Olentangy Local Schools: Effective Management of Diabetes at School

The primary goal of the Olentangy district nurses is to provide nursing services that promote the student’s ability to learn. Our goals are to:

* Assist the student to independently care for his/her health;
* Ensure a safe school environment; and,

* Enhance stabilization of the student’s health condition while they are in school so that our students are ready to learn.

Diabetes can affect a student’s ability to learn if the blood sugar levels are not well controlled. To help achieve this goal, each building has a certified school nurse who works with school personnel, individual diabetic students and their families, and the student’s health care provider.

Olentangy school personnel will provide the following in order to promote a safe school day for your child.

* Nursing assessment and data collection
* Nursing care provided by the school nurse or her delegate:
  - Blood sugar monitoring
  - Ketone testing
  - Administration of insulin and other medication
  - Individualized meal plan
  - Emergency care plan
  - Student education and counseling
  - Staff training
  - Communication and developing the student’s plan of care

In addition, parents will provide the following in order to assist the school nurses to provide a high level of care for your son or daughter.

* A written diabetes management plan utilizing the enclosed form or a plan provided by your health care provider
* Signed authorization by parent/guardian for medication and treatment at school
* Completed Diabetes questionnaire
* Release of information signed by parent so that school nurses may speak to the student’s physician
*Actions for Bus Driver to be given to child’s bus driver by parent

*All changes in student’s diabetic management plan is to be received in a written format (per e-mail or note from parent/guardian)

*If the student is able to independently perform blood glucose monitoring and insulin administration, the Health Service Mutual Agreement must be signed by the parent and student indicating the student will be responsible and compliant with his/her diabetic care while in school

In addition to the above, parents must provide adequate supplies, as listed in the student’s diabetes management plan, to the building clinic:

*snacks or glucose tablets to treat low blood sugar

*Medications

*Blood glucose meter, strips and supplies

*Ketone testing strips and equipment

*Glucagon

We are looking forward to helping your child with diabetes be successful in school. Please feel free to contact your building school nurse with any questions or concerns.

School Nurses

Pupil Services Supervisor
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: ____________________________

SYMPTOMS*
Low Blood Glucose
Less than _________

MILD
Hunger
Irritable
Weak
Pallor
Crying
Sweating
Unable to concentrate
Other: __________________

MILD
Dizziness
Shakiness
Anxious
Drowsy
Headache

MODERATE
Sleepiness
Erratic Behavior
Confusion
Slurred speech
Poor condition

MODERATE
Provide sugar source:
3-4 glucose tabs
4 oz. juice
6 oz regular soda
3 tsp glucose gel
Wait 10 to 15 minutes
Retest blood glucose. If less than ______ mg/dl repeat sugar source.
If blood glucose within target range: ______ mg/dl may return to class if feeling better.
Communicate with School Nurse and parent/guardian.

SEVERE
Unable to swallow
Combative
Unconscious
Seizures

SEVERE
Call 911
Give Glucagon, if ordered
Position on side
Notify School Nurse and parent/guardian

ACTION
• Treat symptoms as listed below
• Check Blood Glucose
• Notify School Nurse
Name: ____________________________ Pager: ____________________________

MILD
Provide sugar source:
3-4 glucose tabs
4 oz. juice
6 oz regular soda
3 tsp glucose gel
Wait 10 to 15 minutes
Retest blood glucose. If less than ______ mg/dl repeat sugar source.
If blood glucose within target range: ______ mg/dl may return to class if feeling better.
Communicate with School Nurse and parent/guardian.

School Nurse Signature: ____________________________ Copy given to: ____________________________

Date: ____________________________ Date: ____________________________

* Never send a child with suspected low blood glucose anywhere alone.

Adapted from the Saint Paul Public Schools, 1/06
**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: ________________________________

<table>
<thead>
<tr>
<th>Person to contact:</th>
<th>Relationship:</th>
<th>Work Phone:</th>
<th>Home Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<tr>
<td>2.</td>
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</table>

Preferred Communication method: □ Phone □ Written □ In Person □ 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? ________________

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.

□ hunger or “butterfly feeling” □ irritable □ difficulty with speech

□ shaky/trembling □ weak/drowsy □ difficulty with coordination

□ dizzy □ inappropriate crying or laughing □ confused/disoriented

□ sweaty □ severe headache □ loss of consciousness

□ rapid heartbeat □ impaired vision □ seizure activity

□ pale □ anxious □ 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
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:

<table>
<thead>
<tr>
<th>Skill</th>
<th>Does alone</th>
<th>Does with help</th>
<th>Done by adult</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Picks/pokes blood glucose site</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reads meter and records</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counts carbs for meals/snack</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can interpret sliding scale</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selects insulin injection site</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measures insulin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administers insulin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measures ketones</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pump skills</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Medication taken on a regular basis:

<table>
<thead>
<tr>
<th>Name</th>
<th>By (mouth, injection, etc.)</th>
<th>Dose</th>
<th>Time of Day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Insulin taken on a regular basis:

<table>
<thead>
<tr>
<th>Name</th>
<th>Type</th>
<th>Units</th>
<th>Time of Day</th>
<th>Delivery Method (Pen, syringe, pump)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Name</th>
<th>By (mouth, injection, etc.)</th>
<th>Dose</th>
<th>Time of Day</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

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 ___________

Adapted from the Minneapolis Healthy Learners Board Asthma Initiative and the Saint Paul Public Schools Asthma Management for Students Program, 1/06
DIABETES MEDICAL MANAGEMENT PLAN FOR SCHOOL

Student: ___________________________ DOB: ___________________________

Student ID #: ___________________________ School: ___________________________

Type of Diabetes:  □ Type 1    □ Type 2    □ Pre-Diabetes    □ Other: ________________

Date of Diagnosis: ___________________________

Blood Glucose Monitoring

□ Meter type: ___________________________

□ 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.

Blood glucose target range: _______ - _______ mg/dl

Blood glucose testing times:

□ 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 _______ md/dl above _______ mg/dl.

(Correction bolus can be given with meals or every 3 hours if blood glucose levels are high)

<table>
<thead>
<tr>
<th>Blood Glucose Value (mg/dl)</th>
<th>Units of Insulin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 100</td>
<td></td>
</tr>
<tr>
<td>100-150</td>
<td></td>
</tr>
<tr>
<td>151-200</td>
<td></td>
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<tr>
<td>201-250</td>
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<td>251-300</td>
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<tr>
<td>301-350</td>
<td></td>
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<tr>
<td>352-400</td>
<td></td>
</tr>
<tr>
<td>More than 400</td>
<td></td>
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</tbody>
</table>

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

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

Adapted from the Saint Paul Public Schools, 1/06

Continued
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 __________________________

Adapted from the Saint Paul Public Schools, 1/06
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.

Continued
This agreement is good for one year and will be reviewed for renewal. If a change in status occurs, any party may call for an immediate review.

<table>
<thead>
<tr>
<th>Student Signature</th>
<th>Date</th>
<th>Parent/Guardian Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>School Nurse Signature</td>
<td>Date</td>
<td>School Administrator Signature</td>
<td>Date</td>
</tr>
<tr>
<td>Designated Staff Signature</td>
<td>Date</td>
<td>Designated Staff Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>