OLDHAM COUNTY BOARD OF EDUCATION
ADMINISTRATIVE REGULATION FORM

INDIVIDUAL DIABETES HEALTH CARE PLAN **9009.01F**

Relates to: 9009.01AR

Student Name: _____ DOB: _____ School Year: _____

School: _____ Grade: _____ Teacher: _____

☐ Type 1 Diabetes ☐ Type 2 Diabetes

☐ Other condition requiring blood glucose monitoring: _____

HYPOGLYCEMIA MANAGEMENT (LOW BLOOD SUGAR):

☐ GLUCAGON ☐ BAQSIMI EXPIRATION DATE: _____

LOCATION: ☐ OFFICE/HEALTH ROOM: ☐ ON PERSON

- SIGNS & SYMPTOMS: *hunger, staring, dizzy, crying, headache, clammy, sweating, nervous, confused, shaky, blurry vision, restless, weak, disoriented, sleepy, change in personality*

LOW BLOOD SUGAR FOR THIS STUDENT REQUIRES INTERVENTION IF LESS THAN _____.

1. If exhibiting symptoms of hypoglycemia OR if blood sugar is less than _____ mg/dl, provide 15 grams of simple sugar (examples include 15 skittles, one juice box, 3-4 glucose tablets)
2. Wait 15 minutes and recheck blood sugar.
3. If blood sugar level is less than _____ mg/dl, repeat steps 1 and 2.
4. If blood sugar greater than _____ mg/dl, provide a 15-gram complex carbohydrate or LUNCH if scheduled within _____ minutes.
5. Student is not to load PM bus, leave campus, or drive if blood sugar is less than: _____
6. Notify parent/guardian if student does **not** respond to treatment. Notify school nurse**.**

EMERGENCY PLAN OF ACTION:

1. If student is able to follow command, offer sips of juice, milk, soft drink with sugar.
2. If student is unconscious, unresponsive or has a seizure, CALL EMS -911 and administer emergency medication. Notify school personnel trained in CPR
3. Position student on their side in the recovery position, due to potential of vomiting. Monitor airway.
4. Contact Parent/Guardian or emergency contact. OCBE employee must accompany student to medical facility.

HYPERGLYCEMIA MANAGEMENT (HIGH BLOOD SUGAR):

- SIGNS & SYMPTOMS: *dry mouth, frequent urination, thirsty, headache, nausea, vomiting, hungry, fruity smelling breath, sleepy*

HIGH BLOOD SUGAR FOR THIS STUDENT REQUIRES INTERVENTION IF GREATER THAN _____
(encourage sugar free liquids such as water, allow frequent restroom breaks)

1. Student is not to ride a PM bus or drive if blood sugar is greater than _____ Notify parent
2. Can student correct a high blood sugar with insulin other than at lunch?
   ☐ yes* ☐ no *directive _____
3. Does student check ketones at school? ☐ yes* ☐ no (Call parent if ketones present)
   ***See Ketone supplementation formula under insulin therapy**
4. If blood sugar is greater than _____, do not participate in PE, exercise or sports.

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INSULIN THERAPY:

Type: _____

Insulin Delivery Device: ☐ insulin pen ☐ insulin pump ☐ syringe

Insulin – to – Carbohydrate Ratio (lunch only): 1 unit of insulin per _____ grams of carbohydrates

Should insulin calculations be rounded?

☐ Yes* ☐ No

☐ *Half unit ☐ Whole unit

High Blood Sugar Correction prior to lunch (if applicable):

Increase insulin by _____ unit(s) for every _____ points above _____

If blood sugar is _____ to _____ give _____

If blood sugar is _____ to _____ give _____

If blood sugar is _____ to _____ give _____

If blood sugar is low prior to lunch, will student administer lunch time insulin <u>after</u> meal is eaten?

☐ YES ☐ NO

Low blood sugar correction prior to lunch (if applicable):

_____

SNACKS:

Does student require a **SCHEDULED** snack during the day? ☐ Yes* ☐ No

Snack time: _____ *If yes, will insulin be required with snack? ☐ Yes ☐ No

Insulin order for snack: _____

Foods to avoid, if any: _____

EXERCISE AND PHYSICAL ACTIVITY:

Check blood sugar before exercise? ☐ Yes ☐ No

Check blood sugar after exercise? ☐ Yes ☐ No

Snack before exercise? ☐ Yes ☐ No

Snack after exercise? ☐ Yes ☐ No

Directives regarding PE or exercise:

_____

Does your student participate in after school activities such as Band, Cheer, Dance, Academic Teams, Sports Teams, Clubs or other organized activities in which staff supervising your student would require emergency medication administration training?

☐ **Yes** ☐ **No**

If yes please list all activities:_____

_____

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DISEASE MANAGEMENT SKILLS: (to be completed by physician or licensed member of provider staff)

A1C results: _____ Date last completed: _____

Can student administer own insulin injections? ☐ yes ☐ no

Can student calculate carbs and determine the correct amount of insulin? ☐ yes ☐ no

Can student determine high/low correction doses and treat accordingly? ☐ yes ☐ no

Can student dial correct dose of insulin? ☐ yes ☐ no

Is student independent in insulin pump function to include re-insertion and troubleshooting problems? ☐ yes ☐ no

Has student demonstrated use of blood glucose monitoring equipment, including meter, lancet device, test strips, test sites/protocol to ensure accurate readings to manage disease? ☐ yes ☐ no

Does the student have your permission to carry all diabetes management supplies including Glucagon Kit, insulin, and sharps? ☐ ☐

Can the student perform ketone monitoring and evaluate results? ☐ yes ☐ no

Has the student demonstrated understanding of blood sugar readings and can treat high/low results? ☐ yes ☐ no

SCHOOL/CLASSROOM ACCOMMODATIONS

(*Relates to Management of Diabetes 9009.01AR***)**

- Please provide a person to accompany student with Diabetes to the school office when:

  _____

- Students with Diabetes are offered the following accommodations across **ALL** school environments:
  1. Restroom privileges
  2. Access to foods, water/sugar-free liquids (includes during transportation)
  3. Check blood sugar in accordance with Physician Authorization/Diabetes Health Care Plan
  4. Phone Privileges in school office
  5. Access to diabetes care supplies in accordance with Physician Authorization/Diabetes Health Care Plan
  6. Encouraged to perform and treat blood sugar levels prior to national, state, and classroom assessments.

PHYSICIAN SIGNATURE AND CONTACT INFORMATION:

Myself or a licensed member of my staff has witnessed the student demonstrate the disease management skills to determine competency. The information was not determined solely by parent report. Changes or updates to this health care plan will be made available when requested by licensed medical personnel of the Oldham County Board of Education.

_____ _____

Physician Signature *Date*

_____ _____ _____

Physician Printed Name *Telephone* *Fax*

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PARENT/GUARDIAN CONTACT AND RELEASE OF INFORMATION, DISCLOSURE:

PARENTS WILL PROVIDE ALL DIABETIC CARE SUPPLIES INCLUDING: SNACKS, JUICE, BLOOD GLUCOSE METER, LANCET DEVICE, LANCETS, EMERGENCY GLUCOSE, EMERGENCY MEDICATION AND ANY OTHER NEEDED SUPPLIES.

I hereby give my consent for medical records and reports to be shared with the Oldham County Board of Education and for the physician referenced below to discuss my child's medical condition referenced above with school or District personnel to assist them in planning or providing care for my child while at school or school events.

In the event of a crisis requiring immediate intervention, a trained school employee will administer an injection or other prescribed drug. The undersigned understands that the employee administering the prescribed medication is not a licensed healthcare professional. The employee will make his or her best effort to comply with the recommended procedure developed by the child's physician, and in accordance with the training conducted by an OCBE Nurse. The undersigned hereby consents to the intervention of the employee under these circumstances.

Additionally, the undersigned agrees to hold the Board of Education, its members and employees, and the intervening staff member harmless for any injuries resulting from the emergency care unless the injury was caused by the employee's negligence. The parent/guardian further agrees to indemnify and hold harmless any employee and the Board and its members from any claim resulting from self-administration of medication per state law.

Parent/Guardian Signature: _____ Date: _____

It is the responsibility of the parent/guardian to notify school personnel regarding changes in contact information:

Parent/Guardian #1

Print Name: _____ _____
Daytime phone

Parent/Guardian #2

Print Name: _____ _____
Daytime phone

RETURN TO:

Oldham County Board of Education
Health Services Dept.
6165 W. Highway 146
Crestwood, Ky. 40014

Phone: (502) 241-3500 Fax: (502) 241-3466

GLUCAGON RECEIVED

BAQSIMI RECEIVED

_____ _____
OCBE staff *Date*

_____ _____
Parent/guardian *Date*

***CARE PLAN REVIEW:**

_____
OCBE Health Services RN