

Acalanes Union High School District

School Nurse
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School Nurse
Campolindo H.S.
300 Moraga Rd.
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School Nurse
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School Nurse
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750 Moraga Way
Orinda, CA 94563
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Diabetes Individualized Healthcare Plan Parental Consent and Physician Authorization

Student Name: _____ Date of Birth: _____ Grade: _____

1. **Blood Glucose Testing before:** a.m. snack lunch PE for suspected hypoglycemia

2. **Meal Plan:** a.m. snack lunch mandatory at student's discretion
Extra food allowed at student's discretion.

3. **Routine Care of Hypoglycemia when blood glucose is below:** _____

Self-treatment of mild lows Assistance for all lows

SEE ATTACHED DIABETES EMERGENCY PLAN FOR ACTIONS NEEDED.

Emergency Care of Severe Hypoglycemia:

SEE ATTACHED DIABETES EMERGENCY PLAN FOR ACTIONS NEEDED.

Glucose gel: Conscious
Glucagon injection: Unconscious Dosage: _____

4. **Care of Hyperglycemia when blood glucose is above:** _____

240 or above 300 or above other: _____
 Check ketones if _____ or above.

5. **Insulin at school:**

Not at this time

Insulin: Humalog Novolog **via:** syringe pen pump

Sliding scale as follows:
Blood glucose from ____ to ____ = ____ Units
Blood glucose from ____ to ____ = ____ Units
Blood glucose from ____ to ____ = ____ Units
Blood glucose from ____ to ____ = ____ Units

Lunchtime dose - **use sliding scale:** (above)

Correction lunchtime dose

Use sliding scale: (above)

Other: _____

Carbohydrate counting: ____ # units per ____ grams carbohydrate

Morning snack Lunch Afternoon snack

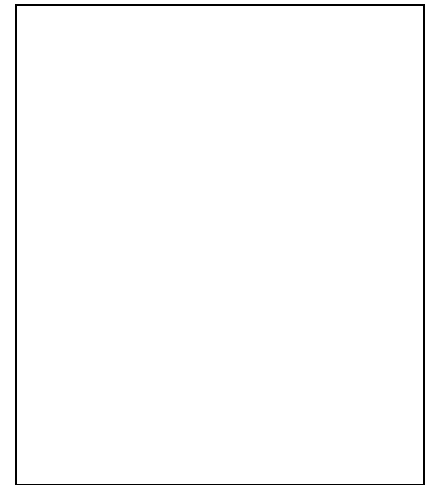
Dose preparation by:

Pupil Parent Parent Designee* Licensed nurse

(*All parent designees are trained by the parent and are not employees of the school or district)

Parent Designee: _____ Phone: _____ Cell phone: _____

STUDENT PHOTO



6. **PE Guidelines:**

- Liquid or solid carbohydrate source must be available before, during and after exercise.
- No exercise if blood glucose >300 AND ketones present. May exercise if negative ketones.
- Eat 15 grams carbohydrate before PE.

7. **Disaster Preparedness Plan – Please have at least a 3 day supply of the following available at all times:**

- 1 vial/pen of each: Novalog Humalog NPH Lantus Levemir Other

In case of emergency (food not available):

Give ___ units of _____ SQ at 8am, and ___ units of _____ SQ at 9pm.

Give _____ insulin according to sliding scale below. Give these doses at 8am and 6pm.

Sliding scale as follows:

- 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
- Blood glucose from ___ to ___ = ___ Units

Additional Instructions:

Supplies to be kept at School (provided by student’s family)

On Person (at all times):

- o Blood glucose meter, lancets and test strips
- o Urine ketone strips
- o Insulin and applicable delivery device
 - o Insulin pump and supplies
 - o Insulin, pen needles, insulin cartridges
 - o Insulin, syringes,
- o Fast-acting source of glucose
- o Carbohydrate containing snack
- o Glucagon Emergency Kit
- o

In School Nurse Office:

(include 3-day disaster supply)

Diabetes Supply Kit location: _____

- o Blood glucose meter (if available), lancets and test strips, spare batteries
- o Urine ketone strips
- o Insulin and applicable delivery device supplies
 - o Insulin pump batteries, tubing and infusion set
 - o Insulin and syringes
- o Fast-acting source of glucose
- o Carbohydrate containing snack
- o Glucagon Emergency Kit
- o Bottled water

EMERGENCY CONTACT INFORMATION

Mother/Guardian

Home Phone Work Phone Cell Phone

Emergency Contact #1

Home Phone Work Phone Cell Phone

Healthcare Provider

Phone #1 Phone #2

Father/Guardian

Home Phone Work Phone Cell Phone

Emergency Contact #2

Home Phone Work Phone Cell Phone

Hospital in Case of Emergency

STUDENT NAME: _____ Date of Birth: _____ Grade: _____

DIABETES EMERGENCY CAREPLAN

Hypoglycemia (Low Blood Sugar)

SYMPTOMS

MILD

- Hunger
- Shakiness
- Weakness
- Paleness
- Anxiety
- Irritability
- Dizziness
- Sweating
- Drowsiness
- Personality change
- Inability to concentrate
- Headache
- Other: _____

Circle student's usual symptoms.

MODERATE

- Sleepiness
- Headache
- Behavior change
- Poor coordination
- Blurry vision
- Slurred speech
- Weakness
- Confusion
- Other: _____

Circle student's usual symptoms.

SEVERE

- Inability to swallow
- Combativeness
- Seizure
- Loss of consciousness

Circle student's usual symptoms.

ACTIONS NEEDED

- NEVER leave diabetic student with symptoms unattended.
- NEVER send student with suspected low blood sugar anywhere alone.
- Notify School Nurse, Administrator, or trained staff.
- If possible, check blood glucose per Diabetes IHP.

Diabetic Supply Kit location: _____

MILD

- Provide 1 quick sugar source:
 - 3-4 glucose tablets
 - 4 oz. juice
 - 6 oz. regular soda
 - 3 tsp. glucose gel
- Wait 10-15 minutes.
- Recheck blood glucose
- Repeat sugar source if blood glucose < _____ and/or symptoms persist.
- If blood glucose within target range: _____, follow with snack of carbohydrate and protein (cheese and crackers).
- Student may return to class after blood glucose is stable and student is symptom-free.

MODERATE

- Assist student in treatment
- Give student quick-sugar source per mild guidelines.
- Wait 10 – 15 minutes.
- Recheck blood glucose.
- If glucose < _____ repeat with sugar source.
- Notify parent/guardian.
- Provide snack of carbohydrate and protein (cheese and crackers) if no meal for more than 1 hour.
- Student may return to class after blood glucose is stable and student is symptom-free.

SEVERE

- Call 911.
- Position on side if possible.
- DO NOT attempt to give anything by mouth.
- Contact School Nurse, Administrator, or trained staff.
- Administer glucagon per Diabetes IHP.
- Contact parents/guardian.
- Stay with student.

Parental Consent for Management of Diabetes at School

I (We) the parent(s)/guardian(s) of the above named student, give permission to the School Nurse and other designated trained staff members of _____ High School to perform and carry out the diabetes care tasks as outline by _____'s Diabetes Individualized Healthcare Plan (IHP) and in accordance with CA Education Code Section 49423.5. I (We) also consent to the release of information contained in this IHP to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I also agree to:

1. Complete the Diabetes Emergency Care Plan and provide emergency contacts.
2. Provide necessary supplies and equipment.
3. Notify the School Nurse if there is a change in pupil health status or attending physician.
4. Notify the School Nurse immediately and provide new consent for any changes in doctor's orders.

Parent/ Guardian Signature: _____ **Date:** _____

Physician Authorization for Diabetes Management in School

I have instructed _____ (Student's Name) in the proper way to check blood glucose and administer insulin. It is my professional opinion that _____ (Student's Name) should be allowed to carry diabetic supplies, check blood glucose, and administer insulin independently.

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with Education Code 49423.5. I understand that specialized physical health care services, *excluding insulin administration*, may be performed by unlicensed designated school personnel under the training and supervision provided by the School Nurse, or as designated and trained by the parent. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization.

Date: _____ Physician's Stamp: _____
 Physician's Name: _____
 Physician's Signature: _____
 Address: _____
 City: _____ Zip: _____
 Phone #: _____ Fax #: _____

TO BE COMPLETED BY SCHOOL NURSE:
DESIGNATED TRAINED STAFF FOR MANAGEMENT OF DIABETES IHP
(EXCLUDING INSULIN ADMINISTRATION)

_____	_____	_____	_____
Name	Position	Phone Extension	Date Trained
_____	_____	_____	_____
Name	Position	Phone Extension	Date Trained
_____	_____	_____	_____
Name	Position	Phone Extension	Date Trained

Reviewed by School Nurse (Signature): _____ Date _____

Reviewed by Principal (Signature): _____ Date _____