Acalanes Union High School District

School Nurse ☐
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School Nurse ☐
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School Nurse ☐
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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 EMERGENY PLAN FOR ACTIONS NEEDED.

   Emergency Care of Severe Hypoglycemia:

   SEE ATTACHED DIABETES EMERGENY 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.

STUDENT PHOTO

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: _____

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):

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

In School Nurse Office:
(include 3-day disaster supply)
Diabetes Supply Kit location: _____

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

EMERGENCY CONTACT INFORMATION

Mother/Guardian	Father/Guardian
Home Phone Work Phone Cell Phone	Home Phone Work Phone Cell Phone
Emergency Contact #1	Emergency Contact #2
Home Phone Work Phone Cell Phone	Home Phone Work Phone Cell Phone
Healthcare Provider	Hospital in Case of Emergency
Phone #1 Phone #2	

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_____