Dear Parent/Guardian:

Our school records show that your student has a history of **Diabetes**.

If your student's physician does not provide you with a complete and comprehensive Physician Medical Order and Individual Health Care Plan (IHP) for the school, please notify your student's school nurse for a copy of CMCSS Diabetes Individual Health Care Plan (HEA-F042). The CMCSS Individual Health Care Plan includes forms that your child's physician will need to complete.

Both types of Individual Health Care Plans require you and the school nurse to complete them together. ALL Individual Health Care Plans are required to be updated at the beginning of each school year.

Using the Individual Health Care Plan, the school nurse will develop an emergency plan of care that will be distributed to all school personnel that have a responsibility to your student throughout the school day. This emergency plan of care will include the following information:

- Emergency contact information for parent/guardian and health care provider
- Causes of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar)
- Symptoms of hypoglycemia and hyperglycemia that your student experiences
- Actions for treating hypoglycemia and hyperglycemia

We greatly appreciate your time and effort in completing these forms. This is another step in keeping your child safe while getting the best possible education at school. Please feel free to contact your school nurse if you would like to discuss your student's condition or need help completing these forms.

Clarksville-Montgomery Country School System
HEALTH SERVICES
DIABETES INDIVIDUAL HEALTH CARE PLAN
School Year 20____ - 20____

The **student's physician and parent/guardian should complete this plan**. Information provided will serve as a tool to manage the student's diabetes while at school. **Please print** information requested.

Part 1 (*Completed by parent/guardian*)

Student's Name:_____Grade:_____
DOB:_____Age of Diabetes Diagnosis:_____Teacher:_____
Type of diabetes: _____ Type 1 _____ Type 2

Contact Information
Parent(s)/Guardian:_____
Address:_____
_____
Telephone: _____ _____ _____
_____ _____ _____
Other Emergency Contacts
Name:_____ Phone:_____
Name:_____ Phone:_____
Physician:_____Telephone:_____Fax:_____
Address:_____

Part 2 (*Completed by Physician*)

Blood Glucose Monitoring
Target range for blood glucose is ____ 70-150 ____ 70 - 180 ____ Other_____
Usual times to check blood glucose_____
Times to do extra blood glucose checks (*check all that apply*)
____ before exercise
____ after exercise
____ when student exhibits symptoms of hyperglycemia
____ when student exhibits symptoms of hypoglycemia
____ other (explain)_____
Can student perform his/her own blood glucose checks? _____ Yes _____ No
Exceptions_____
Type of blood glucose meter student uses_____
Base dose of Insulin
____ Humalog/Novolog/Regular (circle type) insulin at lunch is _____units.
____ Flexible dosing using _____ units/ _____ grams carbohydrate
____ Intermediate/NPH/Lente/Lantus/Ultralente (circle type) insulin at lunch is _____units.
____ Additional comments_____
_____

Insulin Correction Doses
Parental Authorization should be obtained before administering a correction dose for high blood glucose levels.
_____ Yes _____ No

_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl

Can student give his/her own insulin injections? _____ Yes _____ No
Can student determine correct amount of insulin? _____ Yes _____ No
Can student draw correct dose of insulin? _____ Yes _____ No
_____ (Physician Initials) Parents are authorized to adjust the insulin dosage under the following circumstances:_____
_____

For Students With Insulin Pumps

Type of pump:_____ Basal rates: _____ 12am to _____
_____ _____ to _____
_____ _____ to _____
Type of insulin in pump_____
Type of infusion set_____
Insulin/carbohydrate ratio_____ Correction factor_____

Student Pump Abilities/Skill

Count carbohydrates	_____ Yes	_____ No
Bolus correct amount for carbohydrates consumed	_____ Yes	_____ No
Calculate and administer corrective bolus	_____ Yes	_____ No
Calculate and set temporary basal rate	_____ Yes	_____ No
Disconnect pump	_____ Yes	_____ No
Reconnect pump at infusion set	_____ Yes	_____ No
Prepare reservoir and tubing	_____ Yes	_____ No
Insert infusion set	_____ Yes	_____ No
Troubleshoot alarms and malfunctions	_____ Yes	_____ No

For Students Taking Oral Diabetes Medications

Medication Dose Time of dose
_____
_____

Meals and Snacks Eaten at School

Is student independent in carbohydrate calculations and management? _____ Yes _____ No

Meals/Snack	*Time*	*Food content/amount*
Breakfast	_____	_____
Mid-morning snack	_____	_____
Lunch	_____	_____
Mid-afternoon snack	_____	_____

Snack before exercise? _____ Yes _____ No
Snack after exercise? _____ Yes _____ No
Other times to give snacks and content/amount_____
Preferred snack foods (to be provided by parent/guardian)_____
Instructions for when food is provided to the class (class party or food sampling)
_____
_____

Exercise and Sports

Fast-acting carbohydrates such as _____should be available at the site of exercise or sports. These will be provided by the parent/guardian.
Restrictions on activity, if any:_____
Student should not exercise if blood glucose level is below _____mg/dl or above _____mg/dl or if moderate to large ketones are present.

Hypoglycemia (*Low Blood Sugar*)

Usual symptoms of hypoglycemia_____
Treatment of hypoglycemia_____
_____
_____ Glucagon should be given if the student is unconscious, having a seizure, or unable to swallow.
Route _____ Dosage _____ Site for glucagon injection: _____ arm, _____thigh, _____other.
NOTE: IF GLUCAGON IS ADMINISTERED, EMS (911) IS CALLED.

Hyperglycemia (*High Blood Sugar*)

Usual symptoms of hyperglycemia_____
Treatment of hyperglycemia_____
_____
Urine should be checked for ketones when blood glucose levels are above _____ mg/dl.
Treatment for ketones_____
Supplies provided by parents/guardian for use at school
_____ Blood glucose meter, blood glucose test strips, batteries for meter
_____ Lancet device, lancets, alcohol pads
_____ Urine ketone strips
_____ Insulin vials and syringes
_____ Insulin pump and supplies
_____ Insulin pen, pen needles, insulin cartridges
_____ Fast acting source of glucose_____
_____ Glucagon emergency kits
Other physician orders_____
_____
_____

This Diabetes Individual Healthcare plan has been approved by:

Physician Name:_____Date:_____
Physician Signature:_____

Part 3 (Completed by parent/guardian)

I give permission to the school nurse and/or other designated staff member (Trained Diabetes Personnel) of the CMCSS to perform and carry out the diabetes care tasks or assist student with diabetes care tasks outlined in the Diabetes Individual Health Care Plan. I also consent to the release of the information contained in this Diabetes Individual Health Care Plan to CMCSS employees and emergency contact persons (listed in Part 1) on a need to know basis of this information, to maintain my child's health and safety.

I give permission for school nurse and Health Care Provider to exchange health care information about my child's diabetic condition and the management of the diabetic condition.

I am aware that the nurse will keep me informed (telephone or written communications) of eventful occurrences about my child's medical condition.

I am aware that it is my responsibility to provide all necessary supplies and snacks that my child needs for monitoring and managing his/her medical condition.

_____ _____

Parent(s)/Guardian Signature Date

SPACE BELOW FOR SCHOOL NURSE TO NOTE CHANGES IN PHYSICIAN'S ORDERS

HYPOGLYCEMIA
(Low Blood Sugar)
School year: _____

Student's Name: _____ Date of Plan: _____

School: _____ Teacher: _____ Grade: _____

Emergency Contact Information:

Mother / Guardian: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Father / Guardian: _____

Home phone: _____ Work phone: _____ Cell phone: _____

NEVER SEND OR LEAVE A STUDENT WITH SUSPECTED LOW BLOOD SUGAR ANYWHERE ALONE

Causes of Hypoglycemia:

- o Too much insulin
- o Delayed food
- o Missed food
- o Unscheduled exercise
- o Too much or too intense exercise

Onset:

- o Sudden

Symptoms:

Mild	***Moderate***	***Severe***
___Irritability ___Sweating	___Blurry Vision ___Headache	___Loss of consciousness
___Shakiness ___Paleness	___Confusion ___Weakness	___Seizure
___Weakness ___Anxiety	___Behavior change	___Inability to swallow
___Drowsiness ___Hunger	___Slurred speech	
___Dizziness ___Personality chang	___Poor coordination	
___Inability to concentrate	___Other_____	
___Other_____		
(check student's USUAL symptoms)	***(check student's USUAL symptoms)***	***(check student's USUAL symptoms)***

What to do:

Notify School Nurse or Trained Diabetic Personnel

Check Blood Sugar

When in doubt, always TREAT FOR HYPOGLYCEMIA

Mild / Moderate

- o Student ____ **MAY** / ____ **MAY NOT** treat self
- o Provide quick sugar source
  (3 - 4 glucose tablets OR 4 oz. juice OR 6 oz regular, non-diet, soda OR 3 tsp glucose gel)
- o Wait 10-15 minutes then recheck blood sugar
- o Repeat food if symptoms persist or if blood sugar is less than _____
- o Follow with a snack of protein and carbohydrate
  (cheese crackers OR peanut butter crackers)

Severe

- o Do **NOT** attempt to give anything by mouth
- o Contact School Nurse or Trained Diabetic Personnel
- o Administer glucagon
- **Location:** _____
- o Position student on side
- o Call 911
- o Contact parents / guardian.

HYPERGLYCEMIA
(High Blood Sugar)
School year: _____

Student's Name: _____ Date of Plan: _____

School: _____ Teacher: _____ Grade: _____

Emergency Contact Information:

Mother / Guardian: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Father / Guardian: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Causes of Hyperglycemia:		***Onset:***
o Too much food	o Illness	o Over time - several hours or days
o Too little insulin	o Infection	
o Decreased activity	o Stress	

Symptoms:

Mild	***Moderate***	***Severe***
___Thirst	MILD SYMPTOMS PLUS:	MILD and MODERATE SYMPTOMS PLUS:
___Frequent urination	___Dry mouth	___Labored breathing
___Fatigue/sleepiness	___Stomach cramps	___Very weak
___Increased hunger	___Nausea	___Confused
___Blurred vision	___Vomiting	___Unconscious
___Weight loss	___ Other_____	
___Stomach pains		
___Flushed skin		
___Lack of concentration		
___Sweet, fruity breath		
___Other_____		
(check student's USUAL symptoms)	***(check student's USUAL symptoms)***	***(check student's USUAL symptoms)***

What to do:

o Allow student free use of the bathroom	o Administer insulin per Diabetic IHP
o Encourage student to drink water	o If student has nausea, vomiting or is lethargic
o Contact School Nurse or Trained Diabetic Personnel	contact parent/guardian
o Check urine for ketones, if indicated	o If parent/guardian not available, call **911**

PLEASE NOTE:

____ Student is permitted, per IHP, to carry testing supplies and check blood sugar anywhere but **CANNOT treat high blood sugar per self. REQUIRES DIRECT ADULT SUPERVISION.**

____ Student is permitted, per IHP, to carry testing supplies as well as insulin; **MAY** test and treat self anywhere without direct adult supervision.

Clarksville-Montgomery County School System
20____ - 20____

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

PLEASE NOTE **:** Medications must be brought to and picked up from school by a parent/guardian or his/her adult designee. Children may not bring medication to school or take medication home unless it is an emergency rescue medication that must remain with the student at all times. Prescription Medication must be in a properly labeled prescription bottle with the student's name, pharmacy name and phone number, date (within current school year), prescriber's name, name of medication, dose and frequency imprinted on the pharmacy label. Over the Counter Medication must be in the manufacturer's original and unopened container which shows a list of ingredients.

The following section is to be completed by the PARENT/GUARDIAN:

School:	**Student's Name:**	**Date of Birth:**

I request that my child be assisted in taking medication, described below, at school by legally authorized persons or permitted to medicate himself/herself as also authorized by my child's physician. I also give my permission for school personnel to contact my child's physician. I understand that in a health or safety emergency involving my child, school officials may share confidential health information to appropriate and necessary health, safety or welfare officials.

I, _____, will assume any and all responsibility and liability for any problems
Parent/Guardian's Printed Name
with my child taking this medication at school. I release CMCSS and its personnel from any legal claims which they have now, or thereafter have, arising out of medication taken while at school.

_____ _____ (____)_____ (____)_____

Date **Parent/Guardian Signature** **Home Phone** **Emergency Phone**

The following section is to be completed by the PHYSICIAN for prescription medications or by PARENT/GUARDIAN for Over the Counter Medications

Name of Medication:

Diagnosis for which medication is prescribed:

Route:	**Dose:**

If medication is to be given daily, at what time? (please consider alternate dosing schedule to minimize medication in school)

If medication is to be given "when needed" describe indications:

How soon can it be repeated?	**Length of time treatment recommended?** **___Current School Year ___Other:_____**

List significant side effects:

Provider to initial yes or no for each of the following:
Is student permitted to carry and self-administer emergency rescue medication? _____ **YES** _____ **NO**
Has student been instructed in self administration of prescribed rescue medication? _____ **YES** _____ **NO**

Date **Physician's Signature**

Physician's Name, Address and Phone Number:

Clarksville-Montgomery County School System
HEALTH SERVICES
GLUCAGON MEDICATION ADMINISTRATION GUIDELINES

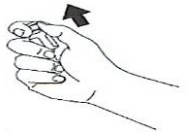
School personnel will be requested to do this procedure only in **emergency situations**.

If the student becomes unconscious and/or has a blood sugar reading of _____ or less (will be specified on physician orders), Glucagon will be given.

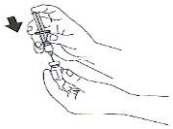
Glucagon will be given as ordered by the physician.

*****CALL 911 if Glucagon is to be administered*** Ask office personnel to contact parent / guardian.**
Procedure:

1. Gather Glucagon kit, alcohol swabs, emesis basin, or other container
2. Remove flip off seal on the bottle/vial of powder containing the medication. Wipe rubber stopper with alcohol swab.

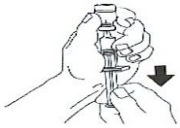


3. Push all fluid from pre-filled syringe into the vial containing the medication. Do not withdraw needle from bottle.



4. Gently shake bottle until all powder is dissolved. The solution should look like water.

5. Turn vial upside down and withdraw all of the solution from the vial. Remove the needle from the vial.



6. Cleanse 2 inch area of upper arm with alcohol swab. (May use thigh or stomach if unable to access arm)
7. Grasp cleansed area between thumb and forefinger with non-dominant hand without squeezing skin.
8. Hold syringe between thumb and forefinger and insert needle at a 90 degree angle using a dart like action.
9. Push plunger all the way down to inject all medication slowly from the syringe.
10. Count to ten and remove the needle. Discard the syringe in the appropriate biohazard container.
11. Turn student to side-lying position. Expect student to vomit, have basin or container ready.
12. Monitor for seizures, breathing, and pulse. If breathing/pulse is absent, begin CPR. If student fully awakens, feed fast acting glucose (i.e. ½ cup juice, soda, milk).
13. Remain with student until arrival of EMS and upon their arrival, follow EMS instructions.