

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

RN Review: _____ SIS: _____
[] Notifications: teacher bus driver office
[] Notes on reverse side

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

<u>Meal/Snack</u>	<u>Time</u>	<u>Carbohydrate servings/grams</u>
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: _____

Supplies

**Supplies kept
In Health office**

**Supplies kept
with student**

- | | | |
|-------|-------|---|
| _____ | _____ | Supplies for blood glucose monitoring (Circle: meter, test strips, extra batteries, 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 liability 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 _____ Date _____
Physician/Health Care Provider

X _____ Date _____
Student's Parent/Guardian

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
Physician or other health care provider releasing the protected health information
School official requesting/receiving the protected health information

RN Review: _____ SIS: _____
 Notifications: teacher bus driver office
 Notes on reverse side

Student Name: _____
Revision 8/2012

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<input type="checkbox"/> Notifications: teacher bus driver office
<input type="checkbox"/> Notes on reverse side