SUSSEX COUNTY PUBLIC SCHOOLS

DIABETES HEALTH CARE PLAN

Please return this diabetes health care plan to your child's school nurse.

Student: ___________________________________ Date of Birth: ___________ School Year: 20___ - 20___

School: ___________________________ Homeroom Teacher: __________________ Grade/Team: ______

EMERGENCY CONTACTS

Parent/Guardian/Contact	***Relationship***	***Phone Number***	***Alt Phone Number***
Diabetes Healthcare Provider:		***Phone Number:***	

EMERGENCY NOTIFICATION

Notify parents of the following conditions:

☐ Loss of consciousness or seizure immediately after calling 911 and administering Glucagon ☐ Blood sugar in excess of ________________ mg/dl. ☐ Positive urine ketones.

☐ Abdominal pain, nausea/vomiting, fever, diarrhea, altered breathing, or altered level of consciousness.

STUDENT'S COMPETENCE WITH PROCEDURES *(Must be verified by parent and Clinic Staff)*

☐ Blood glucose (BG) monitoring	☐ Carry supplies for BG monitoring
☐ Determining insulin dose	☐ Carry supplies for insulin administration
☐ Measuring insulin	☐ Monitoring BG in classroom
☐ Injecting insulin	☐ Self-treatment for mild low blood sugar
☐ Independently operates insulin pump	☐ Determine own snack/meal content

MEAL PLAN

	Time	***Location***	***CHO Content***		***Time***	***Location***	***CHO Content***
☐ Breakfast				☐ Mid-PM			
☐ Mid-AM				☐ Before PE			
☐ Lunch				☐ After PE			

Meal/snack will be considered mandatory. Content of meal/snack will be determined by:
☐ Student ☐ Parent ☐ Clinic Staff ☐ Diabetes Healthcare Provider

LOCATION OF SUPPLIES/EQUIPMENT: Parent to provide and restock supplies. *(Completed by Clinic Staff)*

Blood glucose equipment:	☐ Clinic	☐ With Student
Insulin administration supplies:	☐ Clinic	☐ With Student
Glucagon emergency kit:	☐ Clinic	☐ With Student
Fast acting carbohydrate:	☐ Clinic	☐ With Student
Snacks:	☐ Clinic	☐ With Student

I, this child's parent/guardian, authorize disclosure of information to be shared with pertinent school staff so that my child's medical needs may be served while in attendance in the Sussex County School District. This authorization expires as of the last day of the school year.

►Parent/Guardian's Signature◄ ____ Date: _______________

DIABETES HEALTHCARE PROVIDER AUTHORIZATION

Student: ____ DOB: _____________ Date: _________

BLOOD GLUCOSE MONITORING: (Target range: ________ mg/dl to ________ mg/dl)

□ None required at this time	□ Before PE/activity time	□ 2 hours after correction
□ Before meals	□ After PE/activity time	□ Before dismissal
□ Midmorning	□ Mid-afternoon	□ PRN for suspected low/high BG

INSULIN ADMINISTRATION: □ None Dose determined by: □ Student □ Parent □ Clinic Staff

Insulin delivery system: □ **Syringe**
□ **Pen**
□ **Pump - Complete *Supplemental Authorization for Insulin Pump***

Insulin Type: ______________ □ **CHO Insulin Ratio**: ____ **units per** ____ **gms. CHO**
□ **Set dose of** ____ **units**

CORRECTION BOLUS DOSE: (Check only those which apply)
- □ Use the following formula: BG - _____ / _____ for BG > _____.
- □ Sliding Scale: BG from _____ to _____ = _____ units
  - BG from _____ to _____ = _____ units
  - BG from _____ to _____ = _____ units
  - BG from _____ to _____ = _____ units
- □ Decrease correction dose by _____ units or _____% if PE/activity is anticipated < 1 hour after correction dose.
- □ Decrease correction dose by _____ units if given following a low blood glucose level.
- □ Add CHO bolus to correction bolus for total insulin dose.

MANAGEMENT OF LOW BLOOD GLUCOSE: (below ________ mg/dl)

MILD: BG < ________	**SEVERE: Loss of consciousness or seizure**
□ Never leave student alone.	□ Call 911. Open airway. Turn to side.
□ Give 15 gms glucose; recheck in 10 minutes.	□ Glucagon injection _____ mg IM/SQ
□ If BG < 70, retreat and recheck q 10 minutes x 3.	□ Notify parent.
□ Notify parent if not resolved.	
□ Provide snack with CHO, fat, protein after treating/meal < 1hour	

MANAGEMENT OF HIGH BLOOD GLUCOSE: (Above ________ mg/dl)
- □ Sugar-free fluids/frequent bathroom privileges.
- □ If BG is > _________, initiate insulin orders.
- □ If BG is > _________, check for ketones. Notify parent if ketones are present.
- □ May not need snack.
- □ Note and document changes in status on student's *Health Office Visit.*
- □ Notify parent (Refer to Diabetes Health Care Plan page 1)

EXERCISE: *Staff must be informed, educated regarding management and have easy access to supplies/equipment.*

Student should NOT exercise if BG levels are < ________ mg/dl or > ________ mg/dl + ketones.
□ Eat ________ gms CHO for vigorous exercise □ Before □ During □ After exercise □ As needed
□ Student may discontinue insulin pump for ________ hours or decrease basal rate by ________.

My signature provides authorization for the above orders. I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.

□ If changes are indicated, I will provide new written authorized orders
□ Dose/treatment changes may be relayed through parent.

►Physician's Signature◄ ____ Date: ____________________

PRINT Physician's Name: ________________________________Telephone Number: ______________________