BROWNSBURG COMMUNITY SCHOOL CORPORATION

HEALTH SERVICES

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DIABETES MANAGEMENT PLAN for _____ DOB _____

School Name _____ Year _____
School Phone _____ Fax _____
Primary Caregiver _____ Phone _____ Alt. #_____
Diabetes Physician/NP _____
MD Phone _____ MD Fax _____

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1. **BLOOD SUGAR CHECKS AT SCHOOL—CHECK STUDENT'S BLOOD SUGAR:**
   - BEFORE ALL MEALS
   - IF THE STUDENT FEELS OR ACTS HYPER/HYPO-GLYCEMIC
   - IF THE STUDENT IS ILL
2. **ADDITIONAL BLOOD SUGAR TESTING** IS REQUIRED **(CHECK ALL THAT APPLY):**
   - □ No additional testing needed
   - □ Before □ After Recess/Gym
   - □ Before snacks
   - □ Before getting on the bus
   - □ Other times _____

*****THIS STUDENT'S *TARGET BLOOD SUGAR RANGE* IS _____ TO _____*****

3. **TREATING OUT-OF-RANGE BLOOD SUGARS:**
   ***HYPOGLYCEMIA—Always* treat if blood sugar is less than _____!**
   Give _____ gm fast acting carb. Recheck in ____ minutes.
   Repeat with _____ gm fast acting carb until BS> _____.

*****NEVER** allow a student with actual/suspected *low* blood sugar to go anywhere **alone!*****

***HYPERGLYCEMIA*—Follow specific orders on Page 2**

4. **TRAVEL REQUIREMENTS:**
   For ALL field trips, student will need:
   - Glucose monitor/meter
   - Insulin supplies--specific equipment and emergency supplies used by this student (Page 2)
   - Snacks and water
   - A copy of the student's Health Care Plan
   - ***Parent/Guardian accompanies*** student on all trips or school activities:
     □ **Required** □ **Optional**
   - **If** no parent/guardian is available**, a trained designee will go** with the student.

5. **Student to be granted unlimited water access and restroom breaks throughout the school day.**

PARENT/GUARDIAN STATEMENT OF AGREEMENT:

I understand that all insulin, supplies, monitoring equipment, emergency glucose, snacks and water will be provided by the family. In case of emergency, school personnel will call the 911 Emergency Response team for assistance. If I cannot be reached, the school will contact the physician or diabetic nurse for specific information or instruction. In the event that the school nurse is out of the building or is unable to care for my student, care will be provided by a volunteer diabetic health care aid who has been trained appropriately to manage the care of a diabetic student.

☆ **Parent/Guardian Signature** _____ **Date** _____

We will provide the following Diabetic Management Supplies for _____

☆ Signed (Parent/Guardian) _____

Equipment	Needed	N/A	Received Dates	Notes
Blood sugar monitor				
Extra batteries for monitor				
Test strips for monitoring				
Alcohol preps				
Syringes or Pen for injection (specify in notes)				
Lancets--basic				
Multiclix/lancets for insulin pen				
Needles for insulin pen				
Insulin supply for injection or pump usage (specify name in notes)				
Urine ketone monitoring equipment				
Treatment foods (specify in notes) for hypoglycemic event—stored in clinic				
Water in individual bottles to be stored in the clinic				
Glucagon for emergency use for unconscious student				
Insulin pump				
Extra batteries for pump				
Replacement infusion set(s)				
Replacement reservoir and tubing				

As supplies run out or expire, the school nurse will send this page with refill needs highlighted. Please replace these items promptly to ensure your student's safe care.

INJECTABLE INSULIN PLAN

DIABETES MANAGEMENT PLAN **PAGE 2—INJECTIONS**

» Continuous Glucose Monitor worn? **No** ___ **Yes**: type _____

» Requires 7-8 grams of carbs for every ½ hour of activity unless directly after lunch? **No** _____ **Yes** _____

» **Long-acting** Insulin Type/Name _____ » **Short-acting** Insulin Name _____

AM dose _____units PM dose _____units **Short-acting** given by (*circle one*):

Any long-acting insulin given at school? **No** _____ **Yes**: When? _____ **Pen Syringe Either**

→**Self-Care Instructions for School:**

SKILL	NO SUPERVISION	NEEDS SUPERVISION	ADULT MUST DO
Testing blood sugar			
Treating low blood sugar			
Calculating correct insulin dose			
Measuring correct insulin dose			
Administering insulin injection per syringe or pen			
Calculating/Counting carbs eaten			
Checking ketones			

→**Dosing—Meals and Snacks at School:** *Please <u>circle</u> meals and snacks student will have at school and fill in doses*

MEAL	CARB GRAMS (if set limit)	FOOD DOSE	CORRECTIVE DOSE
Breakfast		1 unit:_____ grams	(BS-_____) + _____
AM Snack		1 unit:_____ grams	(BS-_____) + _____
Lunch		1 unit:_____ grams	(BS-_____) + _____
PM Snack		1 unit:_____ grams	(BS-_____) + _____

BREAKFAST BS	Give (units)	LUNCH BS	Give (units)
< 100		< 100	
101-150		101-150	
151-200		151-200	
201-250		201-250	
251-300		251-300	
301-350		301-350	
351-400		351-400	
>400		>400	

→ **Check KETONES** with **BS>** _____ and **take these actions:**

_____

→ **Call** □ Parent □ MD office for **BS>** _____ → If **BS >** _____ restrict from **PE/Recess**

******FOR HYPOGLYCEMIC EMERGENCY—LOSS OF CONSCIOUSNESS, SEIZURE—GIVE GLUCAGON 1MG. REPEAT IN _____ MINUTES IF NECESSARY. CALL MD OFFICE AND PARENT ASAP!***

Reviewed by: ☆Parent/Guardian: _____ **☆School Nurse:** _____

☆ **Physician Signature:**_____ **Date:** _____

Parents--Please sign the attached authorization form for patient information release and disclosure. This must be signed in order to return this Diabetes Management Plan to the school. Thank you.

INSULIN PUMP PLAN

DIABETES MANAGEMENT PLAN **PAGE 2—PUMP**

» Continuous Glucose Monitor worn? **No** ___ **Yes**: type _____

» Type of Pump: _____

» Insulin Type: ☐ Novolog ☐ Humalog ☐ Aprida

» For blood sugar **over 250 between meals**, student should use:

☐ **Full** corrective dose ☐ **1/2** corrective dose ☐ **No** corrective dose

→**Self-Care Instructions for School:**

SKILL	NO SUPERVISION	NEEDS SUPERVISION	ADULT MUST DO
Testing blood sugar			
Treating mild low blood sugars			
Calculating/Counting carbs eaten			
Checking ketones			
Administering bolus doses on pump			
Preparing reservoir and tubing or pod			
Changing infusion set or pod			
Giving injection with pen or syringe, if needed			
Troubleshooting pump alarms and malfunctions			

→**Insulin Doses and School Meals or Snacks:**

Carb Ratios/I:C **Corrective Dose/ISF** **Basal Rates**

Time	Dose	Time	Dose	Time	Rate

→ **Check KETONES** with **BS>** _____ and **take these actions:**

_____

→ **Call** ☐ Parent ☐ MD office for **BS>** _____ → If **BS >** _____ restrict from **PE/Recess**

******FOR HYPOGLYCEMIC EMERGENCY—LOSS OF CONSCIOUSNESS, SEIZURE—GIVE GLUCAGON 1MG.***

☐ ***Suspend pump*** ☐ ***Do not suspend pump*** ***REPEAT GLUCAGON IN _____ MINUTES IF NECESSARY. CALL MD OFFICE AND PARENT ASAP!***

Reviewed by: ☆Parent/Guardian: _____ ☆School Nurse: _____

☆ **Physician Signature:_____ Date: _____**

Parents--Please sign the attached authorization form for patient information release and disclosure. This must be signed in order to return this Diabetes Management Plan to the school. Thank you.

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION
Related to School Diabetes Management Plan

By signing this authorization, I am allowing my student's health care practitioner and/or organization to release my student's medical information to the school. I understand that the health care practitioner will directly release to the school the attached Diabetes Management Plan and may answer other questions for the school as necessary for the treatment and care of my student while at school. This information may be released throughout the year whenever a change to the treatment plan is required. I also understand that the health care practitioner will rely on the information I provide regarding the name and contact information for the school.

The following conditions apply:

- This authorization will expire one (1) year from the date signed.
- I have the right to revoke this authorization at any time. My revocation must be in writing and must be presented to the health care organization. The revocation will not apply to information already released by this authorization.
- I understand that I do not have to sign this Authorization in order to receive health care treatment.
- I release the health care practitioner and/or organization from any and all liability resulting from a redisclosure of information by the recipient. The health care practitioner and/or organization cannot prevent redisclosure of information by the person/organization who receives the records under this Authorization, and that information may not be covered by state and federal privacy protections after it is released.

Please sign below to indicate that you have read and understand this form, and that you authorize the release of the information as described above.

_____ _____

Parent/Guardian Signature Date signed