Seguin INDEPENDENT SCHOOL DISTRICT — SCHOOL HEALTH SERVICES — exceptional students to exceptional citizens

Diabetes Management & Treatment Plan

Student:______________________ DOB:__________ School Year:________ Grade:________

Diagnosis: Type I______ Type 2______ Other:______________________ Date of Onset:__________

Teacher:______________________ SHARS:________ ID#:______________________

PLEASE FILL IN BLANKS AND CHECK ALL BOXES THAT APPLY

1. **PHYSICIANS OPINION OF STUDENT'S COMPETENCE:**
   - ☐ Blood glucose testing
   - ☐ Carry supplies for BS monitoring
   - ☐ Testing in classroom
   - ☐ Measuring insulin
   - ☐ Injecting insulin
   - ☐ Self treatment for mild lows
   - ☐ Determining insulin dose
   - ☐ Independently operating insulin pump
   - ☐ Carry supplies for insulin administration
   - ☐ Universal precautions and proper disposal of sharps

2. **BLOOD GLUCOSE TESTING:**
   Desired range _______mg/dl to _______mg/dl
   - ☐ Before AM snack
   - ☐ 2 hours after lunch
   - ☐ Before lunch
   - ☐ 2 hours after correction dose
   - ☐ At student's discretion, except, always for suspected hypoglycemia
   - ☐ No blood glucose testing at school required at this time.

3. **MILD HYPOGLYCEMIA INTERVENTION:**
   ☐ BG<70 mg/dl ☐ BG<____mg/dl
   Student must NEVER be alone when hypoglycemia is suspected and should be treated on site.
   - ☐ Give 15 gm/CHO or ☐ _______gm of fast-acting glucose
   - ☐ Recheck in: ☐ 15 minutes ☐ ______ minutes

4. **SEVERE HYPOGLYCEMIA INTERVENTION:**
   Seizure, unconscious, unable to swallow:
   CALL 911 – Ensure open airway
   - ☐ Ok, to use glucose gel inside cheek if conscious
   - ☐ Glucagon injection IM, if unconscious or seizing
     ☐0.5mg ☐1mg

5. **HYPERGLYCEMIA INTERVENTION:**
   If BG is greater than ______mg/dl check ketones in urine. Encourage to drink water. If student is ill or vomiting, call parent to pick up student.
   For confusion, labored breathing or coma – CALL 911
   - ✓ If BG>________mg/dl with ketones moderate to large call parent to pick up.
   - ✓ If BG>________mg/dl with ketones negative to small, child may remain at school if not ill or vomiting.
   - ✓ For above, initiate insulin per sliding scale, ONLY, if more than 2 hours have passed since last insulin dose and encourage sugar free liquids. DO NOT give insulin more frequently than every 2 hours.
   - ✓ If student has a pump, immediately troubleshoot the pump, infusion set and site. Use pump for initial correction dose and recheck blood sugar within one hour to assure adequate delivery of insulin.

6. **INSULIN ORDERS: Complete ONLY if insulin is needed at school.**
   Brand name of insulin:______________________
   Insulin administration route:
   ☐ Syringe ☐ Pump ☐ Pen ☐ Other:__________
   ***Routine administration times**:
   ☐ Breakfast ☐ AM Snack
   ☐ Lunch ☐ Other:______________________
   ***Food/bolus insulin dose**:
   ☐ Insulin to CHO ratio
   ______ unit(s) insulin per _______gm CHO or
   ***Fixed insulin dosing**:
   - ☐ Breakfast dose _______ unit(s) (If given at school)
   - ☐ AM snack dose _______ unit(s)
   - ☐ Lunch dose _______ unit(s)
   - ☐ Other dose _______ unit(s)

   ***Correction Dose**:
   ☐ Give _____ unit(s) for every _____mg/dl above ____mg/dl
   Blood glucose from _______ to _______=_______ units
   Blood glucose from _______ to _______=_______ units
   Blood glucose from _______ to _______=_______ units
   Blood glucose from _______ to _______=_______ units
   Blood glucose from _______ to _______=_______ units
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   Blood glucose from _______ to _______=_______ units

7. **MEAL PLAN**:
   Meal/snack will be considered mandatory, unless, "at student's discretion" box is checked. Attach orders if breakfast or PM snacks are needed. Timing will be routine school times unless indicated.

   Content of meal/snack to be specified by:
   - ☐ Parent
   - ☐ Health Care Provider (attach if necessary)
   - ☐ Student
   - ☐ No snack needed

8. **ILLNESS**:
   - ✓ If student is ill, check ketones and blood glucose.
   - ✓ If ketones are _______ or greater, provide fluids, call parents to pick up.
   - ✓ If ketones and blood glucose are within range, follow standard procedures for an ill child and notify parents.

CONTINUE ON BACK

9. **BUS TRANSPORTATION**: ☐ Blood glucose test NOT required prior to boarding bus. ☐ Test blood glucose 10-20 minutes prior to boarding bus and treat hypoglycemia appropriately. ☐ Notify parent if BS > _______mg/dl or < _______mg/dl 10. Exercise: Complete ONLY if needed. Follow hypoglycemia or hyperglycemia and illness protocols when relevant. Eat _______ extra grams of CHO for vigorous exercise. ☐ Before ☐ Every 30 minutes during ☐ After exercise ☐ Student may disconnect pump for up to _____ hour(s) ☐ Student may decrease basal rate at their discretion.	11. **OTHER NEEDS**: ____ ____ ____ ____ ____ ____ ____ ____

Physician's Signature:____ Print Name: ______________________________

Date:____/____/____ Physician's Phone:_________________________ Fax: ____________________________________

Other Phone Numbers:

Physician's Nurse:______________________________ Phone: _______________________ Fax: ___________________

Dietitian: _____________________________________ Phone: _______________________ Fax: ___________________

Other Health Care Provider:_______________________________________ Phone: ________________________________

As the parent, I understand that I will notify the school immediately if the health status plan of my child changes, change physicians or emergency contact information. I understand that the Unlicensed Diabetic Care Assistant(s) are not liable for civil damages as provided by Section 168.009 of House Bill 984 – Care of Diabetic Students. I also give permission to the school principal and school nurse to communicate with my child's physician and other Health Care Providers listed. This authorization is for the current school year. If changes to this plan occur, I will be required to submit it in writing **with** physician's signature. I understand that all diabetic supplies, snacks, and drinks will be provided by the parent/guardian.

Parent/Legal Guardian Signature:____ Relationship: ____________________

Date:____/____/____ Cell:_____________________ Home:______________________ Cell: _____________________

Special notes/comments: ____

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To be completed by Seguin ISD Health Services Staff:

Received by:____ Date: ____

Revised 05-11-21