



Dear Parent/Guardian:

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

If your student's physician does not provide you with a complete Physician Medical Order, the following forms must be completed and submitted to the school nurse each year.

1. **Diabetes Emergency Action Plan (HEA – F121):** will be completed by the school nurse according to the providers orders and health plan.
2. **Diabetes Individual Healthcare Plan (HEA – F042):** Must be completed by both parent/guardian and health care provider.

We appreciate your time in completing these forms, as they are essential in keeping your child safe while at school. If you have any questions or need assistance completing these forms, please contact your school nurse.

Diabetes Emergency Action Plan

**NEVER SEND OR LEAVE A STUDENT WITH SUSPECTED LOW BLOOD SUGAR ANYWHERE ALONE
ALWAYS REFER TO MEDICAL ORDERS AND IHP**

Student's Name: _____ DOB: _____

School: _____ Teacher/Grade: _____

Emergency Contact Name: _____ Phone Number: _____

Assistance / Supervision

- ☐ Student is **INDEPENDENT**. They may test, treat, and carry all supplies/insulin with them anywhere WITHOUT supervision.
☐ Student requires **DIRECT** Adult Supervision for testing, treating, and insulin administration.

Blood Glucose Testing Times

- ☐ Before breakfast ☐ Mid-morning, before snack ☐ Mid-afternoon, before snack
☐ Before lunch ☐ Before PE/ activity time ☐ After PE/activity time
☐ Dismissal ☐ As needed

***Students who use a cell phone to monitor their glucose with a continuous glucose monitor (CGM) must be able to carry and have access to the cell phone at all times. Diabetic supplies are permitted to be carried with the student at all times.**

HYPOGLYCEMIA / LOW BLOOD SUGAR: <70

***do not exercise if below: _____**

<p>If you see this: SIGNS / SYMPTOMS:</p> <ul style="list-style-type: none"> • Hunger • Change in personality • Paleness • Weakness / shakiness • Tiredness • Dizziness • Headache • Rapid heartbeat • Nausea / loss of appetite • Clamminess / sweating • Blurred vision 	<p>Do this: *Call the school nurse</p> <ol style="list-style-type: none"> 1. Check blood sugar (students who are independent may need help) 2. Give fast acting sugars 15 grams of carbs: 4 oz of juice, 3-4 glucose tabs, 1 oz of fruit snacks 3. Wait 15 minutes 4. Recheck blood sugar 5. Repeat until blood sugar is above 70
	<p>ACTIONS FOR SEVERE LOW BLOOD SUGAR *If student is non responsive, unconscious, or having a seizure:</p> <ol style="list-style-type: none"> 1. Position student on side, if possible 2. Administer emergency rescue medication (do not give anything by mouth) <input type="checkbox"/> Glucagon IM <input type="checkbox"/> Baqsimi INTRANASAL <input type="checkbox"/> Gvoke SQ *Location of Emergency Medication: <input type="checkbox"/> Clinic <input type="checkbox"/> With Student 3. Call 911 and Parent/Guardian 4. Stay with student until EMS arrives

HYPERGLYCEMIA / HIGH BLOOD SUGAR: >250

***do not exercise if above: _____**

<p>If you see this: SIGNS / SYMPTOMS:</p> <ul style="list-style-type: none"> • Increased thirst • Increased urination • Increased appetite • Fatigue • Nausea / vomiting • Fruity breath 	<p>Do this: *Call the school nurse</p> <ol style="list-style-type: none"> 1. Check blood sugar (students who are independent may need help) 2. Give water / sugar free liquids 3. Allow free access to restroom 4. Check ketones if: blood sugar > 250 for 4 hours or 2 consecutive blood sugar checks
	<p>SYMPTOMS OF SEVERE HIGH BLOOD SUGAR *If student is non responsive, unconscious, or vomiting with rapid / shallow breathing: call 911/parents immediately</p>

Clarksville-Montgomery Country School System
DIABETES INDIVIDUAL HEALTH CARE PLAN



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** below.

Student's Name: _____ DOB: _____ School Year: 20__ - 20__
School: _____ Teacher: _____ Grade: _____

Age of Diabetes Diagnosis: _____ Diabetes: Type 1 [] Type 2 []

Emergency Contact Information

Parent(s)/Guardian: _____ Phone: _____
Name: _____ Phone: _____

Physician: _____ Telephone: _____ Fax: _____
Address: _____

Part 1 (Completed by Physician)

___ Student requires ***Direct Adult Supervision***. Student is permitted to carry testing supplies and check blood sugar anywhere but cannot administer insulin per self.

___ Student may ***Independently*** test blood glucose, administer insulin, and keep all diabetes supplies with them anywhere on school property.

Insulin Correction Doses

___ Humalog/Novolog/Regular (circle type) insulin is _____ units for every _____ grams of carbohydrates.
___ Flexible dosing using _____ units for every _____ grams carbohydrate.
___ Intermediate/NPH/Lente/Lantus/Ultralente (circle type) insulin is _____ units.

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

Parent/Guardian may modify doses and sliding scale within 1-2 units. [] 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

___ units if blood glucose monitor reads HIGH

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 _____

Clarksville-Montgomery Country School System
DIABETES INDIVIDUAL HEALTH CARE PLAN

For Students Taking Oral Diabetes Medications

Medication	Dose	Time of dose

Blood Glucose Monitoring

Target range for blood glucose is ____ 70-150 ____ 70 - 180 ____ Other: _____

Hypoglycemia (*Low Blood Sugar*)

Usual symptoms of hypoglycemia _____

Treatment of hypoglycemia: If student is awake and able to swallow, give 15 grams of fast acting carbohydrates. Retest glucose 15 minutes after treatment and repeat until glucose is over 70 mg/dl.

____ 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 _____

This Diabetes Individual Healthcare plan has been approved by:

Physician Name: _____ Date: _____

Physician Signature: _____

Part 2 (*Completed by parent/guardian*)

Blood Glucose Monitoring:

<input type="checkbox"/> Before breakfast	<input type="checkbox"/> Before PE/ Activity Time
<input type="checkbox"/> Midmorning, before snack	<input type="checkbox"/> After PE/ Activity Time
<input type="checkbox"/> Before Lunch	<input type="checkbox"/> Mid afternoon
<input type="checkbox"/> Dismissal	<input type="checkbox"/> As needed for signs/symptoms of low/high blood glucose

Can student perform his/her own blood glucose checks? ____ Yes ____ No

Type of blood glucose meter: _____

Meals and Snacks Eaten at School

Can student independently determine correct portions and number of carbohydrate servings: ☐ Yes ☐ No

Can student independently calculate carbohydrate grams accurately: ☐ Yes ☐ No

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) _____

Clarksville-Montgomery Country School System

DIABETES INDIVIDUAL HEALTH CARE PLAN

Student Pump Abilities/Skills

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

Exercise and Sports

- Quick access to sugar-free liquids, fast-acting carbohydrates, and snacks should be available at the site. 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.
- Activity mode will be initiated on pump 30 minutes prior to start of activity and discontinue after activity has ended. [] Yes [] No

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
Additional comments _____

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