School Plan of Care for Diabetes

STUDENT INFORMATION

Name: ________________________________ Date of Birth: ________________

School Year: 20_____ – 20_____ Grade: ________________ Current Age: ________________

Pediatrician: ________________ Diabetes Physician (if different): ________________

EMERGENCY CONTACT INFORMATION

Parent/Guardian #1 Name: ________________ Relationship: ________________

Home Phone: ____________ Cell Phone: ____________ Work Phone: ________________

Parent/Guardian #2 Name: ________________ Relationship: ________________

Home Phone: ____________ Cell Phone: ____________ Work Phone: ________________

Target Blood Sugar: ________	**Carb Bolus:** 1 unit of insulin for every _______ carbs	**Correction Factor:** ________

PARAMETERS FOR ACTION

Blood Glucose Reading	Action	Rationale
If the value is between _____ **mg/dl &** _____ **mg/dl**	**NO ACTION** necessary	Normal Blood Sugar
If the value is less than _____ **mg/dl**	Follow **HYPOGLYCEMIA** protocol	Low Blood Sugar
If the value is greater than ______ **mg/dl**	Follow **HYPERGLYCEMIA** protocol	High Blood Sugar

If student suspects high or low blood sugar level, he/she will immediately report symptoms & immediate action will be taken to correct according student’s School Plan of Care for Diabetes &/or Diabetes Management Plan.

All equipment and supplies needed are to be provided by parent/guardian.

If any questions or problems arise, parent/guardian will be contacted immediately.

Supplies kept in the Health Room: A supply of the student’s insulin, prescribed emergency medication and several units of rapid acting glucose sources (i.e. juice pouches, gummies, glucose tabs, etc) and any supplies needed (testing strips, meter, lancets, extra pod or pump reservoir tubing, batteries, etc) MUST be kept in the Health Room to assure it is available should the student not self-possess it at the needed time (i.e. forgot/misplaced/lost medication).

Lock-Down or Inability to Leave Classroom: To prepare for a situation that may prohibit the student from leaving the classroom to obtain glucose supply, such as in an “emergency lock-down,” parent/guardian need to send in In an extra supply of rapid-acting glucose sources (juice boxes, gummies, glucose tabs, etc) to be kept in each of the classrooms per student schedule and other commonly visited areas, such as the Media Center, co-curricular classrooms, and school office. It is preferred a minimum of 30 carb rapid glucose supply at each location.

Field Trips (or away from building for school-related function during school hours): Parent/guardian OR School Nurse, Health Assistant, Principal-Designated Trained School Staff or must accompany and be readily accessible to student while on field trip and emergency treatment and medication (if ordered) must always be available to student.

A copy of the School Plan of Care for Diabetes &/or Diabetes Management Plan will be available to school staff on a “need to know” basis. Confidentiality of the health information is always to be maintained. The OCS School Nurse will provide the necessary training for all school staff regarding the student’s plan of care.

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Student's Diabetes Care: If student is "Independent," he/she may test and treat at current location (i.e. classroom). If supervision or full assistance needed, student will come to Health Room for care	**Student's self-care skills**	**Comment:**
Blood Glucose testing: ❑ Finger-stick ❑ Continuous Blood Glucose Monitor (CGM)	❑ Independent ❑ Supervision needed ❑ Full assistance needed	Student may check blood glucose at any time needed/requested
Does Student have his/her own Cell Phone? ❑ Yes ❑ No	❑ Independent ❑ Supervision needed ❑ Full assistance needed	For School Nurse and parent/guardian to have remote access to CGM readings and tor group text with School Nurse & parent/guardian for diabetes-related communication and treatment decisions
Insulin Administration: ❑ Insulin Injection per pen Can student self-administer injections? ❑ Yes ❑ No Can student determine correct amount of insulin?❑ Yes ❑ No Can student dial correct dose of insulin? ❑ Yes ❑ No ❑ Insulin Pump Brand/Type of Pump: ___________________________ Can student troubleshoot pump problems? ❑ Yes ❑ No	❑ Independent ❑ Supervision needed ❑ Full assistance needed	**Name, Dose, & Time of Basal Insulin** _______________________ _______________________ **Name of Corrective Insulin** _______________________ _______________________
Emergency Meds Kept at School: ❑ Glucagon Injectable ❑ Baqsimi Nasal Powder ❑ Glucose Tabs		Glucagon/Baqsimi will be given promptly if student is unconscious, having seizure, or unable to swallow
Ketone Testing:	❑ Independent ❑ Supervision needed ❑ Full assistance needed	If yes, describe circumstances/parameters for Ketone check:

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PROBLEMS/SYMPTOMS TO BE REPORTED INCLUDE:

Low Blood Sugar	High Blood Sugar
• Is Immediate Medical Emergency • **Take Action Immediately**	• Is a potential medical emergency • Student usually has time to adjust and correct adequately
Causes: Too little food, too much insulin, extra exercise	**Causes:** Illness, stress, too much food, too little insulin
Onset: Quicker/More Rapid Onset	**Onset:** Slower/More Gradual Onset
Signs/Symptoms: • Feeling shaky • Sweating • Pale • Dizzy • Weakness/Fatigue • Very Hungry • Blurred Vision • Headache • Fast Heartbeat • Anxious, Angry, Irritable • Confused, Decreased level of or unconscious • Other: ______________________	**Signs/Symptoms:** • Unusual/Extreme Thirst • Unusual Hunger • Frequent Urination • Sleepiness • Blurred Vision • Stomachache • Fruity Breath Odor • Nausea/Vomiting • Dry Skin • Confused, Decreased level of /or unconscious • Other: ______________________
Treatment: 1. Test Blood Glucose 2. **Immediately give a rapid acting sugar source (i.e.):** 4 oz Orange Juice; 1 juice box 6 Lifesavers; 15 Skittles 4 to 6 oz. regular soda; 1 fruit roll-up 4 Starburst; 3 Glucose Tablets 1 tube of Glucose Gel 3. ****If student lethargic, unconscious, or unable to swallow**, administer **Glucagon/Basquimi** (if ordered) 4. If student becomes unconscious, immediately **call 911** & **notify parent/guardian** 5. **Re-test blood sugar level** after 10-15 minutes. 6. Give protein snack if not going to lunch within 15 minutes, (i.e., 4 to 6 cheese crackers or peanut butter crackers).	**Treatment:** 1. Test Blood Glucose 2. Encourage student to **drink extra water**, may have water bottle in classroom 3. Allow student **extra restroom privileges** 4. **Check Ketones** (if ordered) for blood sugar > 300 5. **Exercise** ONLY if Ketones are less than “Moderate” 6. **Notify Parent/Guardian** 7. **Call 911** immediately if student is vomiting and has a decreased level of consciousness when blood glucose is > 300
Extra Blood Glucose monitoring or snacks may be needed.	Extra Blood Glucose monitoring or water may be needed.

Directions for preparation and administration of Glucagon injection &/or Baqsimi nasal power will be added to this document per OCS School Nurse if prescribed by student’s Healthcare provider.

Owensboro Catholic Schools

School Plan of Care for Diabetes

Student's School Plan of Care for Diabetes reviewed and approved by:

Parent/Guardian Name (Signature): ____ **Date:** ________________________________

❑ *Please check this box if you understand that by typing your name, it is the same as your signature*

School Nurse Signature: ____ **Date:** ________________________________

Principal Signature: ____ **Date:** ________________________________

Healthcare Provider's Signature: ____ **Date:** ________________________________

Healthcare Provider's Signature Note: If a separate "Diabetes Management Plan" is obtained and signed by the Healthcare provider, then the Healthcare Provider's signature on the Diabetes Management Plan will supersede his/her signature on the OCS School Plan of Care for Diabetes.

Authorization to Release and Disclose Patient Information for School Year 20____–20____

I understand that the OCS School Nurse/Health Coordinator may have questions and require clarification from the student's Health Care provider to assist in the treatment and care concerning this student. As the parent/guardian of (student's name) ______________________________, I hereby give my permission for exchange of confidential protected health information regarding this student between the OCS School Nurse/Health Coordinator and this student's Healthcare Provider and my signature is an informed consent to share necessary medical information with specified OCS school staff as a "need to know" for academic success and emergency plan as determined by the OCS School Nurse/Health Coordinator.

Parent/Guardian Name (Signature): ____ **Date:** ________________________________

❑ *Please check this box if you understand that by typing your name, it is the same as your signature*