**Diabetic Care Plan – no pump**

Dear Parents/Guardians,

This packet includes an Individualized Health Plan and Health Care Provider Orders for students who DO NOT have an insulin pump. The information on the completed care plan will assist The Classical Academy staff in knowing how to best manage your student’s health condition, should an emergency arise.

The Health Care Provider Orders form is your physician’s order for the school to administer medication. Academy District Twenty and The Classical Academy policies require the signature of a health care provider with prescriptive authority, as well as the parent/guardian signature, for all medications to be given at school. This includes prescription and over-the-counter medications such as cough drops, Tylenol etc. Each medication requires a separate Permission to Administer Medication form. Forms are available on our website at [http://www.tcatitans.org.](http://www.tcatitans.org/) High School students may carry and self-administer their own medications with the exception of controlled substances, which must be kept in the health room with a completed medication form.

Please fill in the parent portion of the care plan and medication forms prior to giving to your physician for completion and signature. Submit all forms to your school nurse before the start of school. **Please be sure to complete all pages of this packet as we will not accept incomplete Care Plans or medications without Health Care Provider Orders form.**

If you have questions, please feel free to contact the school nurse at your student’s campus.

Sincerely,

Your Health Services Team

Page 2: Individualized Health Plan (page 1) Page 3: Individualized Health Plan (page 2)

Page 4: Health Care Provider Order for Student with Diabetes on Injections/Oral Medications

Page 5: Diabetes Management Supplies Addendum

Pages 6 - 8: Standards of Care for Diabetes Management in the School Setting (three pages)

**CONFIDENTIAL The Classical Academy**

Student

Picture

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Individualized Health Plan: Diabetes in School Setting** | **Date of Plan:** |  | **Date of Orders:** |  |
| *To be completed by School Nurse in consultation with Parent, School staff and per HealthCare Provider Orders* |
| **Student:** DOB: \_ |
| **School:** Grade: Teacher:  |

*See Colorado Diabetes Standard of Care Guidelines for the School Setting*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Health Concern:** | Type 1 Diabetes | Type 2 Diabetes | Other: | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | Date of Diagnosis: | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Mother/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Preferred Tel #: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Father/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Preferred Tel #: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **School Nurse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Work#: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Work#: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Diabetes Educator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Work#: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Hospital of Choice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** 504 on file? Yes No |
| **Comments:**  |

|  |  |  |  |
| --- | --- | --- | --- |
| **TARGET RANGE – Blood Glucose:** | mg/dl | **TO** |  **mg/dl** |
| **Notify Parents if Blood Glucose values below:** |  **mg/dl** | **or greater than:** |  **mg/dl** |

**Medications:** Insulin Dosing – see *Insulin Injection Administration or Pump Administration Addendum*

Insulin Delivery Device: Insulin Pen Insulin Pump Syringe & Vial Insulin Type:

Parent/guardian elects to give insulin needed at school Notify parent/guardian for correction if Blood Glucose  **> mg/dl**

**Glucagon Dose: mg Intramuscular in Arm** Buttock Thigh - \*See Severe Hypoglycemia Care

**Required Blood Glucose Monitoring at School** *(See Blood Glucose Treatment Plan)*

Where to check Blood Glucose: Health Room Classroom Other: Student can carry supplies and test where needed and when needed

Continuous glucose monitoring: *Always Confirm glucose level with a fingerstick/meter prior to treatment*

Alarms set for: **Low: mg/dl High: mg/dl**

**When to Check Blood Glucose:**

As needed for signs/symptoms of low/high blood glucose and/or does not feel well Behavior Concern

|  |  |  |  |
| --- | --- | --- | --- |
| Before School Program | Before Snack | Mid-morning | After School Program/Extracurricular Activity |
| Before Lunch | After Lunch | Recess | Before PE After PE |
| School Dismissal Before riding bus/walking home 2.5 hrs after correction Other:  |
| **Student’s Schedule:**Lunch:  | Location of Snacks: PE: |  Recess: | Location Eaten: Snack: |  am | pm |

**Class School Parties or Events with Food:**

In the event of Class Party – may eat the treat and insulin dosage per Provider Orders

Student able to determine whether to eat the treat

Replace with parent supplied treat May *NOT* eat the treat Contact Parent Prior to event for instructions

**Classroom Emergency Preparedness:** Snack/Water in classrooms (provided by parent) Supplies to be kept: (indicate location)

\*\*\*\* This Health Care Plan and any nurse delegation related to this plan are for use during operational school hours. After hours, call 911 and parent(s) for any medical emergencies or concerns.

Form #100 Colorado Kids with Diabetes Care and Prevention Collaborative 1

**Standardized Academic Testing Procedures:** School Staff to notify Parents and School Nurse of upcoming standardized testing in order to create a plan for Blood Glucose monitoring and treatment.

**Student’s Self Care** (ability level to be determined by School Nurse and Parent with input from Health Care Provider prn)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Totally Independent Management | Yes |  | No | Agreement for Student’s Independent Management Completed |
| Assist/supervise blood glucose testing by trained staff | Yes |  | No |  |
| Blood glucose testing to be done by trained staff | Yes |  | No |  |
| Administers Insulin Independently | Yes |  | No |  |
| Insulin injections to be done by trained staff | Yes |  | No |  |
| Self-Injects with verification of dose & supervision | Yes |  | No |  |
| Monitors own snack and meals | Yes |  | No |  |
| Trained staff to monitor food intake | Yes |  | No |  |
| Independently Counts Carbs | Yes |  | No |  |
| Trained staff to assist with carb counting | Yes |  | No |  |
| Self-treats mild hypoglycemia | Yes |  | No |  |
| Tests and interprets urine/blood ketonesOther: \*See Pump Addendum for self-care pumps skills | Yes |  | No |  |

F**ield Trip Information and Special Events:**

**Additional Information**

1. Notify parent and school nurse in advance so proper training can be accomplished

2. Adult staff must be trained and responsible for student’s needs on field trip

3. Extra snacks, BG meter, copy of health plan, glucagon, insulin & emergency supplies must accompany student on field trip

4. Adult(s) accompanying student on a field trip will be notified of student’s health accommodations on a need to know basis

**Exercise and Sports:**

Snack prior to PE Snack after PE Snack before Recess Snack after Recess # of Snack Carbs: In general, there are no restrictions on activity except in these cases:

Student should not exercise if blood glucose is >300 and ketones is > small or until hypoglycemia/hyperglycemia is resolved

A source of fast-acting glucose & glucagon should be available in case of hypoglycemia

Special Instructions:

**Staff Trained:** Monitor blood glucose & treat hypo/hyperglycemia Give Insulin Give Glucagon

1.

2.

 3.

**Further Instructions:**

**See Addendum(s):** Emergency Action Plan: Glucose Monitoring & Treatment Insulin Pump

Insulin Injection & Medication Management Continuous Glucose Monitor Supplies Activity Plan

PARENT/GUARDIAN PERMISSION

I understand that:

• Medication orders are valid for this school year only & need to be renewed at the beginning of each school year.

• New Physician Orders are needed when there are any changes in the medication orders. (e.g. at quarterly clinic visits)

• Medication orders will become part of my child’s permanent school health record.

• Medications must be in original container and labeled to match physician’s order for school use including field trips.

• I have the responsibility for notifying the school nurse of any changes in Medication or care orders.

• I give permission to the school nurse to share information with appropriate school staff relevant to the prescribed medication administration as he/she determines appropriate for my child’s health and safety.

• I give permission to the school nurse to contact the above health care provider for information relevant to the prescribed medication administration, provider orders, and related student health information appropriate for my child’s health and safety.

• I give my permission to the school nurse and designated staff to perform and carry out the diabetes tasks as outlined in this Individualized

Health Plan (IHP).

• I understand that the information contained in this plan will be shared with school staff on a need-to-know basis.

• Parent/Guardian & student are responsible for maintaining necessary supplies,snacks,blood glucose meter,medications & other equipment.

|  |  |  |
| --- | --- | --- |
| Parent Name: | Parent Signature: | Date: |
| School Nurse: | School Nurse Signature: | Date: |

Physican: Physician Signature: Date:

Form #100 Colorado Kids with Diabetes Care and Prevention Collaborative 2

\*\*\*\* This Health Care Plan and any nurse delegation related to this plan are for use during operational school hours. After hours, call 911 and parent(s) for any medical emergencies or concerns.

**Health Care Provider Orders for Student with Diabetes on Injections/Oral Medication**

*To be completed by the Health Care Provider and used in conjunction with the Standards of Care for Diabetes Management in the School Setting – Colorado*

**Student:** DOB: School: Grade:

**Physician/Provider:** Phone:

**Diabetes Educator:** Phone:

|  |  |
| --- | --- |
| **TARGET RANGE – Blood Glucose:** | **mg/dl TO mg/dl** |
| < 5y.o. 80-200mg/dl | 5 – 8 y.o 80-200mg/dl | 9-11y.o 70-180mg/dl | 12-18y.o. 70-150mg/dl | >18y.o. 70-130mg/dl |
| **Notification to Parents: Low <  *target range* and High > 300 mg/dl** or ***Other:*** less than **mg/dl** and | greater than: **mg/dl** |
| Continuous glucose monitoring: Always *Confirm glucose level with a fingerstick/meter prior to treatment* |

|  |
| --- |
| **Hypoglycemia:** Follow *Standards of Care for Diabetes Management in the School Setting – Colorado*, unless otherwise indicated here: |
| **For *Severe Symptoms:*** Call 911 & Administer **Glucagon Dose:** | **mg** | **Intramuscular in Arm Buttocks Thigh** |
| **Hyperglycemia:** Follow *Standards of Care for Diabetes Management in the School Setting – Colorado*, unless otherwise indicated here: |
| **Ketone Testing**: *per Standards of Care for Diabetes Management in the School Setting – Colorado* OR Other: |  |

**When to Check Blood Glucose:** *For provision of student safety while limiting disruption to learning*

**Always for signs & symptoms of low/high blood glucose, when does not feel well and/or behavior concerns**

Before School Program Before Snack Mid-morning After School Program/Extracurricular Activity

|  |  |  |  |
| --- | --- | --- | --- |
| Before Lunch | After Lunch Recess | Before PE | After PE |
| School Dismissal | Before riding bus/walking home | 2.5 hrs after correction | Other: |

|  |
| --- |
| **Blood Glucose Correction and Insulin Dosage Using (Rapid Acting/Short Acting) Insulin Type:** |
| Injection site: Abdomen Arm Buttock Thigh | *Injections should be given subcutaneously & rotated* |
| **Lunchtime Correction:** Give Prior to lunch Immediately after lunch Split ½ before lunch & ½ after lunch Other : |
| **Sensitivity/Correction Factor:** | unit insulin for every mg/dl above target BG range starting at mg/dl |
| Blood Glucose Range: | **mg/dl to mg/dl** | Administer: | **units** | Check ketones |
| Blood Glucose Range: | **mg/dl to mg/dl** | Administer: | **units** | Check ketones |
| Blood Glucose Range: | **mg/dl to mg/dl** | Administer: | **units** | Check ketones |
| Blood Glucose Range: | **mg/dl to mg/dl** | Administer: | **units** | Check ketones |
| Blood Glucose Range: | **mg/dl to mg/dl** | Administer: | **units** | Check ketones |
| Blood Glucose Range: | **mg/dl to mg/dl** | Administer: | **units** | Check ketones |
| Parent/guardian authorized to increase or decrease sliding scale +/- 2 units of insulin *per Guidelines for Insulin Management\** |
| **When hyperglycemia occurs other than at lunchtime:**If it has been greater than **3 hours** since the last dose of insulin, the student may be given insulin via injection using the indicated correction factor on the provider orders **if approved by the school nurse and parent is notified.****Cont**act Health Care Provider for One-time order |

**Carbohydrates and Insulin Dosage: Breakfast Snack Lunch Other:**

**Insulin to Carbohydrate Ratio: unit(s)** for every **grams** of carbohydrate to be eaten

Parent/guardian authorized to increase or decrease insulin to carb ratio 1 unit +/- 5 grams of carbohydrates

|  |  |  |
| --- | --- | --- |
| **Oral Medication:**  |  mg | Time:  |
| **NPH Insulin** Dose: units SQ | Time:  |  |

**Student’s Self Care:** No supervision Full supervision, Requires some supervision: ability level to be determined by school nurse and

parent unless otherwise indicated here:

**Additional Information:**

Signatures: My signature below provides authorization for the written orders above and exchange of health information to assist the school nurse an Individualized Health Plan. I understand that all procedures will be implemented in accordance with state laws and regulations and may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This order is for a maximum of one year.

Physician: Date: Parent: Date:

School Nurse: Date:

Form #201 Colorado Kids with Diabetes Care and Prevention Collaborative 1

\*\*\*\* This Health Care Plan and any nurse delegation related to this plan are for use during operational school hours. After hours, call 911 and parent(s) for any medical emergencies

or concerns.

**Diabetes Management Supplies Addendum**

**Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Supplies to be Provided by Parent/Guardian:** Parents/Guardian and student are responsible for maintaining necessary supplies, snacks, blood glucose meter, medications and other equipment.

**General Supplies:**

Insulin Supply (Pen, Vial) Needed Provided Not Needed Insulin Syringes/needles Needed Provided Not Needed Oral Medication Needed Provided Not Needed Blood glucose meter and glucose strips Needed Provided Not Needed Lancets with lancing device Needed Provided Not Needed Blood ketone monitor/strips Needed Provided Not Needed Urine ketone strips Needed Provided Not Needed Antibacterial skin cleaner or alcohol wipes Needed Provided Not Needed Fast Acting Sugar: (e.g. Glucose tabs, juice, Smartees) Needed Provided Not Needed Glucose Gel/Cake Mate Needed Provided Not Needed Carbohydrate/Protein snack Needed Provided Not Needed Glucagon Emergency Kit® Needed Provided Not Needed Other:

**Pump Supplies:**

Insulin Pump Needed Provided Not Needed

Insulin Pump Batteries Needed Provided Not Needed Insulin Pump Cartridge Needed Provided Not Needed Infusion Set Needed Provided Not Needed Quick-seter/Sof-sert/Sil-serter Needed Provided Not Needed Dressings/tape Needed Provided Not Needed Manufacturer Instructions Needed Provided Not Needed Batteries Needed Provided Not Needed Other:

**Continuous Glucose Monitor**

Manufacturer Instructions Needed Provided Not Needed

Pods for OmniPod Needed Provided Not Needed

Batteries Needed Provided Not Needed

**Disaster Supplies:** Parents determination (insulin/supplies for 72 hours)

Needed Provided Not Needed

**Supplies Location:**

Location of hypoglycemia supplies: Location of other supplies & equipment:

Student Self Carries/Supplies are kept:

**Supplies provided for:**

Extracurricular Activities

Before and After School Programs

Other:

**Notification of needed supplies to Parents/Guardians by**: EMAIL Telephone Text Note home

**Notification to be provided by:** Health Aide Classroom Teacher(s) Programs & Activities Leads

Other:

Physician: Physician Signature: Date/Updated:

Parent:

Parent Signature:

Date/Updated: \_

School Nurse: School Nurse Signature:

Date/Updated:

#100-E Colorado Kids with Diabetes Care and Prevention Collaborative