

Fayette County School Health Services  
**DIABETES HEALTH CARE PLAN**

Please bring or mail this health care plan to the school or send to the secure FAX at 770-460-3928.

Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ School Year: 20\_\_ - 20\_\_

School: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_ Grade/Team: \_\_\_\_\_

**EMERGENCY CONTACTS**

Parent/Guardian/Contact	Relationship	Phone Number	Alternate Phone Number
Diabetes Healthcare Provider:		Phone Number:	

**EMERGENCY NOTIFICATION**

**Notify parents of the following conditions:**

- Loss of consciousness or seizure immediately after calling 911 and administering Glucagon
- Blood sugar in excess of \_\_\_\_\_ mg/dl.
- Positive urine ketones.
- Abdominal pain, nausea/vomiting, fever, diarrhea, altered breathing, or altered level of consciousness.

**STUDENT'S COMPETENCE WITH PROCEDURES** (Must be verified by parent and Clinic Staff)

<input type="checkbox"/> Blood glucose (BG) monitoring	<input type="checkbox"/> Carry supplies for BG monitoring
<input type="checkbox"/> Determining insulin dose	<input type="checkbox"/> Carry supplies for insulin administration
<input type="checkbox"/> Measuring insulin	<input type="checkbox"/> Monitoring BG in classroom
<input type="checkbox"/> Injecting insulin	<input type="checkbox"/> Self treatment for mild low blood sugar
<input type="checkbox"/> Independently operates insulin pump	<input type="checkbox"/> Determine own snack/meal content

**MEAL PLAN**

	Time	Location	CHO Content		Time	Location	CHO Content
<input type="checkbox"/> Breakfast				<input type="checkbox"/> Mid-PM			
<input type="checkbox"/> Mid-AM				<input type="checkbox"/> Before PE			
<input type="checkbox"/> Lunch				<input type="checkbox"/> After PE			
Meal/snack will be considered mandatory. Content of meal/snack will be determined by:							
<input type="checkbox"/> Student <input type="checkbox"/> Parent <input type="checkbox"/> Clinic Staff <input type="checkbox"/> Diabetes Healthcare Provider							

**LOCATION OF SUPPLIES/EQUIPMENT: Parent to provide and restock supplies.** (Completed by Clinic Staff)

Blood glucose equipment:	<input type="checkbox"/> Clinic	<input type="checkbox"/> With Student
Insulin administration supplies:	<input type="checkbox"/> Clinic	<input type="checkbox"/> With Student
Glucagon emergency kit:	<input type="checkbox"/> Clinic	<input type="checkbox"/> With Student
Fast acting carbohydrate:	<input type="checkbox"/> Clinic	<input type="checkbox"/> With Student
Snacks:	<input type="checkbox"/> Clinic	<input type="checkbox"/> With Student

I, this child's parent/guardian, hereby authorize the named Healthcare Provider who has attended to my child, to furnish to the School Health Services Coordinator and/or School Clinic Staff any medical information and/or copies of records pertaining to my child's diabetes and for this information to be shared with pertinent school staff at my child's school.. I understand that as of April 14, 2003, under the Health Insurance Portability and Accountability Act ("HIPAA") disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance in the Fayette County Schools. This authorization expires as of the last day of the school year.

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Clinic Staff's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Implemented: August 2001

Revised: February 6, 2002; August 2003; August 2, 2004; September 9, 2005; February 20, 2006



**SUPPLEMENTAL AUTHORIZATION FOR INSULIN PUMP**

**Student:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PUMP RESOURCE PERSON:** \_\_\_\_\_ **PHONE NUMBER:** \_\_\_\_\_

**Blood Glucose Target Range:** \_\_\_\_\_ **Pump Insulin:**  Humalog  Regular

**Insulin Correction Factor for BG over Target:** \_\_\_\_\_

**Insulin CHO Ratios:** \_\_\_\_\_

**Student to receive insulin bolus for CHO intake**  Immediately before  \_\_\_\_\_ minutes before eating  After eating

**Location of extra pump supplies** \_\_\_\_\_

**INDEPENDENT MANAGEMENT**

*This student has been trained to independently perform routine pump management and to troubleshoot problems including but not limited to:*

- Giving boluses of insulin for both correction of blood glucose above target range and for food consumption.
- Changing of insulin infusion sets using universal precautions.
- Switching to injections should there be a pump malfunction. Parents will provide extra pump supplies.

**NON-INDEPENDENT MANAGEMENT: Child Lock On?  Yes  No**

*Because of young age or other factors, this student cannot independently evaluate pump function nor independently change infusion sets.*

- Insulin for meals and snacks will be given and verified as follows: \_\_\_\_\_
- Insulin for correction of BG > \_\_\_\_\_ will be given and verified as follows: \_\_\_\_\_

**PARENT NOTIFICATION IN THE EVENT OF:**

- |  |  |
|--|--|
| <input type="checkbox"/> Pump alarms/malfunctions            | <input type="checkbox"/> Corrective measures do not return BG to target range within _____ hours |
| <input type="checkbox"/> Soreness or redness at site         | <input type="checkbox"/> Student has to change site  |
| <input type="checkbox"/> Detachment of dressing/infusion set | <input type="checkbox"/> Leakage of insulin  |
| <input type="checkbox"/> Student must give insulin injection | <input type="checkbox"/> Other: _____  |

**MANAGEMENT OF HIGH/VERY HIGH BLOOD GLUCOSE:** *Refer to Healthcare Provider Authorization page 2*

**MANAGEMENT OF LOW BLOOD GLUCOSE:** *Refer to Healthcare Provider Authorization page 2, but in addition:*

- If low blood glucose recurs without explanation, notify parent/ diabetes healthcare provider for potential instructions to suspend pump.
- If seizure or unresponsiveness occurs:
  1. Give Glucagon and/or glucose gel (*Refer to Healthcare Provider Authorization page 2*)
  2. Call 911
  3. Notify Parents
  4. Stop insulin pump by:  Placing in "Suspend" or stop mode  
 Disconnecting at pigtail or clip  
 Cutting tubing
  5. If pump was removed, send with EMS to hospital.

**SPECIAL CONSIDERATIONS AND PRECAUTIONS (including school activities, sports and trips):**

*My signature provides authorization for the above orders. I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.*

*If changes are indicated, I will provide new written authorized orders.*

*Dose/treatment changes may be relayed through parent.*

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician's Name:** \_\_\_\_\_ **Telephone Number:** \_\_\_\_\_