Muscogee County School System
Student Health Services
DIABETIC STUDENT HEALTH CARE PLAN

Please bring or mail this health care plan to the school.
A new health care plan is required every school year.

Student: _____**Date of Birth:** _____**School year:** _____

School: _____**Teacher:** _____**Grade/Team:** _____

Emergency Contacts

Parent/Guardian/Contact	Relationship	Phone Number	Alternate 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
- ☐ Monitoring BG in classroom
- ☐ Determining insulin dose
- ☐ Measuring insulin dose
- ☐ Injecting insulin
- ☐ Independently operates insulin pump
- ☐ Carry supplies for BG monitoring
- ☐ Carry supplies for insulin administration
- ☐ Self-treatment for mild low blood sugar
- ☐ Determine own snack/meal content

Blood Glucose Monitoring:

Target range: _____mg/dl to _____mg/dl

- ☐ None required at this time
- ☐ Before Meals
- ☐ Midmorning
- ☐ Before PE / Activity
- ☐ After PE / Activity
- ☐ Mid-afternoon
- ☐ 2 Hours Before Correction
- ☐ Before Dismissal
- ☐ PRN for Suspected Low / High BG

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Insulin Administration:

☐ None

Dose may be 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 _____ grams 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 hr. 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

Management of Low Blood Glucose (Below _____ mg/dl):

Mild: BG < _____

- ☐ Never leave student alone
- ☐ Give 15gm glucose and recheck in 10 minutes
- ☐ If BG<70, repeat treatment and recheck BG every 10 minutes x3
- ☐ Notify Parent/Guardian if not resolved
- ☐ Provide snack with CHO, fat, protein after treating/meal <1 hour

Describe specific signs of low BG:

- ☐ Shaking
- ☐ Fast Heartbeat
- ☐ Sweating
- ☐ Dizziness
- ☐ Anxiety
- ☐ Hunger
- ☐ Impaired Vision
- ☐ Weakness
- ☐ Fatigue
- ☐ Headache
- ☐ Irritability
- ☐ Shortness of Breath
- ☐ Other: _____

Management of High Blood Glucose (Above _____ mg/dl):

- ☐ Sugar-free fluids / frequent bathroom privileges
- ☐ If BG > _____, initiate insulin orders
- ☐ If BG > _____, check for ketones. Notify parent/guardian if ketones are present.
- ☐ May not need snack.
- ☐ Note and document changes in status
- ☐ Notify parent/guardian (Refer to page 1)

Muscogee County School System
Student Health Services
DIABETIC STUDENT HEALTH CARE PLAN

Describe specific signs of high BG:

- ☐ Extreme Thirst
- ☐ Frequent Urination
- ☐ Dry Skin
- ☐ Hunger
- ☐ Blurred Vision
- ☐ Drowsiness
- ☐ Nausea
- ☐ Abdominal pain
- ☐ Confusion
- ☐ Sweet Odor to Breath
- ☐ Other: _____

Exercise: (Staff must be information, 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 _____

Physician's Authorization

My signature provides 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/guardian.

Physician's Name: _____Phone Number: _____

Physician's Signature: _____ **Date:** _____

Parent Consent for Management of Diabetes at School

I_____(Parent/Guardian) hereby authorize the named Healthcare Provider who has attended to my child, to furnish to the School Health Services Nurse and/or School Clinic Staff 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 at my child's school. I understand that as of April 14, 2003, under the Health Insurance Portable and Accountability Act ("HIPAA") 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 Muscogee County School District. This authorization expires as of the last day of the school year.

I request designated school personnel to administer the medication and treatment orders as prescribed above. I agree to provide the necessary supplies and equipment and to notify the school nurse if there is a change in the student's diabetes management or health care provider.

I understand that it is my responsibility to notify the bus driver, school administration, teacher, clinic worker and school nurse of any and all health conditions for my child.

Parent/Guardian's Signature:_____**Date**:_____