GRIFFIN-SPALDING COUNTY SCHOOLS
DIABETES HEALTH CARE PLAN
School Year: ___________

Student's Name: ______________________ D.O.B.: ______________ Teacher: ______________
School: ______________________ Grade/Team: ______________________
Parent/Guardian's Name: ______________________ Home Phone: ______________
Mother's Work #: ______________________ Father's Work #: ______________
Cell #: ______________ Other #: ______________________
Emergency Contact Other Than Parent: Name: ______________ Relationship: ______________
Phone Number: ______________________

PHYSICIAN INFORMATION	
Primary Healthcare Provider Name: ______________________ Address: ______________________	Phone #: ______________
Endocrinologist Name: ______________________ Address: ______________________	Phone #: ______________

EMERGENCY NOTIFICATON: Notify parents of the following conditions:

A. Loss of consciousness or seizure immediately after calling 911 and administering Glucagon.
B. Blood sugars in excess of 300 mg/dl. With ketones present.
C. Positive urine ketones.
D. Abdominal pain, nausea/vomiting, fever, diarrhea, altered breathing, altered level of consciousness.

STUDENT'S COMPETENCE WITH PROCEDURES (Must be verified by parent and school nurse)

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

Target Blood Sugar Range is ______________ **mg/dl to** ______________ **mg/dl.**

REQUIRED BLOOD SUGAR TESTING AT SCHOOL | **TIMES TO DO BLOOD SUGAR**

Location of testing: ______________________

- ☐ Trained personnel must perform blood sugar test
- ☐ Trained personnel must supervise blood sugar test
- ☐ Student can perform testing independently

- ☐ Before lunch
- ☐ After lunch
- ☐ After P.E.
- ☐ As needed for signs/symptoms of low or high blood sugar

Call parent if values are below __________ **mg/dl or above** __________ **mg/dl**

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EMERGENCY RESPONSE PLAN

Student Name: ______________________________ Grade/Teacher: ______________ Date: ____________

MANAGEMENT OF LOW BLOOD SUGAR:

Symptoms could include (please circle all that apply): hunger, irritability, shakiness, sleepiness, sweating, pallor (change in color), and uncooperative, crying or other behavioral changes.
Additional student symptoms: ____

With any level of low blood sugar **never** leave the student unattended. If treated outside the classroom, a responsible adult should accompany to the clinic or office for further assistance.

MILD: BLOOD SUGAR < _____ mg/dl

- ☐ Never leave student alone
- ☐ Give 15 grams glucose: recheck in 15 mins
- ☐ If blood sugar < 70, retreat and recheck q 15 min x 3
- ☐ Notify parent if not resolved
- ☐ Provide snack with carbohydrate, fat, protein after treating and meal not scheduled > 1 hr

SEVERE: Loss of consciousness or seizure :

- ☐ Call 911. Open airway and turn to side
- ☐ Glucagon injection: ☐ 0.25 mg ☐ 0.5mg ☐ 1.0 mg
- ☐ Notify parent

If student is uncooperative, unable to eat snack and is still conscious, administer ¾ to 1 tube (3 tsp) of glucose gel or cake decorating gel. Place between cheek and gum with head elevated. Encourage student to swallow.

MANAGEMENT OF HIGH BLOOD SUGAR: (Above _______ mg/dl)

Symptoms could include (please circle all that apply): extreme thirst, headache, abdominal pain, nausea, increased urination.
Additional student symptoms: ____

- ☐ Sugar free fluids/ frequent bathroom privileges
- ☐ If blood sugar is greater than 300 mg/dl and it has been 2 hours since last dose, give ☐ HALF ☐ FULL correction formula above
- ☐ If blood sugar is greater than 300 mg/dl and it has been 4 hours since last dose, give FULL correction formula noted above
- ☐ If blood sugar is greater than 300 mg/dl check for ketones. Notify parent if ketones are present.
- ☐ Note and document changes in status
- ☐ Child should be allowed to stay in school unless vomiting and/or moderate or large ketones are present.

Do not allow exercise.

Physician's Signature: ______________________________ **Date:** ____________
Physician's Name: ______________________________ **Phone Number:** ____________

I, (parent/guardian) ______________________, hereby authorize (Healthcare Provider) ______________ who has attended to my child, ______________________, to furnish to the (School Nurse Supervisor or designee), any medical information and/or copies of records pertaining to my child's Diabetes and for this information to be shared with pertinent school staff. I understand that as of April 14, 2003, under the Health Insurance Portability and Accountability Act ("HIPPA") disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance in the Griffin-Spalding County Schools. This authorization expires as of the last day of the school year.

Parent/Guardian's Signature: ______________________________ **Date:** ____________
School Nurse/Administrator: ______________________________ **Date:** ____________

DIABETES HEALTH CARE PLAN

LOCATION OF SUPPLIES/EQUIPMENT: (To be completed by school personnel)

Blood sugar equipment:	☐ Clinic	☐ With student
Insulin administration supplies:	☐ Clinic	☐ With student
Glucagon emergency kit:	☐ Clinic	☐ With student
Glucose gel:	☐ Clinic	☐ With student
Ketone testing supplies:	☐ Clinic	☐ With student
Fast acting carbohydrate:	☐ Clinic	☐ With student
Snacks:	☐ Clinic	☐ With student

MEDICATIONS TO BE GIVEN AT SCHOOL

Insulin Type: ______________________________

Amount taken at lunch: ______________________________

Use the following correction formula: BG – (minus)________ ÷ ________ (for pre lunch blood sugar over ________ mg/dl)

Correction Insulin/Sliding scale for high blood sugar:

	Before lunch	After lunch
______ Unit(s) if lunch blood sugar is between ________ and ________	☐	☐
______ Unit(s) if lunch blood sugar is between ________ and ________	☐	☐
______ Unit(s) if lunch blood sugar is between ________ and ________	☐	☐
______ Unit(s) if lunch blood sugar is between ________ and ________	☐	☐

Insulin/Carb Ratio: ______ Unit(s) for every ______ grams of carbohydrates eaten, plus give ______ unit(s) of insulin for every ______ mg/dl points above ________ mg/dl.

- ☐ Student can draw up and give own insulin
- ☐ Student needs supervision in giving own insulin
- ☐ Trained adult will draw up and administer injection
- ☐ Student cannot draw up own insulin but can give own injection
- ☐ Student can draw up but needs adult to inject insulin
- ☐ Student is on pump but can manage independently
- ☐ Student is on pump and needs assistance in checking insulin dosage
- ☐ Glucagon (subcutaneous injection) dosage: ☐ 0.25 mg ☐ 0.50 mg ☐ 1.0 mg

Insulin Pump Guidelines attached: ☐ Yes ☐ No ☐ N/A

MEAL PLAN:

☐ Snacks/meals mandatory ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Other

Location snacks are eaten: ______________________________

☐ Child needs assistance with prescribed meal plan. Parent/guardian and student are responsible for maintaining necessary supplies, snacks, testing kit, medications and equipment

EXERCISE GUIDELINES:

Activity Restrictions: ______________________________

Exercise should be delayed or avoided if the blood sugar is < __________ mg/dl or > ________ mg/dl or large amount of ketones are present

- ☐ Check blood sugar right before PE to determine need for additional snack
- ☐ If blood sugar is below target range, eat 15-45 grams carbohydrate before, depending on intensity and length of exercise

DIABETES HEALTH CARE PLAN

BUS TRANSPORTATION

- ☐ Blood sugar test not required prior to boarding bus
- ☐ Test blood sugar 10 to 20 minutes before boarding bus
- ☐ Provide 15 grams glucose source (snack) if blood sugar is < __________ mg/dl

FIELD TRIP INFORMATION:

1. Notify parent and school nurse in advance so proper training can be accomplished.
2. Extra snacks, glucose monitoring kit, copy of health plan, glucose gel or other emergency supplies must accompany student on field trip.

Physician's Signature: ______________________________ **Date:** ______________

Physician's Name: ______________________________ **Phone Number:** ______________

As parent/guardian of the above named student, I give permission for use of this health plan in my student's school and for the school nurse to contact my child's diabetes provider for guidance and recommendations. I have reviewed this information form and agree with indicated information. Orders are valid through the end of the current school year unless written documentation of changes is received from the physician.

Parent/Guardian's Signature: ______________________________ **Date:** ______________

School Nurse/Administrator: ______________________________ **Date:** ______________