Does your child use an insulin to adjustment for high or low blood sugar? Yes: No: Ratio: _____

As needed medication:

| Name | By (mouth, injection, etc.) | Dose | Time of Day |
|-------|-----------------------------|-------|-------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Please list any side effects of this student's medications that may affect his/her learning and/or behavior: _____

If a medication is to be given at school, a medication authorization form must be completed yearly. A prescribing health professional may authorize self-administration of medication if the student is capable. The medication must be in the original labeled container. When you get the prescription filled, please ask the pharmacist to put it into two containers so the student will have one for school and one for home use.

What action do you want school personnel to take if this student does not respond to treatment/medication? _____

In an acute emergency, the student will be transported by paramedics to the hospital. Transportation in a non-acute situation is the responsibility of the parent/guardian. Any charges incurred are the responsibility of the parent/guardian.

Has this student received education related to diabetes mellitus? by health care provider at support group

Please add anything else that you would like school personnel to know about this student's diabetes (or related conditions).

Information was provided by _____

 Name Relationship to Student Date

I authorize reciprocal release of information related to diabetes mellitus between the school nurse and the health care provider.

 Parent/Guardian Signature Date

DIABETES MEDICAL MANAGEMENT PLAN FOR SCHOOL

Student: _____ DOB: _____

Student ID #: _____ School: _____

Type of Diabetes: Type 1 Type 2 Pre-Diabetes Date of Diagnosis: _____

Other: _____

Blood Glucose Monitoring

Meter type: _____ Blood glucose target range: _____ - _____ mg/dl

Blood glucose testing times: _____

For suspected hypoglycemia At student's discretion excluding suspected hypoglycemia

Only at student's discretion No blood glucose testing at school

Permission to test independently Supervision of testing/results

Student will need assistance with testing and blood glucose management.

Test blood glucose 10 to 20 minutes before boarding bus.

Diabetes Medication

No insulin at school: Current insulin at home: _____

Oral diabetes medication at school: _____

Insulin at school: Humalog Novolog Lantus Other: _____

Insulin delivery device: Syringe and vial Insulin pen Insulin pump

Insulin dose for school: _____

Standard lunchtime dose: _____

Meal bolus: _____ units of insulin per _____ grams of carbohydrate.

Correction for blood glucose: _____ units of insulin for every _____ mg/dl above _____ mg/dl.
(Correction bolus can be given with meals or every 3 hours if blood glucose levels are high)

| Blood Glucose Value (mg/dl) | Units of Insulin |
|-----------------------------|------------------|
| Less than 100 | |
| 100-150 | |
| 151-200 | |
| 201-250 | |
| 251-300 | |
| 301-350 | |
| 352-400 | |
| More than 400 | |

Note: Insulin dose is a total of meal bolus and correction bolus.

Parent may adjust insulin doses as needed. Student may self manage.

DIABETES MEDICAL MANAGEMENT PLAN FOR SCHOOL (cont.)

Meal Plan

1 carbohydrate choice = _____ Grams of carbohydrate

Meal plan prescribed (see below) Meal plan variable

Breakfast Time: _____ # of carb choices = _____

Morning Snack Time: _____ # of carb choices = _____

Lunch Time: _____ # of carb choices = _____

Afternoon Snack Time: _____ # of carb choices = _____

Plan for pre-activity: _____

Plan for after school activity: _____

Plan for class parties: _____

Extra food allowed: Parent/guardian's discretion Student's discretion

Hypoglycemia

Low Blood Glucose < _____ mg/dl

Self treatment of mild lows Assistance for all lows

Immediately treat with 15 gm of fast-acting carbohydrate (e.g.; 4 oz juice, 3-4 glucose tabs, 4 oz regular pop, 8 oz of skim milk)

Recheck blood glucose in 15 minutes and repeat 15 gm of carbohydrate if blood glucose remains low.

If more than 1 hour until next meal or snack student should have another 15 gm of carbohydrate.

If child will be participating in additional exercise or activity before the next meal, provide an additional carbohydrate choice.

If student is using an insulin pump, suspend pump until blood glucose is back in goal range.

Severe Hypoglycemia

If the child is unconscious or having seizures due to low blood glucose immediately administer injection of:

Glucagon _____ mg (glucagon emergency kit)

- Immediately after administering the Glucagon, turn the child onto their side. Vomiting is a common side effect of Glucagon.
- Notify parent and EMS per protocol.

Hyperglycemia

High Blood Glucose >= _____ mg/dl

Check ketones when blood glucose > _____ mg/dl or student is sick.

Use correction scale insulin orders when blood glucose is _____ mg/dl.

Unlimited bathroom pass.

Notify parent immediately of blood glucose > _____ mg/dl or if student is vomiting.

If student is using an insulin pump, follow DKA prevention protocol.

Special Occasions

Arrange for appropriate monitoring and access to supplies on all field trips.

Signature of Physician/Licensed Prescriber

Date

Print name of Physician/Licensed Prescriber

Clinic Address

Phone

Fax

Returned to: _____
RN, School Nurse

Phone

Fax



ACTIONS FOR THE BUS DRIVER

At the beginning of the school year, identify students on the bus who have diabetes.

Obtain a copy of the pertinent components of the student's Individual School Healthcare Plan (IHP) and keep it on the bus in a known, yet secure place.

Understand and be aware that hypoglycemia can occur at the end of the school day or at the beginning of the day if the student has not eaten breakfast.

Recognize that a student's behavior could be a symptom of blood glucose changes.

Be prepared to recognize the signs and symptoms of hypoglycemia and hyperglycemia, and take initial actions in accordance with the student's IHP, including knowing when and how to contact the school nurse, trained personnel, and/or emergency medical services.

Keep supplies to treat low blood glucose on the bus or be aware of where the student normally keeps his or her supplies, in accordance with the IHP.

- Treat the student with diabetes the same as other students, except to respond to medical needs.
- Allow the student to eat snacks on the bus.
- Provide input to the student's school diabetes team when requested.
- Communicate with the school nurse and/or school diabetes team regarding any concerns about the student.

Provide a written plan for the substitute bus driver that communicates the daily, as well as emergency, needs of the student.

Respect the student's right to confidentiality and privacy.

HEALTH SERVICE MUTUAL AGREEMENT: STUDENT INDEPENDENT PERFORMANCE OF BLOOD GLUCOSE MONITORING AND INSULIN ADMINISTRATION

This agreement will be attached to the Individualized Health Care Plan

This agreement has been designed to ensure student safety and well-being. Persons indicated below will assume designated responsibilities in an agreement which allows this student to:

Student: _____ Date: _____

The following statements delineate specific individual responsibilities and will be initialed by the appropriate party to indicate agreement:

_____ The student will:

- Independently perform blood glucose monitoring in accordance with written procedures.
- Keep daily records of blood glucose test and insulin dose (as agreed upon by parent/guardian and school nurse).
- Seek help from designated school staff if any problems with their diabetes should occur.
- Keep parent/guardian informed of diabetes issues.
- Treat hypoglycemia per written procedure.
- Determine insulin dose based on the health care provider's (HCP) order.
- Self-administer insulin per written procedures.
- Follow Standard Precautions (change lancet device at home, dispose of needle and syringe in a designated sharps container, place cotton ball over lanced skin until bleeding stops).

_____ The parent/guardian will:

- Provide necessary equipment such as: blood glucose monitoring kit, juice, snacks, glucose product, syringes and insulin.
- Within 24 hours, inform the school nurse, in writing, of any changes in the student's health status, medication, or treatment regimen.
- Provide signed consents.

_____ The school nurse will:

- Ensure that the student has the necessary skills, maturity and competence for blood glucose monitoring and independent administration of insulin.
- Evaluate blood glucose monitoring records, consult student and parent/guardian with any concerns regarding interventions or agreement compliance.
- Inform the HCP and/or parent/guardian of any unusual circumstances.
- Arrange to have the parent notified when supplies or insulin are running low.

_____ The designated staff will:

- Intervene as instructed for low blood glucose in accordance with written procedure.
- Record the date and time of insulin administration on a medication log.
- Provide a copy of this log to the HCP's office as directed.
- Notify the school nurse of any unusual circumstances.

