Confidential Diabetes Health Plan: Self Management Diabetes in School Setting

Student Name:	Date of Birth:	Grade:

*DMMP orders	☐ Yes ☐ No	Date of orders: Date of Diagnosis:	Date of Plan:
If no Diabetes Medical Provider orders, only emergency care can be provided - please include Emergency Care Plan			

Family Emergency Contact Information
Print a face sheet with the student's picture to keep with the IHP

Parent/Guardian:	**Preferred Contact Info:**
Parent/Guardian:	**Preferred Contact Info:**
Diabetes Medical Provider:	**Contact Info:**
Diabetes Nurse Educator:	**Contact Info:**
Diabetes Resource Nurse:	**Contact Info:**
School Nurse:	

Target range: ___ mg/dl ____ mg/dl
Notify parent/guardian if values below ___ mg/dl or above ____ mg/dl

Addendums:
☐ **Insulin Medication Addendum** ☐ **Pump Addendum**
☐ **Self-Management Agreement** ☐ **CGM Addendum**

Insulin: **Delivery Device:** CHOOSE 1 **Pump Brand and Model**:

Student's Ability to Self-Manage Diabetes Care
Ability level is to be determined by the parent and provider with consultation from the school nurse and specified on the provider orders/DMMP*

Does the student self-manage their diabetes: ☐ **Yes**

If **yes**, proceed to Emergency Action Plan (all students regardless of age or expertise require a diabetes health plan e.g. Emergency Action plan). Attach *Agreement for Student's Self-Management* **and** include *Emergency Action Plan*

☐ NO (check level of supervision)
☐ Trained/delegated personnel must **perform** diabetes care including insulin administration and BG/SG monitoring
☐ Trained/delegated personnel must **supervise** diabetes care including insulin administration and BG/SG monitoring

☐ Student can administer insulin with supervision
☐ Student can perform BG/SG testing/monitoring

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LOW Blood Sugar (Hypoglycemia) Management

If Symptoms - Take Action: Check Blood glucose/sensor glucose if possible. Treat if below ____mg/dl

- Always treat if in doubt or if blood sugar is unavailable
- Never leave unattended
- Always send to clinic accompanied by responsible person
- Check BG/SG when CGM alarms or when student is symptomatic
- If blood glucose/sensor glucose in range but student symptomatic, may contact parent or provide a complex snack (cheese and crackers, ½ granola bar)
- With insulin pump, DO NOT enter carbs for fast acting sugar used to treat low

LOW Blood Sugar (Hypoglycemia) Management Always treat for hypoglycemia if in doubt or if BG/SG is unavailable.

Emergency Medication: *For Severe Hypoglycemia*
CHOOSE 1 **Dose: _____ Route: _____** (Add the appropriate medication administration instructions to the IHP) **Call 911 if administered or it is not available!**

MILD SYMPTOMS: Hunger, shaky, irritable, dizzy, anxious, sweating, crying, pale, spacey, tired, drowsy, personality change, other:
Mild Treatment:
• **Treat** by giving ___ grams of fast-acting sugar such as glucose tabs, juice box/Capri pouch, regular soda, Smarties candy rolls.
• Wait 15 minutes - student should be observed during this time. Contact RN.
• Recheck BG/SG.
• **Retreat** if BG/SG is still under 70 mg/dl or if symptoms persist.
• Once BG/SG ____ mg/dl or higher, escort student to lunch **OR** provide a complex carb snack of ___ grams
• **Lows MUST be treated before the student goes to lunch.**
  - Dose for carbs **after** eating lunch (do not give a correction dose)
• Notify Parent

MODERATE SYMPTOMS Confusion, slurred speech, poor coordination, behavior changes, unable to focus in order to eat or drink
Moderate Treatment:
• **Treat** with glucose gel or icing keeping head elevated, squeeze gel between cheek and gums, massage the area and encourage student to swallow
• Wait 15 minutes - student should be observed during this time
• **Recheck** BG/SG and if below ___ mg/dl and symptoms persist, retreat until BG/SG above ___ mg/dl
• Once BG/SG ___ mg/dl or higher, escort student to lunch **OR** provide a complex carb snack up to **15 gram** (or ___ gram per parent)
• **Lows MUST be treated before student goes to lunch.**
• Only dose for carbs after eating lunch (do not give a correction dose)
• Notify Parent and RN

SEVERE SYMPTOMS Seizure, Loss of consciousness
Severe Low Treatment:
• **Call 911 and administer Emergency medication. to be administered by trained and delegated staff**
• Position student on side
• Disconnect pump or peel off insertion site like a band-aid. Keep pump with student
• Stay with student until 911 arrives
• Once student responds to glucagon and is able to sit up, treat with glucose gel. When fully alert, offer sips of juice
• Notify Parent and RN

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HIGH Blood Sugar (Hyperglycemia) Management

If Symptoms - Take Action: Check Blood glucose/sensor glucose if possible. If above ____mg/dl

- Encourage to drink water
- Contact parent/guardian
- Allow access to water and restrooms
- Other: _____

HIGH Blood Sugar (Hyperglycemia) Management

MILD SYMPTOMS

Thirst, headache, abdominal discomfort, nausea, increased urination and/or lethargy

Mild Treatment:

• Encourage to drink water or diet soda (caffeine free): 1 ounce water/year of age/per hour

• When hyperglycemia occurs other than lunchtime – contact school nurse to determine correction procedure per provider orders or one-time orders

• Provide blood/sensor glucose correction as indicated in provider orders or per pump

• **Recheck** in 2 hours for students on pump

• **Reminder**: Students taking insulin injections should not be given a correction dosage more than every 3 hours unless directed by provider orders

• Note: If on a pump insulin may need to be given by injection contact school nurse

Hyperglycemia:

If BG/SG is over ____> twice in a row and greater than 2 hours apart:

- **Check** urine/blood ketones - if **moderate to large ketones in urine or if blood ketones are greater than 1.0 mmol and student is symptomatic, call parent/guardian as student should be treated at home. Notify school nurse**
- **If unable to test for ketones and student has symptoms of illness, nausea, vomiting and/or stomachache, notify the school nurse. At this point, the student should be treated/monitored by parent/guardian outside of school. If symptoms of nausea, vomiting and/or stomachache persist or worsened while at school and parent/guardian is unable to be contacted, call 911**
- Exercise restrictions - see Standards of Care and contact your school nurse

* **If student has labored breathing, change in mental status and/or may be dehydrated- call 911**

Access Standards of Care for Diabetes management in the School Setting and Contact School

Nurse www.coloradokidswithdiabetes.org

Attach Self-Management Agreement after this page.

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Agreement for Students Self-Managing Their Diabetes

STUDENT

- I agree to dispose of any sharps either by keeping them in my kit and disposing at 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 (located in _____)
- I understand that the freedom to manage my diabetes independently is a privilege and I agree to abide by this contract.
- I understand that if wifi or cell service is not available, I am able to count carbohydrates and dose my own insulin.

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 the help of a staff member.
- I agree that my child can count their own carbohydrates and dose their own insulin if wifi or cellular connections are not available.
- It has been recommended to me that backup supplies be provided to the health office for emergencies.

Parent/Guardian's Signature: _____ Date: _____

SCHOOL NURSE

- School staff members who need to know about the student's condition and the need for the student to carry their diabetes supplies have been notified.

School Nurse's Signature: _____ Date: _____

Additional Information if needed (Please Initial below).

_____

_____

_____

Student Initials: _____ Parent Initials: _____ School RN Initials: _____