FHUSD Diabetic Management Plan

This plan should be completed by the student's personnel Physician or Licensed Healthcare Provider and parent/guardian. It should be reviewed with relevant school staff and copies should be kept in a place that is easily accessed by the FHUSD Registered Nurse, Health Aides, and other authorized personnel.

Parent/Guardian must complete pages 1 and 2 only. The Physician or Licensed Healthcare Provider must complete the remainder of the FHUSD Diabetic Management Plan.

Diabetic Care Plan For: _____
(Student's Name)

Effective Date: _____/_____/20____ Grade: _____ Homeroom Teacher: _____
(See attached Classroom Schedule for Fountain Hills Middle and High School students)

Birth Date: _____/_____/_____

Date of Diagnosis: ____/____/____ Diabetes Type1 ☐
Diabetes Type 2 ☐

(Apply student photo above)

Emergency Contact Information

Parent/Guardian #1: _____ Home Phone: (_____) _____-_____

Work Phone: (____) _____-_____ Ext# _____ Cell Phone: (_____) _____-_____

Address: _____

Parent/Guardian #2: _____ Home Phone: (_____) _____-_____

Work Phone: (____) _____-_____ Ext# _____ Cell Phone: (_____) _____-_____

Address: _____

Student's Physician/Healthcare Provider: _____

Address: _____

Telephone: (_____) _____-_____ Emergency Telephone or Pager: (____) _____-_____

Other Emergency Contact: _____ Home Phone: (_____) _____-_____

Address: _____ Cell Phone: (_____) _____-_____

Relationship to student: _____ Work Phone: (_____) _____-_____ Ext# _____

Notify parent/guardian or emergency contact in the following situations: _____

_____

Parent/Guardian please read and sign the Consent for Care on next page of this form.

FHUSD Diabetic Management Plan

Diabetic Care Plan For: _____
(Student's Name)

Parent/Guardian Consent for Care

(To be completed by Parent/Guardian)

I/we give permission to the FHUSD Registered Nurse, Health Aides, and other designated staff members of

☐ Mc Dowell Mountain Elementary School ☐ Four Peaks Elementary School
☐ Fountain Hills Middle School ☐ Fountain Hills High School

to perform and carry out the diabetic care task as outlined by _____'s
(Physician/Licensed Healthcare Provider)
Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan 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 understand it is the responsibility of the parent/guardian to inform the physician or licensed healthcare provider and the school of any changes in the student's health status. I/we give permission for release of information to/from the FHUSD to/from the physician/licensed healthcare provider, for the 20_____-20_____ school year.
I have read and received a copy of the FHUSD Diabetic Management Policy and Procedure.

_____ _____
Parent/Guardian # 1 Date Parent/Guardian # 2 Date

Supplies to be kept at School (All supplies listed below are to be provided by the parent/guardian.)

☐ Blood glucose meter, blood glucose test strips, batteries for meter, copy of instruction manual and high/low calibration testing solutions.

☐ Lancet device, lancets, gloves, etc.

☐ Urine ketone strips

☐ Insulin vials and syringes

☐ Insulin pump, supplies and copy of instruction manual

☐ Insulin pen and pen needles

☐ Fast-acting glucose source (i.e., tablets/icing)

☐ Carbohydrate containing snacks

☐ Glucagon emergency kit with prescription label

☐ Extra insulin cassettes/cartridges for insulin pump

☐ Back up insulin vial and syringes in case insulin pump is not properly functioning

☐ Extra water bottles and juices for hydration

☐ Beginning of each school year, new physician/ licensed healthcare provider's orders for the school heath office to follow for appropriate care to be given.

The last three pages are to be completed by the student's Physician/Licensed Healthcare Provider.

FHUSD Diabetic Management Plan

Physician/Licensed Healthcare Provider Plan of Care
(Must be completed by the Physician or Licensed Healthcare Provider)

Please write legibly to ensure quality care for our student

Diabetic Care Plan For: _____
(Student's Name)

Blood Glucose Monitoring

Target Range for Blood Glucose Monitoring:
☐ 70-150mg/dl ☐ 70-180mg/dl
☐ Other _____ to _____mg/dl Comment: _____

Usual times to check blood glucose ☐ Before Lunch ☐ After Lunch ☐ Other: _____
Times to do extra blood glucose checks (check all that apply)
☐ Before Exercise ☐ After Exercise
OR
When student exhibits symptoms of: ☐ Hyperglycemia ☐ Hypoglycemia

☐ Other: _____

May this student perform his/her own glucose checks? ☐ Yes ☐ No

Type of glucose meter student uses: _____

Insulin

Times, types and dosage of insulin injections to be given during school:

Time	Type	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____

Can student give own injection? ☐ Yes ☐ No

Can student determine correct amount of insulin? ☐ Yes ☐ No

Can student draw up correct dosage? ☐ Yes ☐ No

Comments: _____
_____
_____
_____
_____

Students with Insulin Pumps

Copy of instructional manual must be provided to school health office.

Type of pump: _____

Insulin/carbohydrate ratio: _____

Basal rate: _____

Correction factor: _____

Should student disconnect insulin pump during P.E.?
☐ Yes ☐ No

Is student competent regarding insulin pump use?
☐ Yes ☐ No

Can student effectively troubleshoot problems (i.e., ketosis/pump malfunction)?
☐ Yes ☐ No

Comments: _____

FHUSD Diabetic Management Plan

Diabetic Care Plan For: _____
(Student's Name)

Sliding Scale Insulin

Is student using a sliding scale for insulin administration before lunch? ☐ Yes ☐ No
May use Sliding Scale Insulin every _____ to _____ hours? ☐ Yes ☐No

Blood Glucose
<100 mg/dl give _____units of ☐Regular _____units of ☐Humalog _____units of ☐other _____
100-149mg/dl give _____units of ☐Regular _____units of ☐Humalog _____units of ☐other _____
150-199mg/dl give _____units of ☐Regular _____units of ☐Humalog _____units of ☐other _____
200-249mg/dl give _____units of ☐Regular _____units of ☐Humalog _____units of ☐other _____
250-299mg/dl give _____units of ☐Regular _____units of ☐Humalog _____units of ☐other _____
300-349mg/dl give _____units of ☐Regular _____units of ☐Humalog _____units of ☐other _____
350-399mg/dl give _____units of ☐Regular _____units of ☐Humalog _____units of ☐other _____
>400mg/dl give _____units of ☐Regular _____units of ☐Humalog _____units of ☐other _____

Meals and Snacks Eaten at School

(The carbohydrate of the food is important in maintaining a stable blood glucose level).

	Time	Food content/amount
Breakfast	_____	_____
AM Snack	_____	_____
Lunch	_____	_____
PM Snack	_____	_____

Snack before exercise?
☐ Yes _____ ☐ No
Snack after exercise?
☐ Yes _____ ☐ No

Hypoglycemia (Low Blood Sugar)

Usual Symptoms for this student are
☐ Shaky ☐ Hungry ☐ Weak ☐ Sick to stomach
☐ Tired ☐ Dizzy ☐ Sleepy ☐ Hard to think
☐ Pale ☐ Sweaty ☐ Headache
☐ Whiny ☐ Clumsy ☐ Glassy eyes
Treatment for Hypoglycemia _____
_____
_____

Glucagon should be given if student is unconscious, having convulsions or is unable to swallow. **CALL 911**
Route_____ Dosage _____
Site: ☐ Arm ☐ Thigh ☐ Other _____
_____
_____
_____
_____

Other times to give snacks: _____
A source of glucose, such as _____ should be readily available at times.
Foods to avoid, if any _____
_____
Instructions for when food is provided to class: i.e. class party or food sampling. _____
_____

Hyperglycemia (High Blood Sugar)

Usual symptoms for this student are
☐ Drinking more/very thirsty ☐ Headache ☐ Tired
☐ Increased urination ☐ Hunger
Treatment for Hyperglycemia: _____
_____

Physician/Licensed Healthcare Provider note below orders:

1.) Student will be sent home when blood glucose level are 300mg/dl and above. If not, other levels must be stated by physician or licensed healthcare provider. If other state level _____mg/dl

2.) Urine will be checked for ketones when blood glucose levels are 300mg/dl and above. If not, other levels must be stated by physician or licensed healthcare provider. If other state level _____mg/dl

3.) Student will be sent home if there is a trace of ketones or other must be checked by physician or licensed healthcare provider. ☐ Moderate ☐ Large

FHUSD Diabetic Management Plan

Diabetic Care Plan For: _____
(Student's Name)

Antidiabetic Medications ☐ Yes ☐ No

Medication, dose, route and schedule: _____

Other instructions: _____

Parent/Guardian may adjust student's insulin dosage independently of Physician or Licensed Healthcare Provider?
☐ Yes ☐ No Comment: _____

For the safety of our student, if able to use the injection pen, we request the use of an insulin injection pen, rather than drawing up insulin dosages. ☐ Yes ☐ No

Please ensure that the patient has prescriptions for the below listed supplies as applicable. This will ensure appropriate care during the school year. All applicable diabetic supplies listed below are provided by parent/guardian through out the school year.

☐ Back up insulin vial and syringes in case insulin pump is not properly functioning

☐ Insulin pen and pen needles

☐ Fast-acting glucose source (i.e. tablets/icing)

☐ Carbohydrate containing snacks

☐ Extra insulin cassettes/cartridges for insulin pump

☐ Back up insulin vial and syringes in case insulin pump is not properly functioning

☐ Blood glucose meter, blood glucose test strips, batteries for meter, copy of instruction manual and high/low calibration testing solution

☐ Insulin pump, supplies and copy of instruction manual

☐ Lancet device, lancets, gloves, etc.

☐ Urine ketone strips

☐ Glucagon emergency kit with prescription label

☐ Extra water bottles and juices for dehydration

☐ Beginning of each school year, new physician or licensed healthcare provider's orders for the school health office to follow for appropriate care to be given.

Signature

_____ _____
Student's Physician/Licensed Healthcare Provider **Date**

_____
Printed Name of Physician/Licensed Healthcare Provider