

Lafayette School Corporation
Health Services

**Diabetes Management and Treatment Plan for School
(For the non pump student)**

Effective Dates: _____

This plan should be complete by the student's personal health care team and parents/guardian. It should be received by the school nurse (before the first day of school) who will develop the Individualized Health Plan (IHP).

Name: _____

Grade: _____ **School:** _____

Birth Date: _____ **Date of Diagnosis:** _____

Physical condition: **Diabetes type 1** **Diabetes type 2**

CONTACT INFORMATION

Mother/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell _____

Father/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell _____

Student's Doctor/Licensed Health Care Practitioner

Name: _____

Address: _____

Telephone: _____ Emergency number: _____

Fax: _____

Other Emergency contacts:

Name: _____

Relationship: _____

Telephone: Home _____ Work _____ Cell _____

Notify parents/guardian or emergency contact in the following situations:

BLOOD GLUCOSE MONITORING

Target range for blood glucose is: _____

Usual times to check blood glucose: _____

Times to do extra blood glucose checks (check all that apply)

- Before exercise
- After exercise
- When the student exhibits symptoms of hyperglycemia
- When student exhibits symptoms of hypoglycemia
- Other: (explain) _____

Can student perform own blood glucose checks? Yes No Needs supervision

Exceptions: _____

Type of blood glucose meter student uses: _____

INSULIN ORDERS (complete only if insulin is needed at school)

Usual Lunch time Dose

Time insulin should be given: 1. Before eating lunch Yes No
2. After lunch eaten and carbs counted Yes No

Type of and dose:

Lunch dose of _____ insulin is _____ units **or**
(type of insulin)

Does flexible dosing using _____ units/_____ grams carbohydrate

Use of other insulin at lunch: _____ units of _____
(Type of insulin)

Insulin Correction Doses

Parental authorization should be obtained before administering a correction dose for high blood glucose levels. Yes No Other _____

Correcting dose formula if needed: Blood glucose – Number(____) ÷ _____ = _____

Sliding scale if needed:

_____ 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

- Can student give own injections? Yes No Needs supervision
- Can student determine correct amount of insulin? Yes No Needs supervision
- Can student draw correct dose of insulin? Yes No Needs supervision
- Can student independently count carbohydrates? Yes No Needs supervision

Parents are authorized to adjust the insulin dosage under the following circumstances:

MEALS AND SNACKS EATEN AT SCHOOL

Is student independent in carbohydrate calculations and management?

Yes No Needs supervision

Meal/Snack	Time	Food content/amount
Breakfast	_____	_____
Mid-morning snack	_____	_____
Lunch	_____	_____
Mid-afternoon snack	_____	_____
Dinner	_____	_____

Snack before exercise Yes No
Snack after exercise Yes No
Other times to give snack and content/amount: _____
Preferred snack foods: _____
Food to avoid, if any: _____
Instructions for when food is provided to the class (e.g. as part of a class party or food sampling event):

EXERCISE AND SPORTS

A fast-acting carbohydrate such as _____ should be available at the site of exercise or sports.

Restrictions on activity, if any: _____

Student should not exercise if blood glucose level is below ____ mg/dl or above _____ mg/dl or if moderate or large urine ketones or blood ketones of _____ mmol.L are present.

HYPOGLYCEMIA (LOW BLOOD GLUCOSE)

When the student or any staff member believes the student is experiencing signs of low blood sugar, the staff member should seek the school nurse, or VHA if the school nurse is not available, for further assistance while making sure an adult stays with the student or the student is sent with a "buddy" to the school nurse or VHA.

Typical symptoms for this student include: _____

If blood sugar is below _____ and student is conscious and able to swallow: treat as follows:

Treatment for Conscious Person
1. Give 15 grams of a fast acting carbohydrate or 1 treatment from below: <ul style="list-style-type: none">• 4 oz of fruit juice• 3-4 glucose tablets• 1 fruit roll-up• 5-6 life savers• 4 oz regular pop• Glucose gel placed between cheek and side of gum
2. Wait 15-20 minutes. Re-test and re-treat until above target range.
3. Other instructions: _____ _____

(treatment of low blood sugar continued on next page)

Severe Hypoglycemia: If seizure or unresponsiveness occurs:

- If the student with diabetes is unconscious or having a seizure, he/she should receive an injection of Glucagon
- Glucagon can be given by anyone trained to give an injection. It is suggested that in addition to the school nurse, the VHA should be trained in the administration of glucagon.
- Any staff member who finds the student unconscious or having a seizure should immediately contact the school office. The trained office staff should immediately do the following in the order listed:

Treatment of Seizing or Unconscious Person

- **Administer Glucagon Emergency kit per directions**
 - Give 1 vial of glucagon SQ or IM
 - Give ½ of a vial of glucagons SQ or IM**Turn person on their side.**
 - **Contact 911**
 - **Test blood sugar every 10 minutes**
 - **Notify parents and/or child's physician**
- DO NOT GIVE LIQUIDS TO DRINK WHILE UNRESPONSIVE**

Treatment for Hyperglycemia:

High Blood Glucose for this student is BS above _____.

If the student has high blood glucose take the following actions:

- Check ketones when blood glucose \geq _____mg/dl or student is sick.
- Notify parent immediately of blood glucose \geq _____mg/dl, student has moderate to large ketones or if student is vomiting.
- Give 8 oz of water
- Use correction scale insulin orders when blood glucose is _____mg/dl
- Unlimited bathroom pass

Any other instructions: _____

Daily instructions:

A companion should accompany the student if he/she needs to go to the nurse's office when not feeling well.

The student should have free and unrestricted access to water and the bathroom if the blood glucose is running high.

Field Trips and Extracurricular activities:

This student needs parent, school nurse, or trained volunteer health aid to accompany them on a field trip. Yes No Additional information: _____

This student needs a diabetes trained staff member available at the site of all extracurricular activities. Yes No

Additional Information: _____

The student’s diabetes supplies such as blood glucose monitor and fast acting sugar sources and snack should accompany the student on all field trips and extracurricular activities on or away from school premises.

BUS Information: This student rides a bus to and from school. Yes _____ No _____

Other Instructions Particular to this Student: _____

Parent’s responsibilities:

- It is the parent’s responsibility to alert the Nurse/School if their child has been experiencing blood glucose results at home that are atypical.
- It is the parent’s responsibility to notify the Nurse/School of Medical Treatment changes. The parents should educate the nurse on any new treatment supplies or situation.
- Medical supplies should be kept in the Clinic and/or classroom. It is the parent’s responsibility to make sure that these supplies are adequate in quantity and not expired. These include:

Blood glucose meter	Test strips	Control solutions
Extra batteries for meter	Lancet Device	Lancets
Ketone Strips	Glucagon	Low BS treatments
Snacks	Glucose Gel	Water bottle
Syringes	Insulin	

Signatures

This Diabetes Medical Management Plan has been approved by:

Student’s Physician/Health Care Provider

I give permission to the school nurse and other designated diabetic volunteer health aids to perform and carry out the diabetes care tasks as outlined by the above Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child’s health and safety.

Acknowledged and received by:

Student’s Parent/Guardian Date

Student’s Parent/Guardian Date

