Canutillo Independent School District

DIABETES MANAGEMENT & TREATMENT PLAN

THIS FORM SHOULD BE REVIEWED AT THE BEGINNING OF EACH SCHOOL YEAR

Name_______________________________ School__________________ School Year_________Effective Date_________________

Date of Birth_________________ ID#________________Grade______________Homeroom Teacher_________________________

DIAGNOSIS: Diabetes Type I_____Diabetes Type II______Gestational Diabetes______

This plan should be completed by the student's physician and parent/guardian. It should be reviewed with all relevant school staff and copies should be kept in a place that is easily accessed by the school nurse, unlicensed diabetes care assistants and other authorized personnel.

CONTACT INFORMATION:

Parent/Guardian#1:____Address:____

Telephone-Home: ____________________________Work____________________________Cell Phone: ______________________

Parent/Guardian#2:____Address:____

Telephone-Home: ____________________________Work:___________________________Cell Phone: ______________________

Student's Doctor/Health Care Provider: ____Telephone:______________________

Other Emergency Contact: ____Relationship:______________________

Telephone-Home: _____________________________Work:__________________________Cell Phone: ______________________

Does the student wear a medical alert braclet/necklace? ____

BLOOD GLUCOSE MONITORING

Target range for blood glucose: _________mg/dl to_______mg/dl Type of blood glucose meter student uses: __________________

Usual times to test blood glucose: ____

Time to do extra tests (check all that apply): ____Before exercise ____When student exhibits symptoms of hyperglycemia

____After exercise ____When student exhibits symptoms of hypoglycemia

____Other (explain):____

Can student perform own blood glucose tests? ____ Yes ____No Exceptions: ____

INSULIN

Time: ___________ Type of Insulin: ___________ Dose: _________ Time: _________ Type of Insulin: _________ Dose: __________

If Flexible dosing is used:

Time: ___________ Type of Insulin: ___________ Dose: _________ Units/__________ grams of carbohydrates

Can student give own injections? ____ Yes ____No Exceptions: ____

Can student determine correct amount of insulin? ____Yes____No Can student draw correct dose of insulin? ____Yes____No

Insulin Correction Dose:

Blood glucose below_______________mg/dl=no additional insulin

____________units of________________insulin subcutaneously if blood glucose is________________ to________________ mg/dl

____________units of________________insulin subcutaneously if blood glucose is________________ to________________ mg/dl

____________units of________________insulin subcutaneously if blood glucose is________________ to________________ mg/dl

____________units of________________insulin subcutaneously if blood glucose is________________ to________________ mg/dl

Notify parent if blood glucose is over__________________mg/dl Notify MD if blood glucose is over__________________mg/dl

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

____

It is the parent's responsibility to communicate any changes in the treatment plan to school health services personnel.

INSULIN PUMPS

Type of Pump: ___________________________ Basal rates: ___________________________ 12 am to_____________________
Type of Insulin in Pump: _________________________________ Type of Infusion Set: ______________________________
Insulin/Carbohydrate Ration: ______________________________ Correction Factor: _________________________________
Is student competent regarding pump? _____Yes_____No   Can student effectively troubleshoot problems? ____Yes_____No

FOR STUDENTS TAKING ORAL DIABETES MEDICATIONS

Time: ______________________ Name of Medication: ____________________________ Dose: __________________________
Time: ______________________ Name of Medication: ____________________________ Dose: __________________________

MEALS & SNACKS EATEN AT SCHOOL: The carbohydrate content of the food is important in maintaining a stable blood glucose level. 15 grams of carbohydrates= 1 carbohydrate unit)

Time	Food content amount
Breakfast__________	__________________________
A.M. snack________	__________________________
Lunch____________	__________________________
P.M. snack________	__________________________
Dinner____________	__________________________
Snack before exercise?	_____Yes _____No
Snack after exercise?	_____Yes _____No

Other times to give snacks and content/amount_______
____
____
a source of glucose, such as______________________
should be readily available at all times.
Preferred snacks________________________________
Foods to avoid__________________________________
Instructions for when food is provided to the class, e.g. as part of a class party or food sampling____________
____

HYPOGLYCEMIA (LOW BLOOD SUGAR): Signs of hypoglycemia include trembling, sweating, shaking, pallor, feeling weak, dizzy, sleepy, lethargic and or confused, coma or seizures.

1. If blood glucose is below_______________________mg/dl:
   - A. Give child 15 grams of carbohydrates, i.e. 6 lifesavers, 6 oz. of regular soda, 4 oz. of juice, 3-4 glucose tabs.
   - B. Allow child to rest for 10-15 minutes and retest blood glucose.
   - C. If glucose is above______________mg/dl, allow student to proceed with scheduled meal, snack or school activities.
   - D. If symptoms persist or blood glucose remains below____________mg/dl, repeat A & B.
   - E. If symptoms still persist, notify parent and keep child in clinic.

2. If blood glucose is below_______________________mg/dl and the child is unconscious, seizing or unable to swallow:
   - A. Activate emergency medical services.
   - B. Rub a small amount of glucose gel or cake frosting on child's gums and oral mucosa.
   - C. If available, inject Glucagon ______________________mg subcutaneously.
   - D. Notify parent.

HYPERGLYCEMIA (HIGH BLOOD SUGAR): Signs include frequency in urination, excessive thirst, stomach ache and positive urinary ketones.

1. If blood glucose is above_______________________mg/dl:
   - A. Call nurse or unlicensed diabetes care assistant if student is unable to administer own insulin.
   - B. Urine or blood ketones should be tested when blood sugar is over___________________mg/dl or when student is ill.
     - a) If small or trace amounts of ketones are present, encourage water until ketones are negative.
     - b) If moderate or large amounts of ketones are present:
       - (1) Student should remain in clinic for monitoring.
       - (2) Notify parent for pick up.
       - (3) Give 1-2 glasses of water every hour.
       - (4) If student remains in school, retest blood glucose and ketones every 2-3 hours or until ketones are negative.

EXERCISE AND SPORTS

A snack such as ____ should be readily available.
Restrictions on activity, if any: ____
Student should not exercise if blood glucose is below _______ mg/dl or above _______ mg/dl or if moderate to large amounts of ketones are present.

LOCATION OF SUPPLIES:

Blood glucose monitoring equipment: _______________________ Insulin administration supplies: __________________________
Glucagon emergency kit: __________________ ketone testing supplies: ______________________ Snacks: ___________________

It is the parent's responsibility to provide the necessary supplies for the management of their child's medic condition.

AUTHORIZATION SIGNATURES

FOR DIABETIC SELF-CARE ONLY

Does this student have physician permission to provide self-care? Yes____ No____

This student has been provided instruction/supervision in recognizing symptoms of hypoglycemia and is capable of doing self-glucose monitoring and his/her own insulin injection/insulin pump care to include using universal precautions and proper disposal of sharps? Yes____ No____

This student requires the supervision of a designated adult? Yes____ No____

This Student requires the assistance of a designated adult? Yes____ No____

THIS DIABETES MEDICAL MANAGEMENT PLAN HAS BEEN APPROVED BY:

PHYSICIAN NAME/ SIGNATURE: ____DATE: _____________

PHONE NUMBER: ____ FAX NUMBER: ______________________

NAME OF PHYSICIAN'S DIABETES EDUCATOR: ______________________________PH. NUMBER: ____________

As parent/guardian of the above named student, I give permission for use of this health plan and for the school nurse to contact my child's healthcare provider(s) regarding the above condition.

I also give permission to the School Nurse, the Unlicensed Diabetes Care assistant (UDCA) and any other designated staff members of ________________________________ school to perform and carry out the diabetes care tasks as outlined by __________________'s Diabetes Management and Treatment Plan. I also consent to the release of the information contained in this Diabetes Management Treatment 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. I also understand that according to Chapter 168.009 of House Bill 984, Immunity From Disciplinary Action or Liability: a) A school employee(s) may not be subject to any disciplinary proceeding, resulting from an action taken in compliance with the subchapter. The requirements of the subchapter, "Care of Students with Diabetes," are considered to involve the employee's judgment and discretion and are not considered ministerial acts for purposes of immunity from liability under Section 22.0511, Education Code; b) A school nurse is not responsible for and may not be subject to disciplinary action under Chapter 301, Occupations Code, for actions performed by an unlicensed diabetes care assistant.

PARENT/GUARDIAN PRINTED NAME: ____

PARENT/GUARDIAN SIGNATURE: ____DATE: ________________

My child *can* manage his/her diabetes completely independently and *will not* seek assistance for his/her diabetes while at school.

PARENT/GUARDIAN SIGNATURE: ____________________________________DATE:_______________

This diabetes management plan has been read and reviewed by the school nurse and/or unlicensed diabetes care assistant.

School Nurse Signature: ____DATE:_________________

Unlicensed Diabetes Care Assistant Signature: ______________________________________DATE:_________________