Optional Student Photo

DIABETES CARE PLAN-Insulin Pump *Side 1*

TO BE COMPLETED BY HEALTHCARE PROVIDER

EFFECTIVE DATE:		End Date:
STUDENT'S NAME:	Grade:	Date of Birth:
ALLERGIES:		
DIABETES HEALTHCARE PROVIDER INFORMATION Name:		
Phone #: Fax #:		
SCHOOL: Nurse Phone #:		School Fax #:

Monitor Blood Glucose – test ... (reference Hypo/Hyperglycemia treatment protocol for BG < 70 and BG ≥ 250)

☐ If student has symptoms of high or low blood glucose

Breakfast: ☐ Before ☐ After Exercise/PE/gym/recess: ☐Before ☐After

Lunch: ☐ Before ☐ After ☐ Before leaving school

Snack: ☐Before ☐ After ☐ Other: _____

Where to test: ☐ Classroom ☐ Health office ☐ Other: _____

☐ **Without moving student if has low blood glucose symptoms**

Continuous Glucose Monitoring: Type of CGM: _____

Student may use reading from CGM for: ☐ Insulin dosing ☐ End of day check ☐ Before activity check

Perform a finger stick: ☐ Blood glucose is rapidly changing when dosing insulin ☐To confirm hypoglycemia

☐ Hyperglycemia ☐ Calibrations ☐ Other: _____

Insulin Pump Information: Type of pump: _____

Insulin Type: ☐ Rapid-acting (Insulin Lispro/Insulin Aspart/FIASP) ☐ Other: _____

Basal rates during school: See insulin pump as rates may vary

Verify pump for: ☐ Automode ☐Basal IQ ☐Control IQ ☐Suspend Before Low ☐Other:_____

☐ Insulin dosing per pump recommendations

BLOOD GLUCOSE CORRECTION

☐ USE THE FOLLOWING PARAMETERS TO CALCULATE CORRECTION DOSE

Target blood glucose: _____mg/dL **Insulin sensitivity factor:** _____

$$\frac{\textbf{(Current Blood Glucose – Target Blood Glucose)}}{\textbf{Insulin Sensitivity factor}} = \_\_\_\_\_\ \textbf{Units of Insulin}$$

When to give correctional insulin: ☐Before breakfast ☐Before lunch ☐Per pump ☐Other: _____

☐ All BG/SG results to be entered into pump to determine bolus dose.

Do not give correction dose more than once every 3 hours.

CARBOHYDRATE COVERAGE

Meal Insulin: ☐Before eating ☐After eating

☐ If BG <70 before a meal, treat with carbohydrate per the Algorithm for Blood Glucose Results.

☐ USE THE FOLLOWING PARAMETERS TO CALCULATE CARBOHYDRATE COVERAGE DOSE

Time: _____ 1 unit of insulin per _____ grams of carbohydrate

Time: _____ 1 unit of insulin per _____ grams of carbohydrate

Time: _____ 1 unit of insulin per _____ grams of carbohydrate

Time: _____ 1 unit of insulin per _____ grams of carbohydrate

$$\frac{\textbf{Total Grams of Carbohydrates to Be Eaten}}{\textbf{Insulin-to-Carbohydrate Ratio}} = \_\_\_\_\_\ \textbf{Units of Insulin}$$

When to give carbohydrate coverage insulin:

☐With all carbohydrate intake ☐Breakfast ☐Lunch ☐Snack ☐Special Occasions ☐Other: per pump

DIABETES CARE PLAN- Insulin Pump *Side 2*

TO BE COMPLETED BY HEALTHCARE PROVIDER

Optional Student Photo

STUDENT NAME:_____ Date of Birth_____

MEDICATION	Frequency	DOSE	ROUTE	NOTES
☐ Tresiba/Lantus	Once daily at	_____ units	Subcutaneous	Injection to be witnessed or performed by the nurse or trained person.
☐				
☐ PRN Glucagon	PRN Severe Hypoglycemia	☐ 1 mg ☐ 0.5 mg	IM or SC Injection	Administration site includes buttocks, arm, or thigh by the nurse or trained person.

Exercise and Sports

A quick-acting source of glucose such as glucose tabs or sugar-containing juice should be available at the site of physical activity or sports.

Do not exercise with moderate to large ketones per hyperglycemia protocols.

☐ Temp Basal Decrease: ☐ (____% or ____units for ____minutes) ☐ duration of exercise

☐ Activate Temp Target: ☐ Duration of exercise ☐ Start ____minutes before ☐ End ____minutes after exercise.

☐ May disconnect from the pump for exercise to last no more than 2 hours.

☐ Student should monitor blood glucose hourly.

☐ Student should eat _____**grams of carbohydrates:**

☐ Before ☐ Every 30 minutes during ☐ Every 60 minutes during ☐ After vigorous activity

☐ If pre-exercise blood glucose is less than _____ **mg/dL**, student can participate in physical activity once blood glucose is corrected and above _____**mg/dL.**

☐ If pre-exercise blood glucose is less than _____ **mg/dL**, student can participate in physical activity once they consume a ____ gram snack with protein.

If student is to exercise right after lunch, student should subtract ____ gm from their carbohydrate count.

Parent/Guardian Authority to Adjust Insulin Dose

Dose adjustment allowed up to 20% higher or lower ☐ Yes ☐ No

Pump settings should not be changed by school staff (unless under direction of diabetes doctor).

☐ Place pump on suspend when blood glucose is less than **70** mg/dl and re-activate it when blood glucose is at least **85** mg/dl. (Do not override auto mode/basal IQ)

If infusion set comes out or needs to be changed:

☐ Change set at school OR ☐ Insulin via syringe every 3 hours

HCP Assessment of Student's Diabetes Management Skills:

Skill	Independent	Needs Supervision*	Cannot do
Check blood glucose	☐	☐	☐
Count carbohydrates	☐	☐	☐
Calculate insulin dose	☐	☐	☐
Injection	☐	☐	☐
Troubleshoot CGM alarms	☐	☐	☐
Set Temp basal/Temp	☐	☐	☐
Change infusion set	☐	☐	☐

*The RN or other trained staff is expected to observe for accuracy & completion of the skill.

- ***For blood glucose ≥ 250 mg/dL, repeat blood glucose check in 2 hours. If blood glucose remains ≥250 mg/dL, check urine ketones and refer to Hyperglycemia Treatment Protocol.***
- ***Check ketones with signs of illness including abdominal pain, upset stomach and vomiting.***
- ***For blood glucose less than 70 mg/dL, refer to the Hypoglycemia Treatment Protocol.***

Other health concerns:

Notes:

MEDICAL PROVIDER WITH PRESCRIPTIVE AUTHORITY IN ALASKA (PRINTED)	TELEPHONE NUMBER
MEDICAL PROVIDER SIGNATURE AND CREDENTIALS	DATE

STUDENT'S NAME:

ALGORITHMS FOR BLOOD GLUCOSE RESULTS

Student's usual LOW blood glucose symptoms:

_ Shaky or jittery	_ Uncoordinated
_ Sweaty	_ Irritable, nervous
_ Hungry	_ Argumentative
_ Pale	_ Combative
_ Headache	_ Changed personality
_ Blurry vision	_ Changed behavior
_ Sleepy	_ Unable to concentrate
_ Dizzy	_ Weak, lethargic

Student's usual HIGH blood glucose symptoms:

Hyperglycemia	*Emergency levels*
_ Increased thirst, dry mouth	_ Extreme thirst
_ Frequent or increased urination	_ Nausea, vomiting
_ Change in appetite, nausea	_ Severe abdominal pain
_ Blurry vision	_ Fruity breath
_ Fatigue	_ Heavy breathing, shortness of breath
_ Other	_ Increasing sleepiness, lethargy

CHECK BLOOD GLUCOSE

BELOW 70

1. Give 15 gm fast-acting carbohydrate
2. Observe for 15 minutes then retest blood glucose.
   a. If less than 70, repeat 15 gm carbohydrate and retest in 15 min.
   b. If over 70 and not eating a meal within an hour, give carbohydrate and protein snack without insulin coverage.
3. Notify school nurse and parent if no improvement.
4. Student should not exercise.

CALL 911 if student becomes unconscious, seizures or is unable to swallow

- Turn student on side to ensure open airway
- Give glucagon as ordered. Keep student in recovery position on side.
- If on insulin pump, either place it in 'suspend' or stop mode, disconnect it at the pigtail or clip, or cut tubing. If pump was removed, send it with EMS to the hospital.
- Notify school nurse, parent and HCP
- Wait 15 minutes; if no response, repeat glucagon.
  - If responsive, offer juice. Wait 15 minutes and give protein & carbohydrate snack.

70 – 90

1. If prior to exercise or immediately following strenuous activity and **NO** meal/snack is planned within 30 minutes, give 15 gm carbohydrate and protein snack.

2. If **NOT** exercise-related and student is symptomatic, observe and recheck in 15 minutes.

3. If **NOT** exercise-related and is NOT symptomatic, return to class.

15 GM FAST-ACTING CARBOHYDRATE =

- ½ c. juice
- 3-4 glucose tablets
- Tube of glucose **gel**
- ½ c. regular (not diet) soda
- 6-7 small sugar candies (to chew)
- 1 c. skim milk

Do not give chocolate

91-125

Student may eat before exercising or recess.

126-300

No action needed.

ABOVE 250

STUDENT TREATED BY **INJECTION**

1. Use correction scale or formula at lunch or every 2-3 hours
2. Check ketones if symptoms or if blood glucose>250 twice in a row:
   a. If ketones are *absent or small*, encourage exercise and water
   b. If ketones moderate or large:
      - No exercise; give water
      - Add units of insulin per orders
3. Notify school nurse and parent
4. **Provide free, unrestricted access to water and the restroom.**

STUDENT TREATED BY **PUMP**

1. If 2-3 hours since last bolus, treat with correction bolus via pump. Re-check in 2- 3 hrs. Trouble shoot pump function.
   - Check for redness at site, tubing for kinks or air bubble, insulin supply
2. If blood glucose still ≥ 250 mg/dl and not explained, check ketones:
   a. If ketones are *absent or small*, encourage exercise and water
   b. If ketones moderate or large:
      - Give insulin correction dose per orders **via syringe**.
      - No exercise; encourage water
3. Change infusion set or continue insulin injections every 2-3 hours via syringe.
4. Notify school nurse and parent
5. **Provide free, unrestricted access to water and the restroom.**

CALL 911 if the student vomits, becomes lethargic and/or has labored breathing.
Notify school nurse, parent and HCP.

EXERCISE AND SPORTS

✓ Assure has quick access to water for hydration, fast-acting carbohydrates, snacks and monitoring equipment.
✓ Student should not exercise if blood glucose level is below 70 mg/dl or if has moderate to large ketones.

Never send a child with suspected low blood glucose *anywhere* alone.

Optional Student Photo

MEDICATION ADMINISTRATION:

PARENTAL AUTHORIZATION FOR SCHOOL STAFF TO ADMINISTER *(for Non-Delegable Medication)*

Student_____ **Birthdate**_____ **Grade** _____

Parent/Guardian _____ **Contact** _____

Background. All students attending public schools must have access to health care during the school day and for school sponsored activities, if necessary, to enable the student to participate fully in the school program. The federal laws include the Americans with Disabilities Act, Individuals with Disabilities Education Act (IDEA), and Section 504 of the Rehabilitation Act of 1973.

The Alaska Board of Nursing does not authorize registered nurses to delegate certain medications to unlicensed assistance personnel. Examples include but are not limited to: **injectable** medications, medications via gastrostomy tube and "as needed" **controlled substances**. However, parental delegation of these medications, when a school nurse is not available to administer them, is allowed in 12 AAC 44.975, Exclusions (2) under "other legal authority." In an Alaska Board of Nursing advisory opinion dated 4-2-12, the ***Medication Administration in the School Setting Delegation Decision Tree*** was adopted as a plan to allow parents to delegate to school staff with nurse involvement in training and follow up. The trained school staff must provide care for the student consistent with the Individualized Healthcare Plan (IHP) prepared by the nurse based on healthcare provider instructions and parent input.

Parent Authorization. I, the parent/legal guardian, understand that in the absence of the school nurse, other trained school staff will administer this medication. I agree to defend and hold named school district employees harmless from ANY liability resulting from the medication or the manner in which it is administered, and to defend and indemnify the school district and its employees for any liability arising out of these arrangements. **I will notify the school immediately if the medication is changed and understand that the nurse may contact the health care provider or pharmacist regarding this medication.**

As a parent or guardian of _____, I hereby acknowledge that I have read and understand this form and agree to its content. I have authorized the nurse to train school staff using a standardized curriculum to administer the medication(s) (below) to my child according my child's IHP when the school nurse is not available.

☐ I attended the training session(s) provided to the school staff identified below, agree that the content was appropriate for medication administration to my child.

☐ I did not attend the training session(s) provided to the school staff identified below but have reviewed the curriculum and agree that the content is appropriate for medication administration to my child.

Name(s) of school staff authorized to be trained to administer_____ to my child.
name of medication(s)

1._____ 2._____ 3. _____ 4._____

_____	_____	_____	_____
Parent signature	***Date***	***Home phone***	***Cell phone***

PLEASE SIGN AND RETURN THIS FORM TO YOUR SCHOOL OFFICE - if no form is on file, it will be assumed that authorization for parental delegation has not been granted and there will be no trained school staff assigned to your child.

INDIVIDUALIZED HEALTHCARE PLAN - DIABETES

SCHOOL AND PARENT PART

Student's photo

STUDENT'S NAME:	**PLAN EFFECTIVE DATE:**
Diabetes information Date of Diagnosis: ☐ Diabetes Type 1 ☐ Diabetes Type 2 ☐ Other	

SCHOOL INFORMATION

Grade: *Teacher:* *504 plan on file:* ☐ Yes ☐ No

CONTACT INFORMATION:

Parent/Guardian 1:	Name			Call first ☐
Phone numbers:	Home	Work	Cell	Other
Parent/Guardian 2:	Name			Call first ☐
Phone numbers:	Home	Work	Cell	Other
Other/emergency:	Name:		Relationship:	
Phone numbers:	Home	Work	Cell	Other

Additional Times to Contact Parent...

Student treated by **injection**
- ☐ Blood Glucose test out of target range
- ☐ Routine Daily Insulin injections
- ☐ Correction dose

Student treated by **pump**:
- ☐ Blood Glucose test out of target range
- ☐ Carbohydrate bolus
- ☐ Correction bolus
- ☐ Infusion set comes out/needs to be replaced

STUDENT DIABETES SELF-MANAGEMENT PLAN

Student will manage diabetes independently

☐ **Student has signed** *Agreement for Student Independently Managing Diabetes*

Trained staff will supervise student self-care
- ☐ Verify blood glucose test
- ☐ Check carbohydrate count
- ☐ Confirm dose
- ☐ Supervise insulin self-injection
- ☐ Monitor bolus administration
- ☐ Trouble shoot pump alarms, malfunction
- ☐ Watch infusion set change

Trained staff will provide care
- ☐ Test blood glucose
- ☐ Count carbohydrates
- ☐ Calculate insulin dose and inject as above
- ☐ Provide insulin injection
- ☐ Administer bolus
- ☐ Trouble shoot pump alarms, malfunction
- ☐ Change infusion set

Comment:

FOOD PLAN	Time	Notes	Monitor/Remind Student	
			Yes	No
Breakfast				
Morning snack				
Lunch				
Afternoon snack				
Extra snack Before exercise				
After exercise				

Food at a classroom/school party:
- ☐ Student will eat treat
- ☐ Replace the treat with a parent-supplied alternative
- ☐ Put in baggie to take home with teacher note
- ☐ Student should not eat treat
- ☐ Modify the treat as follows:

BUS TRANSPORTATION PLAN

Bus transportation: ☐ To school ☐ Home

- ☐ Test blood 10-20 minutes before boarding school bus home. **Student must have blood glucose > 70 mg/dl to board bus**; if ≤ 70, provide care based on algorithm and call to have student picked up.
- ☐ Blood test not required.
- ☐ Student may test blood glucose and self-manage diabetes while on the bus.

FIELD TRIPS
- ☒ **School nurse to be notified two weeks before the field trip to assure qualified personnel are available.**
- ☐ All diabetes supplies are taken and care is provided according to this Plan (copy to accompany trip).
- ☐ Lunch and snack times should not change.

SCHEDULED AFTER- OR BEFORE-SCHOOL ACTIVITIES List of clubs, sports, etc. that student anticipates:

If parent wants trained staff coverage for an activity, parent will notify school nurse two weeks before it begins

STUDENT'S NAME: | **PLAN EFFECTIVE DATE:**

SUPPLY LIST

☑ Means student uses this item **AND** parent will provide.

☐ *Blood Glucose Test Kit*

- ☐ Meter
- ☐ Test strips
- ☐ Lancing device and lancet
- ☐ Sharps container
- ☐ Anti-bacterial cleaner/alcohol swabs
- ☐ cotton balls
- ☐ spot band-aids

Glucose meter brand/model:

☐ *Insulin*

Treatment by Injection

- ☐ Insulin pen
- ☐ Pre-filled syringes (labeled per dose)
- ☐ Insulin vials and syringes

Treatment by Pump

- ☐ Pump syringe
- ☐ Pump tubing/needle
- ☐ Batteries
- ☐ Tape
- ☐ Sof-serter
- ☐ Insulin vial and syringes

Infusion set type: _____

Pump type

- ☐ Medtronic MiniMed www.minimed.com (800) 826-2099
- ☐ Animas www.animas.com (877) 767-7373
- ☐ Omnipod www.myomnipod.com (800) 591-3455

☐ *Low Blood Glucose (5-day supply)*

- ☐ Fast-acting carbohydrate drink (apple juice, orange juice, regular soda pop – NOT diet), ≥ 6 containers
- ☐ Pre-packaged snacks (e.g., crackers with cheese or peanut butter, nite bite), ≥ 5 servings
- ☐ Supply of fast-acting glucose at least equal to 15 gm per day for 5 days (e.g., ≥ 75 gm total)

☐ *Glucagon Kit*

☐ *High Blood Glucose*

☐ Urine ketone test strips/bottle ☐ Urine cup ☐ Water bottle (Timing device may be wall clock or watch)

☐ *3-day Disaster Kit*

- ☐ Complete daily insulin dose schedule (separate page)
- ☐ Blood glucose test kit (testing strips, lancing device, lancets, meter batteries)
- ☐ Vial of insulin and 6 syringes; insulin pens and supplies
- ☐ Insulin pump and pump supplies
- ☐ Hypoglycemia treatment supplies, ≥ 3 episodes
- ☐ Other medications, including glucagon kit
- ☐ Urine ketone strips/plastic cup
- ☐ Antiseptic wipes or hand sanitizer
- ☐ 3-day food supply with meal plan
- ☐ Other:

☐ *Other*

SUPPLY LOCATIONS

	With student	In classroom	In health office	Other		With student	In classroom	In health office	Other
Daily breakfast, snacks and lunch					Blood glucose test kit Extra kit				
Extra snacks					Pump supplies				
Low blood glucose supplies					Insulin Daily use Extra/emergency				
High blood glucose supplies					Disaster Disaster food				
Other									

SIGNATURES

As parent/guardian of the above-named student, I give permission for the school nurse and/or other trained staff of

_____ to perform and carry out the diabetes care tasks as outlined in this Individualized Healthcare Plan.
(school)

- I have reviewed this plan and agree with the indicated instructions. I understand that the school is not responsible for equipment loss or damage, or expenses associated with these treatments and procedures.
- I understand that the information contained in this plan will be shared with other school staff on a need-to-know basis.
- I give permission to the school nurse to contact my child's physician/health care provider and discuss my child's care related to this plan.
- I will notify the school nurse whenever there is any change in my child's health status or care.
- My child and I are responsible for maintaining the necessary supplies, snacks, blood glucose meter, medications and other equipment.

_____ _____
Student's parent/guardian Date Student's parent/guardian Date

☐ Approved by School Nurse

_____
School nurse Date

AGREEMENT FOR STUDENTS INDEPENDENTLY MANAGING THEIR DIABETES

Student: _____ Grade: _____

Student
☐ I agree to dispose of any sharps either by keeping them in my kit and taking them home, or placing them in the sharps container provided at school. ☐ I will notify the health office if my blood sugar is below _____ mg/dl or above _____ mg/dl. ☐ I will not allow any other person to use my diabetes supplies. ☐ I plan to keep my diabetes supplies: ☐ With me ☐ In the school health office ☐ In an accessible and secure location (_____) ☐ I will seek help in managing my diabetes from _____ if I need it. ☐ I understand that the freedom to manage my diabetes independently is a privilege and I agree to abide by this contract. Student's signature: _____ Date: _____

Parent/Guardian
☐ I agree that my child can self-manage his/her diabetes and can recognize when he/she needs to seek help from a staff member. ☐ I will provide back-up supplies to the health office for emergencies. ☐ I understand that this contract is in effect for the current school year unless revoked by my son/daughter's physician or my son/daughter fails to meet the above safety guidelines. Parent's signature: _____ Date: _____

School nurse
☐ I will assure that school staff members that need to know about this student's condition and that he/she must to carry their diabetes supplies with them have been notified. School Nurse's signature: _____Date: _____