Individualized Health/Emergency Care Plan For Diabetes

Student's Name______________________________Grade_____ Age _____ HR__________________School Year _______

Type 1 Insulin Dependent Diabetes

Diabetes is a disorder in the body's ability to use blood sugar (glucose) and is usually a result of the pancreas not producing enough insulin. The result is too much sugar in the blood. Treatment consists of daily injections of insulin, food management, and exercise. Diabetes is not contagious. The priority for a child with diabetes is to lead a normal life. While the fact that they have diabetes should not be hidden, the student does not want to be singled out. With careful management, diabetes can be well controlled and allow children to lead healthy, active, fun-filled lives.

LOW BLOOD SUGAR (HYPOGLYCEMIA)

The emergency situation you are most likely to encounter in the school setting is low blood sugar. It occurs most commonly when blood sugar levels fall below 70 mg/dl. Most students are aware when their blood sugar is low but sometimes it can occur suddenly and if not treated promptly, it can be an emergency.

Causes: Too much insulin, extra exercise, a missed snack, or less food at a meal than usual.

Prevention: Eat meals/snacks at specified time - especially during periods of exercise, recognize and treat symptoms

SIGNS OF HYPOGLYCEMIA (LOW BLOOD SUGAR) REACTION:

- Hunger
- Headache
- Tiredness
- Nausea/stomachache
- Inability to concentrate
- Day-dreaming
- Weakness/dizziness
- Irritability
- Pale, moist skin
- Confusion
- Slurred Speech
- Poor coordination
- Sweating (clammy)
- Shakiness
- Personality changes
- Crying
- Uncooperative
- Combative
- Other (specific to child)
  ____
  ____

If the above symptoms are ignored or go unrecognized, loss of consciousness or seizures may result. These serious side effects, however, rarely occur.

NEVER SEND STUDENT TO NURSE ALONE WHEN HAVING SYMPTOMS!

Type of treatment for symptoms of low blood sugar should be based on the student's level of consciousness: (When possible check blood glucose)

1. **IF THE STUDENT IS CONSCIOUS AND ABLE TO SWALLOW-**give one of the following:
   - *Fruit Juice (1/2 to 1 cup)
   - Glucose Tablets (2-4)
   - Regular soda (6 oz)
   - Glucose Gel (squirt in side of mouth and massage)
   - ______________________ (student preference)

After the administration of the item listed above, the student's symptoms should improve within 15 minutes. If not, repeat treatment. Student should not be left alone until symptoms are completely gone.

Once symptoms subside, give a small snack like crackers or milk to prevent reoccurrence of the symptoms if the next meal or snack is not within 1/2 hour.

***Note to school personnel:** Juice is the preferred treatment because it is quickly absorbed and fast acting. Do not hesitate to give to student-it will not harm them. If you do not have a can of apple juice (or crackers) please see the school nurse. This juice must be readily available. Please write down where you will keep it for substitute personnel.
Juice will be kept: ________________________________.

2. **IF THE STUDENT BEGINS TO LOSE CONSCIOUSNESS, IS UNABLE TO SWALLOW OR IS HAVING A SEIZURE:** the school nurse or designated person(s) _________________________ MUST ADMINISTER **GLUCAGON INJECTION IMMEDIATELY.**
   - Emergency kit with Glucagon is kept: __________________________________
   - **CALL 911** (ACTIVATE EMS)
   - Notify parent or guardian

Does your child wear a medic alert tag? ___Yes ___No

Will student always carry a form of sugar on them? ___Yes ___No If Yes, where______________________

HIGH BLOOD SUGAR (Hyperglycemia): Occurs when blood sugar levels get too high. Symptoms (such as excessive thirst, fatigue, weakness, increased trips to bathroom and blurred vision) typically develop gradually, over a period of days.

If blood sugar is over__________________ at school, please do the following: ______________________________

_ ______________________ ____

BLOOD GLUCOSE TESTING

Blood sugar testing involves pricking a finger, placing a drop of blood on a test strip, using a glucometer, and recording the results. The information is then recorded and insulin doses adjusted based on test results.
This procedure is typically done in the nurse's office.

- **Testing Times**

___Before Lunch ___ Before snacks
___Before exercise ___ Symptoms of high/low glucose
___After exercise ___ Other: ________________________

REGULAR MEALS AND SNACK TIMES

- Allow the student to follow his or her routine inconspicuously. When the child needs a snack, to test blood sugar, or to take insulin, help by allowing the necessary time and not calling attention to these special actions.
- All school personnel will permit the student to eat a snack in the classroom or wherever the child is (Including, but not limited to gym, field trips and school bus)

Will student eat a scheduled snack in school? _____Yes _____No
Eat snack before or after exercise/gym class? _____Yes _____No
If Yes, list times of snack: ____________________________ Will student need a reminder to eat snack?___yes ___no

WATER AND BATHROOM ACCESS

- The student shall be permitted to have immediate access to water by keeping a water bottle with them, and by permitting the student to use the drinking fountain without restriction
- The student shall be permitted to use the bathroom without restriction

SCHOOL PARTIES AND SPECIAL EVENTS

_____ Student may consume any classroom food or drink without restriction
_____ Student may only consume food ***pre-approved by parent**
*Teacher must obtain parent permission for snack to be approved
_____ Student will consume ONLY the food/drink sent in by parent
_____ Other: ____

BUS TRAVEL

Student is permitted to drink/eat food on the bus at any time
Please indicate any other necessary arrangements or care needed on bus: ____
____
____

FIELD TRIPS Please Indicate any special arrangements needed on field trips:
____
____
____

CAFETERIA Indicate any special arrangements necessary during meals in cafeteria:
____
____

***PHYSICAL EDUCATION (GYM)**

- Low blood sugars may occur during exercise, and a source of instant sugar (juice) should be nearby. Often a snack is eaten before gym and the child may be delayed in getting started. Exercise is very important for children with diabetes. Typically, exercise is not scheduled before a meal. It is important to schedule gym class at an appropriate time during the day.

- ***Parents**: Please contact the school before the first day to check on your child's gym schedule

OTHER

Please address any other issues, guidelines or special precautions that you feel are important to your child's safety and care during the school day. Please include any **FOOD ALLERGIES or SPECIAL DIETARY NEEDS.**

____

____

SUPPLIES AND EQUIPMENT

Parents are to provide the following necessary supplies and equipment:

1. **Emergency Low Blood Sugar Kit(s)**:
   - Glucagon
   - Glucose Gel
   - Juice
   - Glucose Tablets
   - Prepackaged snacks
   - Other: _________

   * **Please indicate where you would like the kits to be kept:** (i.e. Nurses office, classroom, bus, etc.):
   ____

2. High Blood Glucose Supplies
   Ketone Test strips/bottle
   Water Bottle or drink indicated for highs
3. Insulin Supplies: Insulin, syringes and extra pump supplies
1. Regular Snacks /Juice
2. Glucometer: meter, testing strips, lancing device, lancet

The information in this Care Plan is a supplement to more detailed information, instructions and physicians orders, which are kept in the Nurse's office. Including but not limited to: Guidelines for Managing the Student with Diabetes and Physicians Orders for Management of Insulin.

Parent Consent for Management of Diabetes at School

We (I), the undersigned, the parent(s)/guardian(s) of the above named pupil, request that the above Health Care Plan service for Management of Diabetes in school be administered to our (my) child.

I will:

1. Provide the necessary supplies and equipment
2. Notify the school nurse if there is a change in pupil health status
3. Notify the school nurse immediately and provide new physicians consent for any changes

I authorize the school nurse to communicate with the physician when necessary.
For the safety and well being of your child we MUST be able, to reach a parent at all times.

My signature below indicates that I have read and completed the above information and give my permission for this Individualized Health Plan to be released to all school personnel.

→ **Parent/Guardian Signature ____ Date ____________**

Physician Authorization For Diabetes Management In School

My signature below provides authorization for the above written orders and also for **Guidelines for Managing the Student with Diabetes** (colored flip cards). This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization upon request.

→ **Physician Name ____________________ Physician Signature _________________________ Date ____________**

Rev 5/03

TYPE I INSULIN DEPENDENT DIABETES

DEER LAKES SCHOOL DISTRICT
PHYSICIAN ORDERS FORM

Student's Name____ ____________
Last **First** **Grade**

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons or permitted to medicate herself/himself (as outlined below) also by me and my physician. We agree to hold the school, its offices, agents and employees harmless in administering the medication pursuant to the physician's written instructions. We further agree to notify you promptly when it is no longer necessary to administer this medication.

X____
Parent/Guardian Signature **Date**

The following is to be completed by PHYSICIAN:

SCHEDULED AND EMERGENCY MEDICATIONS

1. **If Insulin to be given at school, please indicate:**
   Brand name and Type: ____________________________ **Form** _______________ **Time**____________
   Dose ________________________________ **/or**
   Sliding Scale as follows:

   Blood Glucose from _______________**to** __________________ = ____________**Units**
   _______________**to** __________________ = ____________**Units**
   _______________**to** __________________ = ____________**Units**
   _______________**to** __________________ = ____________**Units**
   _______________**to** __________________ = ____________**Units**
   _______________**to** __________________ = ____________**Units**

   Carbohydrate Counting: ______ **#units per** ______**gms Carbohydrate**

   Other Information:
   ____
   ____
   ____
   ____

2. **Glucagon Injection**
   Brand name and Type: ________________________________ **Form:** **Injection** **Time: PRN**
   Dose ____
   Indicated For: Loss of consciousness, seizure, inability to swallow or:
   ____

   Other Information:
   ____
   ____
   ____

   Student may carry Insulin Pen or Syringe in case and/or Glucagon in school or on field trip ___Yes ___No

Date: _________________________ **Physician's Signature** ______________________________________

Note: Prescription medication must be in the original prescription labeled container.

Rev 5/03