Monitor Blood Glucose – test ...  
[ ] If student has symptoms of high or, **without moving student**, low blood glucose
  - Before breakfast
  - Before mid-morning snack
  - Before lunch

Where to test:  [ ] Classroom  [ ] Health office  [ ] Other: ________________

**Without moving student if has low blood glucose symptoms**

Routine Daily Insulin Injection:

- **Insulin Delivery:** [ ] Syringe/vial  [ ] Pen
- **Type:** [ ] rapid acting (Humalog / NovoLog / Apidra)  [ ] regular or [ ] other: ________________
- **Calculate insulin dose for carbohydrate intake:**
  - Give _____ unit(s) of rapid-acting insulin for ___ grams of carbohydrate.
  - Give at:  [ ] breakfast  [ ] AM snack  [ ] lunch  [ ] PM snack  [ ] parties.

Correction insulin dose for high blood glucose:

- **Time to be given:** [ ] Before lunch  [ ] Other: ________________

**Do not give insulin correction dose more than once every 2 to 3 hours.**

- **Use correction scale**

<table>
<thead>
<tr>
<th>Blood glucose range (mg/dl)</th>
<th>Insulin units (mg/dl)</th>
</tr>
</thead>
<tbody>
<tr>
<td>mg/dl</td>
<td>mg/dl</td>
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<tr>
<td>mg/dl</td>
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<td>mg/dl</td>
<td>mg/dl</td>
</tr>
<tr>
<td>mg/dl</td>
<td>mg/dl</td>
</tr>
</tbody>
</table>

**Check ketones** if nausea, vomiting or abdominal pain OR if blood glucose >300 twice when tested 2 hours apart.

- Give ________________ of rapid-acting insulin for moderate ketones, or
- ________________ for large.

- Repeat ketone test in 2 hours, and repeat additional insulin as above if moderate or large ketones are still present.

Exercise and Sports  [ ] Student should monitor blood glucose hourly.

Parent/Guardian Authority to Adjust Insulin Dose

- Dose adjustment allowed up to 20% higher or lower [ ] Yes  [ ] No

Other Health Concerns and Medications

- **Other health concerns:**
  - [ ] Glucagon  Dose: ________________  IM or SC per thigh or arm
  - [ ] Oral diabetes medication(s)/dose: ________________  Times to be given: ________________
  - [ ] Other medication(s)/dose: ________________  Times to be given: ________________

HCP Assessment of Student’s Diabetes Management Skills:

<table>
<thead>
<tr>
<th>Skill</th>
<th>Independent</th>
<th>Needs supervision</th>
<th>Cannot do</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check blood glucose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count carbohydrates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calculate insulin dose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injection</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: ________________

Healthcare Provider Signature/Stamp:

Updated  Change  Date  Initials
INDIVIDUALIZED HEALTHCARE PLAN – DIABETES WITH PUMP

HEALTHCARE PROVIDER ORDERS

<table>
<thead>
<tr>
<th>EFFECTIVE DATE:</th>
<th>End Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>STUDENT’S NAME:</td>
<td>Date of Birth:</td>
</tr>
</tbody>
</table>

**DIABETES HEALTHCARE PROVIDER INFORMATION** | Name: |
| Phone #: | Fax #: | Email |

**SCHOOL:** | School Fax: |

---

**Monitor Blood Glucose** – test ...
- If student has symptoms of high or low blood glucose:
  - Before breakfast:
  - After lunch:
  - Before mid-morning snack:
  - Before afternoon snack:
  - Before exercise/PE:
  - Before lunch:
  - Before leaving school:
  - Other:

Where to test: Classroom, Health office, Other: ________________

**Without moving student if has low blood glucose symptoms**

---

**Insulin Pump Information**
- Humalog or NovoLog or Apidra by pump

Basal rates during school:
- Place pump on suspend when blood glucose is less than ____mg/dl and re-activate it when blood glucose is at least _____mg/dl.

**Pump settings should not be changed by school staff.**

---

**Carbohydrate Bolus**
Give 1 unit of insulin per
- gm carbohydrate at breakfast
- gm carbohydrate at AM snack
- gm carbohydrate at lunch
- gm carbohydrate at PM snack

Bolus should occur: before eating, or other: ________________

---

**Correction Bolus for Hyperglycemia**
Time to be given: Before lunch, Other: ________________

**Do not give correction dose of insulin more than once every 2 to 3hrs**
- Give ___ units of insulin for each ____mg/dl of blood glucose with a target blood glucose of _____mg/dl.
- Check ketones if nausea, vomiting or abdominal pain OR if blood glucose >300 twice when tested 2 hours apart.
- Via syringe, give ___________________________rapid-acting insulin for moderate ketones, or ___________________________________for large.

Repeat blood glucose test in 2 hours, and repeat additional insulin as above if moderate or large ketones are still present.

- If BG <70 before a meal treat with carbohydrate per algorithm.

---

**Exercise and Sports with Pump**
Temporary Basal Decrease: No Yes (___% or ____ units for _____ minutes or ___ duration of exercise)
- Student should monitor blood glucose hourly.

---

**HCP Assessment of Student’s Diabetes Management Skills:**

<table>
<thead>
<tr>
<th>Skill</th>
<th>Independent</th>
<th>Needs supervision</th>
<th>Cannot do</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check blood glucose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count carbohydrates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calculate insulin dose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change infusion set</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trouble shoot alarms, malfunctions</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Notes:**

---

**Parent/Guardian Authority to Adjust Insulin Dose**
Dose adjustment allowed up to 20% higher or lower Yes No

Other health concerns:
- Glucagon Dose: ___________IM or SC per thigh or arm
- Oral diabetes medication(s)/dose: _______________Times to be given: _______________
- Other medication(s)/dose: _______________Times to be given: _______________

---

**HEALTHCARE PROVIDER SIGNATURE/STAMP:**

<table>
<thead>
<tr>
<th>DATE</th>
<th>Initials</th>
</tr>
</thead>
</table>

---

**UPDATED** Change

**Date**

**Initials**

---

Created by the Alaska Division of Public Health and the American Diabetes Association, Alaska Area  Revised 8/2016
**Student’s Name:**

**Student’s usual LOW blood glucose symptoms:**
- Shaky or jittery
- Sweaty
- Hungry
- Pale
- Headache
- Blurry vision
- Sleepy
- Dizzy
- Uncoordinated
- Irritable, nervous
- Argumentative
- Combative
- Changed personality
- Changed behavior
- Blurry vision
- Headache
- Changed personality
- Hungry
- Argumentative
- Sweaty
- Irritable, nervous
- Sleepy
- Unable to concentrate
- Weak, lethargic

**ALGORITHMS FOR BLOOD GLUCOSE RESULTS**

**Below 70**

2. Observe for 15 minutes then retest glucose.
   - If less than 70, repeat 15 gm carbohydrate and retest in 15 min.
3. Notify school nurse and parent if no improvement.
4. Student should not exercise.

**Check Blood Glucose**

**70 – 90**

1. If prior to exercise or immediately following strenuous activity and NO meal/snack is planned within 30 minutes, give 15 gm carbohydrate and protein snack.
2. If NOT exercise-related and student is symptomatic, observe and recheck in 15 minutes.
3. If NOT exercise-related and is NOT symptomatic, return to class.

**91-125**

Student may eat before exercising or recess.

**126-300**

No action needed.

**Above 300**

**Student treated by PUMP**

1. If 2-3 hours since last bolus, treat with correction bolus via pump. Re-check in 2-3 hrs. Troubleshoot pump function.
   - Check for redness at site, tubing for kinks or air bubble, insulin supply
2. If ketones moderate or large:
   - No exercise; encourage exercise and water
3. If ketones still ≥ 300 mg/dl and not explained, check ketones:
   - a. If ketones are absent or small, encourage exercise and water
   - b. If ketones moderate or large:
     - Give insulin correction dose per orders via syringe.
     - No exercise; encourage water
4. Change insulin therapy and/or has labored breathing. Notify school nurse, parent and HCP.
5. Provide free, unrestricted access to water and the restroom.

**Exercise and sports**
- Assure has quick access to water for hydration, fast-acting carbohydrates, snacks and monitoring equipment.
- Student should not exercise if blood glucose level is below 70 mg/dl or if has moderate to large ketones.

**Never send a child with suspected low blood glucose anywhere alone.**
INDIVIDUALIZED HEALTHCARE PLAN - DIABETES

SCHOOL AND PARENT PART

**STUDENT’S NAME:**

**Diabetes information**  Date of Diagnosis:
- [ ] Diabetes Type 1
- [ ] Diabetes Type 2
- [ ] Other

**PLAN**  **EFFECTIVE DATE:**

**SCHOOL INFORMATION**

<table>
<thead>
<tr>
<th>Grade:</th>
<th>Teacher:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

504 plan on file:
- [ ] Yes
- [ ] No

**CONTACT INFORMATION:**

**Parent/Guardian 1:**

Name:  Call first:
- [ ]

Phone numbers:
- Home
- Work
- Cell
- Other

**Parent/Guardian 2:**

Name:  Call first:
- [ ]

Phone numbers:
- Home
- Work
- Cell
- Other

**Other/emergency:**

Name:  Relationship:

Phone numbers:
- Home
- Work
- Cell
- Other

**Additional Times to Contact Parent...**

Student treated by **pump:**
- [ ] Blood Glucose test out of target range
- [ ] Carbohydrate bolus
- [ ] Correction bolus
- [ ] Infusion set comes out/needs to be replaced

Student treated by **injection**
- [ ] Blood Glucose test out of target range
- [ ] Routine Daily Insulin injections
- [ ] Correction dose

**STUDENT DIABETES SELF-MANAGEMENT PLAN**

Student will manage diabetes independently
- [ ]

- [ ] Student has signed
  Agreement for Student Independently Managing Diabetes

Trained staff will supervise student self-care
- [ ] Verify blood glucose test
- [ ] Check carbohydrate count
- [ ] Confirm dose
- [ ] Supervise insulin self-injection
- [ ] Monitor bolus administration
- [ ] Trouble shoot pump alarms, malfunction
- [ ] Watch infusion set change

Trained staff will provide care
- [ ] Test blood glucose
- [ ] Count carbohydrates
- [ ] Calculate insulin dose and inject as above
- [ ] Provide insulin injection
- [ ] Administer bolus
- [ ] Trouble shoot pump alarms, malfunction
- [ ] Change infusion set

**FOOD PLAN**

<table>
<thead>
<tr>
<th>Time</th>
<th>Notes</th>
<th>Monitor/Remind Student</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morning snack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lunch</td>
<td></td>
<td></td>
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<tr>
<td>Afternoon snack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extra snack</td>
<td>Before exercise</td>
<td></td>
</tr>
<tr>
<td></td>
<td>After exercise</td>
<td></td>
</tr>
</tbody>
</table>

Food at a classroom/school party:
- [ ] Student will eat treat
- [ ] Replace the treat with a parent-supplied alternative
- [ ] Put in baggie to take home with teacher note
- [ ] Student should not eat treat
- [ ] Modify the treat as follows:

**BUS TRANSPORTATION PLAN**

<table>
<thead>
<tr>
<th>Bus transportation:</th>
<th>To school</th>
<th>Home</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ]</td>
<td></td>
</tr>
</tbody>
</table>

- [ ] Test blood 10-20 minutes before boarding school bus home. **Student must have blood glucose > 70 mg/dl to board bus; if ≤ 70, provide care based on algorithm and call to have student picked up.**
- [ ] Blood test not required.
- [ ] Student may test blood glucose and self-manage diabetes while on the bus.

**FIELD TRIPS**

- [ ] School nurse to be notified two weeks before the field trip to assure qualified personnel are available.
- [ ] All diabetes supplies are taken and care is provided according to this Plan (copy to accompany trip).
- [ ] Lunch and snack times should not change.

**SCHEDULED AFTER- OR BEFORE-SCHOOL ACTIVITIES**

List of clubs, sports, etc. that student anticipates:

If parent wants trained staff coverage for an activity, parent will notify school nurse two weeks before it begins
### ADDITIONAL NOTES

**STUDENT’S NAME:** [Blank]  
**PLAN EFFECTIVE DATE:** [Blank]

☑ Means student uses this item AND parent will provide.

#### Blood Glucose Test Kit
- Meter
- Test strips
- Lancing device and lancet
- Sharps container
- Anti-bacterial cleaner/alcohol swabs
- cotton balls
- spot band-aids

#### Insulin
**Treatment by Injection**
- Insulin pen
- Pre-filled syringes (labeled per dose)
- Insulin vials and syringes

**Treatment by Pump**
- Pump syringe
- Pump tubing/needle
- Batteries
- Tape
- Sof-selter
- Insulin vial and syringes

- Infusion set type: ____________________________

- Pump type
  - Medtronic MiniMed
    - www.minimed.com
    - (800) 826-2099
  - Animas
    - www.animas.com
    - (877) 767-7373
  - Omnipod
    - www.myomnipod.com
    - (800) 591-3455

#### Low Blood Glucose (5-day supply)
- Fast-acting carbohydrate drink (apple juice, orange juice, regular soda pop – NOT diet), ≥ 6 containers
- Pre-packaged snacks (e.g., crackers with cheese or peanut butter, nite bite), ≥ 5 servings
- Supply of fast-acting glucose at least equal to 15 gm per day for 5 days (e.g., ≥ 75 gm total)

#### Glucagon Kit

#### High Blood Glucose
- Urine ketone test strips/bottle
- Urine cup
- Water bottle

- (Timing device may be wall clock or watch)

#### 3-day Disaster Kit
- Complete daily insulin dose schedule (separate page)
- Blood glucose test kit (testing strips, lancing device, lancets, meter batteries)
- Vial of insulin and 6 syringes; insulin pens and supplies
- Insulin pump and pump supplies
- Hypoglycemia treatment supplies, ≥ 3 episodes

- Other medications, including glucagon kit
- Urine ketone strips/plastic cup
- Antiseptic wipes or hand sanitizer
- 3-day food supply with meal plan
- Other: ____________________________

#### Other

<table>
<thead>
<tr>
<th>Daily breakfast, snacks and lunch</th>
<th>With student</th>
<th>In classroom</th>
<th>In health office</th>
<th>Other</th>
<th>Blood glucose test kit</th>
<th>Extra kit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extra snacks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low blood glucose supplies</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>High blood glucose supplies</td>
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<tr>
<td>Other</td>
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<td></td>
</tr>
</tbody>
</table>

### SUPPLY LOCATIONS

<table>
<thead>
<tr>
<th>With student</th>
<th>In classroom</th>
<th>In health office</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood glucose test kit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extra kit</td>
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<tr>
<td>Pump supplies</td>
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<tr>
<td>Insulin</td>
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<td>Extra/emergency</td>
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<tr>
<td>Disaster</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Disaster food</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### SIGNATURES

As parent/guardian of the above-named student, I give permission for the school nurse and/or other trained staff of ____________________________ to perform and carry out the diabetes care tasks as outlined in this Individualized Healthcare Plan.

- (school)
  - I have reviewed this plan and agree with the indicated instructions. I understand that the school is not responsible for equipment loss or damage, or expenses associated with these treatments and procedures.
  - I understand that the information contained in this plan will be shared with other school staff on a need-to-know basis.
  - I understand that the school nurse may contact my child’s physician/health care provider and discuss my child’s care related to this plan.
  - I will notify the school nurse whenever there is any change in my child’s health status or care.
  - My child and I are responsible for maintaining the necessary supplies, snacks, blood glucose meter, medications and other equipment.

**Student’s parent/guardian**

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
</table>

**School nurse**

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
</table>
**AGREEMENT FOR STUDENTS INDEPENDENTLY MANAGING THEIR DIABETES**

Student: _________________________________________  Grade: _____

**Student**

- [ ] I agree to dispose of any sharps either by keeping them in my kit and taking them home, or placing them in the sharps container provided at school.
- [ ] If so indicated in my Individualized Healthcare Plan, I will notify the health office if my blood sugar is below _____ mg/dl or above _____ mg/dl.
- [ ] I will not allow any other person to use my diabetes supplies.
- [ ] I plan to keep my diabetes supplies:
  - [ ] With me
  - [ ] In the school health office
  - [ ] In an accessible and secure location (_________________________)
- [ ] I will seek help in managing my diabetes from __________________________ if I need it.
- [ ] I understand that the freedom to manage my diabetes independently is a privilege and I agree to abide by this contract.

Student’s signature: _________________________________  Date: ______________

**Parent/Guardian**

- [ ] I agree that my child can self-manage his/her diabetes and can recognize when he/she needs to seek help from a staff member.
- [ ] I authorize my child to carry and self-administer diabetes medications and management supplies and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-management or storage of diabetes medications and blood glucose management products.
- [ ] I will provide back-up supplies to the health office for emergencies.
- [ ] I understand that this contract is in effect for the current school year unless revoked by my son/daughter’s physician or my son/daughter fails to meet the above safety guidelines.

Parent’s signature: _________________________________  Date: ______________

**School nurse**

- [ ] I will assure that school staff members that have the need to know about the student’s condition and the need to carry their diabetes supplies with them have been notified.

School Nurse’s signature: _________________________________  Date: ______________

*Based on a form posted on the Colorado Kids with Diabetes website ([http://www.coloradokidswithdiabetes.org/index.php/Nurse-Files.html](http://www.coloradokidswithdiabetes.org/index.php/Nurse-Files.html))*
**INDIVIDUALIZED HEALTHCARE PLAN - DIABETES**
**SCHOOL NURSE AND PARENT-AUTHORIZED TRAINED STAFF COVERAGE WORKSHEET**

### School nurse will be on-site

<table>
<thead>
<tr>
<th></th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
</tr>
</thead>
<tbody>
<tr>
<td>First period</td>
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<tr>
<td>Second period</td>
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<tr>
<td>Third period</td>
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<tr>
<td>Fourth period</td>
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<tr>
<td>Seventh period</td>
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<tr>
<td>Field Trip</td>
<td></td>
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</tr>
</tbody>
</table>

#### Notes/comments:

**Schedule for Parent-Authorized Trained Staff**

<table>
<thead>
<tr>
<th>Staff person’s Name</th>
<th>Day(s) responsible</th>
<th>Time(s) responsible</th>
<th>Contact phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M T W Th F</td>
<td>From: or Period:</td>
<td>To:</td>
</tr>
<tr>
<td></td>
<td>M T W Th F</td>
<td>From: or Period:</td>
<td>To:</td>
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<td>M T W Th F</td>
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<td>M T W Th F</td>
<td>From: or Period:</td>
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<td>From: or Period:</td>
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<tr>
<td></td>
<td>M T W Th F</td>
<td>From: or Period:</td>
<td>To:</td>
</tr>
</tbody>
</table>

- Before school starting ____ AM
- After school ending ____ PM
- Other

Attach if needed
- Delegation training completion
- Parent delegation authorization
ALASKA INDIVIDUALIZED HEALTHCARE PLAN – DIABETES
WITH INJECTION OR WITH PUMP

Instructions

Purposes:
This healthcare plan is for all students with diabetes that monitor blood glucose at school and/or are on insulin or other hypoglycemic medication and/or have a glucagon prescription.

1. Healthcare providers should use it to prescribe a particular treatment regimen including medication(s) for school (HEALTHCARE PROVIDER ORDERS pages)
   a. It documents the ability level of the student to self-manage their diabetes.
   b. It provides the medical parameters for management of an individual student’s diabetes in the school setting.

2. It describes the standard of care for school staff to follow based on blood glucose test results and is the Emergency Care Plan for students with diabetes. (ALGORITHMS FOR BLOOD GLUCOSE RESULTS page) NOTE: The standard of care represents the care to follow in most cases; any individualization of clinical care for the student will be reflected in the HEALTHCARE PROVIDER ORDERS.

3. School nurses and parents should use it to plan and implement individualized health interventions in the school setting, based on the Healthcare Provider Orders page. (SCHOOL AND PARENT PART pages)
   a. To support quality assurance of school health services.
   b. To document parental wishes for diabetes management-related contact by school staff.
   c. To document diabetes supplies needed at school, their locations and parental responsibility for maintaining certain supplies at school.
   d. To facilitate a safe process for the delegation of diabetes-management tasks to trained unlicensed school staff, as needed.

4. School nurses and parents may use it to identify times when the school nurse will not be available to provide diabetes management assistance and plan for coverage by trained school staff. (SCHOOL NURSE AND PARENT-AUTHORIZED TRAINED STAFF COVERAGE WORKSHEET)

While current, this form should be kept in the school health office or with the staff member who is assisting with the health management of the student.

Process:

1. Healthcare provider completes either the WITH INJECTION or the WITH PUMP page of the form to describe anticipated medications/treatment needs for the entire school year, and sends it to the school nurse (if known) and/or the student’s parent to bring into the school.
   a. If medications and/or treatment change during the school year, a new form should be completed. Fax only the page with new orders to the school.
   b. Most categories are self-explanatory. On either form, check all boxes that apply and add information as appropriate.

   DIABETES WITH INJECTION notes:
   • In the Routine Daily Insulin Injection box, there are three options for Type. NPH and Lantis are examples of “other.” The relevant doses/times for these injections would be listed in the “Standard daily insulin injection” table.
   • Instructions in the Correction insulin dose for high blood glucose box are for a routine day as correction dosing is generally given at mealtime, which means that:
     o Action directed by the algorithm page supersedes “before lunch only” when it is checked because it is based on the student’s symptoms and blood glucose levels.
o The “Do not give insulin correction dosing more often than every 2 to 3 hours” statement applies to symptomatic treatment based on blood glucose levels in most instances.

- In the Parent/Guardian Authority to Adjust Insulin Dose box, parental authority to adjust the dose up to 20% higher or lower allows the parent to recommend dose adjustments to the nurse which the nurse could follow without contacting the health care provider if the dose is within 20% of the range ordered by the provider. If the dose recommended by the parent falls outside of the range, either higher or lower, the nurse would need to contact the health care provider to verify the dose.

c. Healthcare provider signs and dates the WITH INJECTION or WITH PUMP page and faxes or sends the orders to the school.

2. While meeting with the school nurse, the parent uses the boxes at the top of the ALGORITHMS page to indicate which of the symptoms of low and high blood sugar generally occur for their child.

3. Together, the school nurse, parent and the student, if student is self-managing his/her diabetes, complete the SCHOOL AND PARENT PART of the form.
   a. Most categories are self-explanatory. Check all boxes that apply and add information as appropriate.
      - In the Student Diabetes Self-Management Plan box:
        o The repeated skills list (from the healthcare provider section) allows parent input and school nurse assessment of the student skill level and the level of supervision or assistance needed. If the student skill level increases during the school year, this section allows the school nurse and parent to adjust the self-management plan accordingly.
        o “Trained staff” (right-side column) in this instance includes the school nurse.
        o For “Change infusion set” under “Trained staff will provide care”, the school nurse is typically the only trained staff changing the infusion set for a student on a pump. Add this comment when needed.
      - The SUPPLY LIST is intended to promote best practice. Generally, it should be interpreted by the nurse and the parent as a guide.
      - If the parent is unable to provide urine ketone test strips, contact the American Diabetes Association (907-272-1424). They will send some.
   b. Parents and School Nurse sign and date the SCHOOL AND PARENT PART. If student will be self-managing, student signs the STUDENT SELF-MANAGEMENT AGREEMENT.
   c. Update as needed and/or on a yearly basis.

4. The school nurse may use the WORKSHEET page to identify times when he/she will regularly be unavailable to assist the student with diabetes management and plan for coverage by trained school staff.

5. File the entire document with student’s health record at the end of the year or upon student withdrawal.