Diabetic Health History and Management Plan

Student's Name: _____Date of Birth:_____ Grade:_____

Diagnosis: ☐ diabetes type 1 ☐ diabetes type 2 Date of diabetes diagnosis: _____

Last hospitalization/ER visit for diabetes: _____ Has glucagon ever been administered? ☐Yes ☐No

Physician/Health Care Provider:_____Telephone _____

Notify parents/guardian or emergency contact in the following situations:

_____

BLOOD GLUCOSE MONITORING

Will student need blood glucose monitoring at school? ☐ Yes ☐ No

Can student perform own blood glucose checks? ☐ Yes ☐ No

(Note: The school nurse or designee may check blood glucose levels at school during a crisis or emergency situation)

Target range for blood glucose is ☐ 70-150 ☐ 70-180 ☐ Other _____

INSULIN

Will student need insulin administration at school? ☐ Yes ☐ No

Can student give own injections? ☐ Yes ☐ No

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

Can student draw correct dose of insulin? ☐ Yes ☐ No

INSULIN ORDERS:

Time, type and dosage of insulin to be given during school:

Time Type Dosage

_____ _____ _____

_____ _____ ____units per _____ grams of carbohydrate. Correction Factor: ____ units for every _____mg/dl the blood sugar is over target range. Target range: _____

FOR STUDENTS WITH INSULIN PUMPS

Type of pump: _____ Basal rates _____ 12 am to _____

_____ _____ to _____

Type of insulin in pump: _____ Type of infusion set_____

Unit/carbohydrate ratio: _____ Correction factor: _____

Student Pump Abilities/Skills:	***Needs Assistance***
Count carbohydrates	☐ Yes ☐ No
Correct bolus amount for carbohydrates consumed	☐ Yes ☐ No
Calculate and administer corrective bolus	☐ Yes ☐ No
Calculate and set basal profiles	☐ Yes ☐ No
Calculate and set temporary basal rate	☐ Yes ☐ No
Disconnect pump	☐ Yes ☐ No
Reconnect pump at infusion set	☐ Yes ☐ No
Prepare reservoir and tubing	☐ Yes ☐ No
Insert infusion set	☐ Yes ☐ No
Troubleshoot alarms and malfunctions	☐ Yes ☐ No

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☐ Notes on reverse side

Student Name: _____
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FOR STUDENTS TAKING ORAL DIABETES MEDICATIONS

Type and dosage of medication: _____ Timing: _____
Other medications: _____ Timing: _____
Other medications: _____ Timing: _____

MEALS AND SNACKS EATEN AT SCHOOL

Is student independent in carbohydrate calculations and management? ☐ Yes ☐ No

Meal/Snack	***Time***	***Carbohydrate servings/grams***
Breakfast	_____	_____
Mid-morning snack	_____	_____
Lunch	_____	_____
Mid-afternoon snack	_____	_____
Dinner	_____	_____

Snack before exercise? ☐ Yes ☐ No Snack after exercise? ☐ Yes ☐ No
Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event):
_____
Please list all school sports or clubs that student participates in:
_____

EXERCISE AND SPORTS

€A fast-acting carbohydrate such as _____ should be available at the site of exercise or sports.
€Restrictions on activity, if any: _____
€Student should not exercise if blood glucose level is below _____ mg/dl or above _____mg/dl or if moderate to large urine ketones are present.

HYPOGLYCEMIA (LOW BLOOD SUGAR)

****School personnel to initiate MPS Hypoglycemia Emergency Action Plan****

Usual symptoms of hypoglycemia: _____
_____

Treatment of hypoglycemia: _____
_____
_____

Glucagon orders: € 1mg €1/2mg Route: € IM € SC Site:_____

HYPERGLYCEMIA (HIGH BLOOD SUGAR)

****School personnel to initiate MPS Hyperglycemia Emergency Action Plan****

Usual symptoms of hyperglycemia: _____
_____
Treatment of hyperglycemia: _____
_____
Urine should be checked for ketones when blood glucose levels are above _____ mg/dl.
Treatment for ketones: _____

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Supplies

Supplies kept In Health office	Supplies kept with student	
_____	_____	Supplies for blood glucose monitoring (Circle: meter, test strips, extra batt-Eries, other:_____)
_____	_____	Supplies for insulin administration: Circle: Insulin, syringes, lancets, other: _____)
_____	_____	Extra supplies for Insulin pump (List: _____)
_____	_____	Snacks (List:_____)
_____	_____	Fast-acting source of glucose/carbohydrate (List:_____)
_____	_____	Urine ketone strips
_____	_____	Glucagon emergency kit

Please note: If supplies are to be kept in the health office, please provide enough supplies for one month. Parents are responsible for replenishing diabetic maintenance school supplies at the beginning of each month during the school year. Parents are to pick up supplies on the last day of school.

Diabetes Management

€ My child will need supervision by trained personnel for daily management of diabetes at school and obtain physician signature below

Self -Management

€ My child can perform daily management of diabetes at school without supervision. Sign in the box below and obtain physician signature below

I, the parent of legal guardian of this student, give permission for him/her to perform glucose monitoring, diet selection, and self administer insulin independently during the school day. I have instructed my child to seek assistance from school personnel as needed. I understand that, absent any negligence, the school shall incur no libility as a result of any injury arising from the self-care and self-administration of medication by my child.
Signature of parent/guardian_____Date _____

Signatures

This Diabetes Health History and Management Plan has been approved for implementation at Moberly Public School District by:

X_____ _____
Physician/Health Care Provider Date

X_____ _____
Student's Parent/Guardian Date

Student Name: _____
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HIPAA-Compliant Authorization for Release of Health Information

Patient/Student Name:_____ Date of Birth:_____

I hereby authorize _____[*insert health care provider name, address and telephone*] to release my/my child's health information/records for the purpose listed below to:

_____ [*insert name of school official*]

_____MOBERLY PUBLIC SCHOOLS_____[*insert name of school/school district*]

_____Moberly, MO 65270_____ [*insert school address*]

Description:
The information to be disclosed consists of:

Purpose:
This information will be used for the following purpose(s):

Authorization

This authorization is valid for one calendar year. It will expire on _____[*insert date*]. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that these records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

_____
Parent Signature Date

_____
Student Signature* Date

*If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student
shall sign this authorization form.

Copies: Parent or student
Physcian or other health care provider releasing the protected health information
School official requesting/receiving the protected health information

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