

# Galena Park

Independent School District

## Diabetes Management and Treatment Plan

### \*Annual Health Service Prescription - Physician/Parent Authorization for Diabetic Care

\*This form is to be renewed at the beginning of the school year: DATE OF PLAN \_\_\_\_\_

Student: \_\_\_\_\_ Birth date: \_\_\_\_\_

#### TO BE COMPLETED BY PHYSICIAN:

Please respond to the following questions based on your records and knowledge of the student.

#### 1. Procedures:

 (parent to provide supplies for procedures):

Test blood glucose before lunch and as needed for signs/symptoms of hypoglycemia.  
Test urine ketones when blood glucose is hyperglycemic, and/or when child is ill.

#### 2. Medication:

 (Child may \_\_\_ may not \_\_\_ prepare/administer insulin injection).

**Rapid Acting Insulin [Regular/Humalog/Novolog]** given subcutaneously prior to lunchtime (within 30 minutes prior to lunch) based on the following guidelines:

a. Fixed dose: \_\_\_\_\_ units plus insulin correction scale; *OR*

b. Insulin to Carbohydrate Ratio: 1 unit insulin per \_\_\_\_\_ grams carbohydrate plus insulin correction scale

##### Insulin Correction Scale

Blood glucose below \_\_\_\_\_ = no additional insulin

Blood glucose from \_\_\_\_\_ to \_\_\_\_\_ = \_\_\_\_\_ unit(s) insulin subcutaneously

Blood glucose from \_\_\_\_\_ to \_\_\_\_\_ = \_\_\_\_\_ unit(s) insulin subcutaneously

Blood glucose from \_\_\_\_\_ to \_\_\_\_\_ = \_\_\_\_\_ unit(s) insulin subcutaneously

Blood glucose over \_\_\_\_\_ = \_\_\_\_\_ unit(s) insulin subcutaneously

(Notify parent if blood glucose is over \_\_\_\_\_.)

c. Oral Diabetes medication: \_\_\_\_\_ Dose \_\_\_\_\_ Time \_\_\_\_\_

d. Student is to eat lunch following pre-lunch blood test and required medication.

e. Parent/family instructed in diabetes self-management. Parent may \_\_\_ may not \_\_\_ adjust pre-lunch insulin dosage by up to 10% every 4 to 5 days as indicated by glucose trends. **Parent will communicate changes to school health services personnel.**

#### 3. Precautions:

Refer to the physician's orders for Guidelines for Responding to Blood Glucose Test Results on the following page:

a. **Hypoglycemia:** Signs of hypoglycemia include trembling, sweating, shaking, pale, weak, dizzy, sleepy, lethargic, confusion, coma, or seizures.

b. **Hyperglycemia:** Signs include frequency of urination, excessive thirst and positive urinary ketones.

#### 4. Meal Plan:

a. The *Constant Carbohydrate Diet* emphasizes consistency in the number of grams of carbohydrate eaten from day to day at each meal or snack. Proteins and fats are "free foods" in that they have minimal effect on the blood glucose level. The child and parent can choose the carbohydrate product that they wish to use for meals or snacks. **Parent will communicate meal plan changes to school personnel.**

Breakfast \_\_\_\_\_ grams at \_\_\_\_\_ (time) Mid AM snack \_\_\_\_\_ grams at \_\_\_\_\_ (time)

Lunch \_\_\_\_\_ grams at \_\_\_\_\_ (time) Mid PM snack \_\_\_\_\_ grams at \_\_\_\_\_ (time).

b. The *Insulin to Carbohydrate Ratio Meal Plan* allows a variable amount of carbohydrate to be eaten at any meal or snack, but requires appropriate insulin to balance the carbohydrate. The ratio is listed above at # 2-b.

Does this student have an insulin pump? Yes \_\_\_ No \_\_\_. If yes, please attach student's pump guidelines.

FOR DIABETIC SELF-CARE ONLY

Does this student have physician permission to provide self-care? Yes \_\_\_\_\_ No \_\_\_\_\_
This student has been provided instruction/supervision in recognizing signs/symptoms of hypoglycemia and is capable of doing self-glucose monitoring and his/her own insulin injections/insulin pump care, including using universal precautions and proper disposal of sharps? Yes \_\_\_\_\_ No \_\_\_\_\_
This student requires the supervision of a designated adult \_\_\_\_\_ This student requires the assistance of a designated adult \_\_\_\_\_

Physician portion continued on following page

GUIDELINES FOR RESPONDING TO BLOOD GLUCOSE TEST RESULTS

1. If glucose is BELOW \_\_\_\_\_: (hypoglycemia or low blood sugar)

- A. Give child 15 grams carbohydrate, i.e.:
6 lifesavers 6 ounces of regular soda
4 ounces of juice 3 - 4 glucose tabs
B. Allow child to rest for 10 - 15 minutes, and retest glucose.
C. If glucose is above \_\_\_\_\_, allow student to proceed with scheduled meal, class or snack.
D. If symptoms persist (or blood glucose remains below \_\_\_\_\_), repeat A and B.
E. If symptoms still persist, notify parent and keep child in clinic.

2. If blood glucose is BELOW \_\_\_\_\_ and the child is unconscious or seizing:

- A. Call emergency medical services.
B. Rub a small amount of glucose gel (or cake frosting) on child's gums and oral mucosa.
C. If available, inject Glucagon \_\_\_\_\_ mg. SQ.
D. Notify parent.

3. If blood glucose is FROM \_\_\_\_\_ to \_\_\_\_\_: Follow usual meal plan and activities (unless otherwise directed by insulin correction scale for insulin administration)

4. If blood glucose is OVER \_\_\_\_\_:

- A. If within 30 minutes prior to lunch, nurse or unlicensed diabetes care assistant to be called if student unable to administer correction dose of insulin per student's sliding scale orders.
B. Student checks urine ketones.
If Ketones are negative or small
• Encourage water until ketones are negative.
If Ketones are moderate or large:
• Student should remain in clinic for monitoring.
• Notify parent for pick up.
• Give 1-2 glasses of water every hour.
• If student remains at school, retest glucose and ketones every 2-3 hours or until ketones are negative.
C. Student not to participate in PE or other forms of exercise if blood sugar is above 250 and ketones are present.
D. If student develops nausea/vomiting, rapid breathing, and/or fruity odor to the breath, call 911, the nurse and the parents.

Physician signature \_\_\_\_\_ Date \_\_\_\_\_

Clinic/facility \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Nurse or Certified Diabetes Educator: Name \_\_\_\_\_ Phone \_\_\_\_\_

Clinical Dietitian: Name \_\_\_\_\_ Phone \_\_\_\_\_

TO BE COMPLETED BY THE PARENT: We (I) the undersigned, the parents/guardians of \_\_\_\_\_ request that the above Diabetes Management and Treatment Plan be implemented for our (my) child. Delivery of this form to the school nurse constitutes my participation in developing this Plan, and is my consent to implement this Plan. I will notify the school immediately if the health status of my child changes, if I change physicians or emergency contact information, or if the procedure is canceled or changes in any way. Information concerning my child's diabetes health management may be shared with/obtained from the diabetes health care providers.

Signature \_\_\_\_\_ Relationship \_\_\_\_\_

Date \_\_\_\_\_ Phone (Hm) \_\_\_\_\_ (Wk) \_\_\_\_\_



# Emergency Care Plan



## DIABETES - HYPOGLYCEMIA

Student: \_\_\_\_\_ Grade: \_\_\_\_\_ School Contact: \_\_\_\_\_ DOB: \_\_\_\_\_

Mother: \_\_\_\_\_ MHome #: \_\_\_\_\_ MWork #: \_\_\_\_\_ MCell #: \_\_\_\_\_

Father: \_\_\_\_\_ FHome #: \_\_\_\_\_ FWork #: \_\_\_\_\_ FCell #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

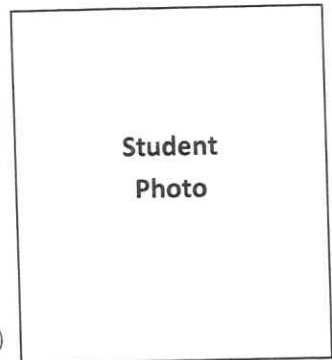
### SYMPTOMS OF A HYPOGLYCEMIC EPISODE MAY INCLUDE ANY/ALL OF THESE:

- Shaking, fast heartbeat, sweating, anxiety, irritability
- Complaints of hunger, impaired vision, weakness or fatigue
- **Onset may be sudden and can progress to Insulin Shock**

### SEVERE SYMPTOMS INCLUDE:

- Appears very pale, feels faint, loss of consciousness
- Seizure activity

**STAFF MEMBERS INSTRUCTED:**  Classroom Teacher(s)  Special Area Teacher(s)  
 Administration  Support Staff  Transportation Staff



Student Photo

### TREATMENT:

Stop any activity immediately.

Accompany the student to the Health Office. Notify school nurse immediately.

If off school grounds, provide a source of glucose:

1/2 - 3/4 cup juice

Glucose tabs

Hard candy

Regular soda (not diet!)

Glucose gel

Notify parents/guardian (do not delay treatment by calling – treat or obtain treatment for student first).

### STEPS TO FOLLOW FOR A HYPOGLYCEMIC EMERGENCY:

Glucagon ordered:  Yes  No

If Glucagon is ordered, it should be given by a willing volunteer who has been trained by the school nurse if student is unconscious, unresponsive or having a seizure.

After Glucagon is given, call 911. Notify parents Preferred Hospital if transported: \_\_\_\_\_

Students receiving glucagon without their parent or guardian present should be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present.

Healthcare Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Written by: \_\_\_\_\_ Date: \_\_\_\_\_

Copy provided to Parent

Copy sent to Healthcare Provider

**Parent/Guardian Signature** to share this plan with Provider and School Staff: \_\_\_\_\_

# Emergency Care Plan

## DIABETES - HYPERGLYCEMIA

Student: \_\_\_\_\_ Grade: \_\_\_\_\_ School Contact: \_\_\_\_\_ DOB: \_\_\_\_\_

Mother: \_\_\_\_\_ MHome #: \_\_\_\_\_ MWork #: \_\_\_\_\_ MCell #: \_\_\_\_\_

Father: \_\_\_\_\_ FHome #: \_\_\_\_\_ FWork #: \_\_\_\_\_ FCell #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### SYMPTOMS OF A HYPERGLYCEMIC EPISODE MAY INCLUDE ANY/ALL OF THESE:

- Gradual Onset
- Extreme thirst, very frequent urination, drowsiness
- Flushed skin, heavy breathing, blurred vision
- Vomiting, fruity or wine-like odor to breath

Student  
Photo

### SEVERE SYMPTOMS INCLUDE:

- Stupor
- Unconsciousness

### STAFF MEMBERS INSTRUCTED:

- Administration     Classroom Teacher(s)     Special Area Teacher(s)  
 Support Staff     Transportation Staff

### TREATMENT:

Stay with the student.

Notify school nurse immediately.

**Call 911 to access Emergency Medical Services – transport to hospital by ambulance**

Preferred Hospital if transported: \_\_\_\_\_

Notify parents/guardian (do not delay treatment by calling – obtain treatment for student first).

Healthcare Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Written by: \_\_\_\_\_ Date: \_\_\_\_\_

- Copy provided to Parent     Copy sent to Healthcare Provider

**Parent/Guardian Signature** to share this plan with Provider and School Staff: \_\_\_\_\_