## APPENDIX A:

## Sample Health Care Plans

**Note:**
**Schools have a responsibility to be knowledgeable about all relevant state and federal laws, and about how they impact the policies, procedures and health care plans for diabetes management in schools.**

American Diabetes Association: *Diabetes Medical Management Plan*
http://www.diabetes.org/living-with-diabetes/parents-and-kids/diabetes-care-at-school/written-care-plans/diabetes-medical-management.html

American Diabetes Association: *Individualized Health Plan*
http://www.diabetes.org/living-with-diabetes/parents-and-kids/diabetes-care-at-school/written-care-plans/individualized-health-plan.html

Juvenile Diabetes Research Foundation. 2012. *Emergency Forms*.
http://www.jdrf.org/index.cfm?page_id=104014

## Individualized Emergency School Health Plan for Diabetes Management

Student Name_____ Grade_____ Date_____

I have **INSULIN DEPENDENT DIABETES** which means I must take insulin every day along with balancing diet and exercise. Several times a day, I check my blood sugar levels by using a special meter that I keep with me. It is important for you to understand some important things about diabetes while I am in your care.

**LOW BLOOD SUGAR REACTIONS:**
Occasionally, my blood sugar may be too low (insulin reaction). This can be very dangerous. A low blood sugar reaction can be a result of receiving too much insulin, skipping a meal or snack or an unusual amount of exercise. If you think my blood sugar is low, I may check my blood sugar in the classroom. If I go elsewhere to check my blood sugar, **someone must accompany me**. Some symptoms of low blood sugar may be:

- Shakiness
- Change in personality
- Confusion
- Sweatiness
- Feeling "low" or "hungry" or "tired"
- Looking pale or flushed in the face

If my blood sugar is low, **I NEED FAST-ACTING SUGAR QUICKLY**.

You can give me_____. I should start to feel better in 10-15 minutes. If my blood sugar remains low, call my parents and do the following:

_____

_____

If my blood sugar drops too low, I may become unconscious or have a seizure. If this happens:

**1. Call 911**
**2. Administer GLUCAGON by injection according to my emergency care plan**
**3. Call my parents**
**Glucagon is not life threatening even if it is given when not needed.**

**EMERGENCY NUMBERS:**

| | | | |
|---|---|---|---|
| Mother's Name | Home phone | Work phone | Cell phone |
| Father's Name | Home phone | Work phone | Cell phone |
| Other | Home phone | Work phone | Cell phone |
| Health Care Provider | | Work phone | Cell phone |

Preferred hospital _____

Date prepared_____

**Individualized Health Care Plan for Diabetes Management**

Student _____ DOB_____ Date _____
School _____ Grade _____ Teacher _____

**BLOOD SUGAR TESTING (Check ALL that apply)**
**(Parent's permission and physician's authorization must be signed.)**

___ Will not test at school.
___ Will be done by student every day at _____
___ Will be done by student when symptoms are present _____
___ Will need assistance from an adult.
___ Will not need assistance from an adult.
___ Testing supplies will be kept at school in _____

**INSULIN NEEDS (Check ALL that apply)**
**(Parent's permission and physician's authorization must be signed.)**

___ Will not need insulin at school.
___ Will need insulin at school.
___ Will be using an insulin pump and is self-sufficient in its use.
___ Will be using an insulin pump and will need assistance.

**FOOD PLAN (Check ALL that apply)**

___ Will bring daily morning snack of _____ carbohydrates to be eaten at _____a.m.
___ Will bring daily afternoon snack of _____ carbohydrates to be eaten at _____ p.m.
___ Will eat _____ carbohydrate servings or _____ grams of carbohydrates at lunch.
___ On special occasions, student can eat same snack provided to classmates.
___ On special occasions, student will select alternate snack from supply provided by parent.

**MEALS AND INSULIN NEEDS**

| **Breakfast** | **Snack** | **Lunch** | **Snack** | **Snack** | **Supper** | **Snack** |
|---|---|---|---|---|---|---|
| Insulin/Carbs | Insulin/Carbs | Insulin/Carbs | Insulin/Carbs | Insulin/Carbs | Insulin/Carbs | Insulin/Carbs |
| **TIME:____** | _____ | _____ | _____ | _____ | _____ | _____ |

**Insulin Type: _____**

**Blood Glucose Target Range: _____**

**Sliding Scale (S/S)**

| Blood Sugar | ---------- | Insulin Dose |
|---|---|---|
| _____ mg/dl | ---------- | _____units |
| _____ mg/dl | ---------- | _____units |
| _____ mg/dl | ---------- | _____units |
| _____ mg/dl | ---------- | _____units |

Comments: _____
Date Completed: _____

**LOW BLOOD SUGAR SYMPTOMS**

| | | | | | |
|---|---|---|---|---|---|
| Blurred vision | Fatigue | Irritability | Trembling | Dizziness | Headache |
| Personality change | Weakness | Fast heartbeat | Hunger | Sweating | |

Comments_____

**LOW BLOOD SUGAR TREATMENT** (TEACHERS: Students with symptoms MUST be escorted to Health Room).

If student is experiencing symptoms, **TEST BLOOD SUGAR**.
For blood sugar < _____ give 15 gms fast acting carbohydrate _____
For blood sugar < _____ give 30 gms fast acting carbohydrate _____
If lunch or snack time – allow child to eat normal amounts of carbohydrate.
If not lunch or snack time – repeat blood sugar in 15 – 20 minutes. Repeat treatment as needed.
*(Parent will provide appropriate drinks and/or food)*

Retest blood sugar in _____ minutes. If under _____, repeat above treatment. If student is feeling better, s/he can: _____ .

**LOW BLOOD SUGAR TREATMENT FOR INSULIN PUMP THERAPY**: (In addition to the interventions listed above, if student who is using an insulin pump becomes unconscious due to a severe low blood sugar, **disconnect tubing from insulin pump**, call 911 and the child's parent.)

**For severe hypoglycemia with loss of consciousness or seizure, call 911, administer Glucagon 1 mg. by injection, and call parents.**
Comments: _____

**HIGH BLOOD SUGAR SYMPTOMS**

| | | | | |
|---|---|---|---|---|
| • Blurred vision | • Frequent urination | • Nausea/vomiting | • Drowsiness | • Heavy, labored breathing |
| • Stomachache | • Extreme thirst | • Hunger | | |

Comments _____
Test blood sugar, if over _____. Student should drink large amounts of water.
Test urine ketones if blood sugar is over _____, or if child is experiencing symptoms of high blood sugar.

**HIGH BLOOD SUGAR TREATMENT FOR INSULIN PUMP THERAPY**: (In addition to the interventions listed above, if student is using an insulin pump and blood sugar is over 240 for two readings in a row, call parent.)
**Blood Glucose Target Range:** _____
**On Insulin Pump Therapy – High blood sugar before meals and 2 hours after:**

- Assess for pump/tubing/site problems if using an insulin pump.
- Blood sugar is greater than _____ give extra insulin by using the Sliding Scale (S/S) or Insulin Sensitivity Factor (ISF) as written below Repeat blood sugar within _____ HOURS(s) if previous blood sugar greater than _____.
- If repeat blood sugar greater than _____ give insulin by syringe using the S/S or ISF.
- Contact parents and/or health care provider if blood sugar greater than _____ and vomiting, difficulty breathing or lethargy (or other symptoms of ketoacidosis).
- Repeat blood sugar every _____ HOUR(s). Give insulin using the S/S or ISF until the blood sugar is less than _____.

| **Insulin Sensitivity Factor (ISF)** | **Sliding Scale (S/S)** | | |
|---|---|---|---|
| (correction factor) | Blood Sugar | ---------- | Insulin Dose |
| 1 unit of insulin will bring the blood sugar | _____ mg/dl | ---------- | _____units |
| Level down by _____ mg/dl. | _____ mg/dl | ---------- | _____units |
| | _____ mg/dl | ---------- | _____units |
| | _____ mg/dl | ---------- | _____units |

Comments: _____

**Individualized Health Care Plan for Diabetes Management**
**AUTHORIZATION/SIGNATURES FORM**

Student _____DOB_____
School/Grade_____Date _____

Individualized Health Care Plan for: _____

School/Grade_____

I have reviewed and approved the Individualized Health Care Plan for Diabetes Management. I understand that specialized health care services will be performed by designated school personnel under the training and supervision provided by the School District Nurse. This consent shall remain in effect through the end of the current school year unless discontinued or changed in writing.

_____ _____
Physician's Signature Date

_____ _____
Parent Date

_____ _____
School Nurse Date

_____ _____
Building Administrator Date

Staff Members Signature (responsible for implementing the care plan):
_____
_____
_____

*Reprinted with Permission from Wisconsin Department of Education Document*

Date: _____

**Emergency Care Plan for the Student with Diabetes**

Name_____ Birth Date_____
Parent/Guardian _____
Emergency phone (home) _____
Emergency phone (work) _____
Primary health care provider _____
Address _____
Student ID _____
Phone _____
Photo

Hospital _____
Diabetes Specialists _____
Address/Phone_____

**Specifics of Management**

1. Insulin Dosage: _____
Times: _____
2. Glucose monitoring: _____
Location of monitor: _____
Type of monitor: _____
Times to monitor: _____
3. Diet: _____
Snack time(s): _____
4. ID bracelet: Yes _____ No_____
5. Time and day of physical education: _____
6. School Lunch/Recess: _____

**Protocol for Hypoglycemic Episode**

1. General symptoms: hunger, dizziness, sweaty palms or forehead, and change in behavior.
2. Signs/symptoms particular to this student_____
_____
3. Action to take: _____
_____
_____
*attach additional information if needed.
4. Contact Parent/guardian if:_____

5. Cake gel or other substance to be given:_____
6. Glucagon ordered: Yes___ No____
*if yes (current Authorization for Medication Administration on file)

**DO NOT LET STUDENT GO TO HEALTH OFFICE ALONE. CALL 911 IF STUDENT UNCONSCIOUS OR CONVULSING and GIVE NOTHING BY MOUTH.**

7. Individual considerations for this particular student_____
_____
8. Contact parents/guardians if student vomits or has a fever and refer to IHCP.
9. Signatures/photocopies to (where applicable):

Parent/guardian_____ Principal_____
Student_____ Teacher_____
School Nurse_____ Lunch Aide_____
Physician_____ Bus Driver_____
Diabetes Educator_____ P.E. Teacher_____
Other Education Specialists: Guidance Dept._____ Music_____
Art_____ Library_____
Other_____

*Ridgefield Public Schools*
*Adapted from J. School Health Nursing, April 1997*

## Diabetic Student Contract

Student's Name: _____ DATE: _____

**School Year**

I understand that it is essential to my health that I take proper doses of my insulin daily.
I understand that I will test my blood sugar in the nurse's office daily at _____.
I understand that if I fail to test my blood sugar, I will have to eat lunch in _____.
I understand that I will write my blood sugar results daily in my notebook kept in the nurse's office.
I understand that it is my responsibility to bring in snacks/juice to be kept I the nurse's office.
I understand the need to report to the nurse's office any time I feel low to test and record my blood sugar.

**Student's Signature**: _____

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

**School Nurse's Signature**: _____

Copies to: Student
Parent
School Nurse
Guidance Counselor
Principal
Other_____

## Staff Training Record

## Diabetes Training Record

| Staff Member Name | Diabetes Basics | Blood Glucose Monitoring | Notes |
|---|---|---|---|
| | | | |