Madison School District 321

Diabetes Action Plan

Individualized Health Care Plan (IHC)

School Year:	Student Picture
School:	
Grade:	

STUDENT INFORMATION			
Student:		DOB:	
Parent:	Phone:	Email:	
Parent:	Phone:	Email:	
Healthcare Provider:	Phone:	Fax:	
District Nurse: Kim Ward	Phone: 503-871-2834	Fax: 208-359-3370	

SPECIAL CONSIDERATIONS

Special considerations and precautions (regarding school activities, field trips, sports, etc.):

Blood Glucose Testing:

Target range for blood glucose BG: * 100-200 * 80-150 * Other:_____

Time to test: *Before Meals *Before Exercise *After Exercise *If Symptomatic Other_____

Contact parent/Guardian if: *Blood glucose level is less than_____mg/dL or more than_____mg/dL

*Urine/Blood ketones are moderate to large

Continuous Glucose Monitoring (CGM):

*This student uses a **Contiuous Glucose Monitor (CGM)**

CMG Manufacturer/Model:_____

*The CGM is FDA approved for insulin dosing based on glucose values, and the Parent/Guardian approves the school personnel or school nurse to dose from the CGM.

*Re-check blood glucose level by finger prick if CGM value is less than_____mg/dL or more than_____mg/dL Or If:_____

*CGM readings are for trends only. **ALWAYS** verify with blood glucose before any dosing.

*This student uses a smart phone or other monitoring technology to track blood glucose values.

*Please specify:*_____

Insulin prescribing Information:

Insulin Name: *Humalog *Apidra *Novolog *Other:_____	**Method of Administration:** **Purpose:** Lower blood glucose level *Insulin vial/syringe *Insulin Pen **Route:** Subcutaneous *Insulin pump (Product name)_____ **Possible Side Effects:**
I:C Ratio (Insulin to Carbohydrate Ratio): Breakfast : 1 unit for every_____grams of carbohydrate. Lunch: 1 unit for every_____grams of carbohydrate. Snack: 1 unit for every_____grams of carbohydrate.	**Correction Dose:** Administer_____ unit(s) insulin for every_____mg/dL above blood glucose level_____mg/dL. **(Correction dose can only be administered at meal times unless on a pump. See pump orders on the next page.)**

Insulin Pump Correction (If applicable):

*If using insulin pump, carbohydrate ratio and correction dose are calculated by pump.

*Correction doses at times other than meals are to be done per PUMP calculation ONLY.

*For blood glucose greater than_____mg/dL that has not decreased within_____hour(s) after correction, consider pump or infusion site failure. **Notify parent/guardian.**

*Other instructions:_____.

Independence Level:

*Independently calculates and gives own injections.

*May calculate/administer own injections with supervision

*Requires trained staff to calculate dose and student can administer injections with supervision.

*Requires trained staff to calculate dose and admiinister injections.

HYPOGLYCEMIA

Causes of Hypoglycemia

Too much insulin	Getting extra, intense, or unplanned physical activity
Missing or delaying meals or snacks	Being ill, particularly with gastrointestinal illness
Not eating enough food (carbohydrates)	Sudden onset - symptoms may progress rapidly

Symptoms - MILD TO MODERATE (please circle student's usual symptoms)

shaky or jittery	pale	sleepy/lethargic	lightheaded	disoriented
sweaty	headache	argumentative	confused	uncoordinated
hungry	dizzy	combative	can't concentrate	irritable or nervous
weak	blurry vision	changed personality or behavior		other:_____

Treat for hypoglycemia if showing any symptoms above, OR if blood glucose is less than _____ mg/dL

Treatment for MILD TO MODERATE Hypoglycemia

If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than _____mg/DL:

1. Provide quick-acting glucose (sugar) product equal to _____ grams of carbohydrates.
   Examples of 15 grams of carbohydrates are:
   - * 4 glucose tablets
   - * 1 tube of glucose gel
   - * 4 ounces of fruit juice
   - * 4-6 ounces (1/2 can) of soda (not diet or reduced sugar)
2. Recheck blood glucose in 15 minutes and repeat treatment if blood glucose level is less than _____ mg/dL.
3. Contact student's parents/guardians and District Nurse.
4. Additional treatment: _____

Testing supplies, snacks, and insulin are located:_____

The student should **NEVER** be left alone. Always have an **adult** accompany the student when they are experiencing hypoglycemia.

When in doubt, ALWAYS treat for hypoglcemia!

Symptoms for SEVERE Hypoglycemia (please circle student's usual symptoms)

inability to eat or drink	unresponsive
unconcious	seizure activity or convulsions (jerking movements)
other:_____	

Treatment for SEVERE Hypoglycemia

1. Position the student on his/her side and **DO NOT** attempt to give anything by mouth!!
3. Administer glucagon: _____mg at _____ site **(see glucagon dosing on next page)**
4. While treating, instruct another person to **call 911** & parents/guardians
5. Stay with student until EMS arrives
6. Notify District Nurse & document on Incident Report Form

Emergency Medications are located:_____

****Emergency med administration for Hypoglycemia on next page****

Glucagon Administration for treatment of SEVERE Hypoglycemia

Person to give Glucagon:

*Trained staff (specify):_____

* Parent *EMS

Glucagon dosing:

Nasal: * 3.0 mg ***or*** Injection: * 0.5mg *1.0mg Site:_____

Other:_____

HYPERGLYCEMIA

Causes of Hyperglycemia

Too little insulin or other blood glucose-lowering medications	Illness	Decreased physical activity
Insulin pump or infusion malfunction	Infection	Severe physical or emotional stress
Food intake that has not been covered adequately by insulin	Injury	Onset - over several hours or days

Hyperglycemia Symptoms

Mild to Moderate	Severe
Increased thirst and/or dry mouth	Chest pain
Frequent or increased urination	Confusion
Change in appetite/nausea/stomach pain	Breathing changes/Labored breathing
Blurry vision	Severe abdominal pain
Sweet/fruity breath	Very weak
Fatigue/sleepiness	Decreased consciousness/Unconscious
Other_____	Blood sugar > _____
Increased hunger	Other_____
Inablility to concentrate	
Flushing of the skin	

Actions for Treating Hyperglycemia

Treatment for Mild to Moderate Hyperglycemia

Check the blood glucose level

For blood glucose greater than_____mg/dL AND at least_____hours since last insulin dose, give:

*Correction dose calculation

target blood glucose (_____) ***Insert numbers in equation below**

correction factor (_____)

(current blood glucose level) - (target blood glucose) = _____units of insulin

(correction factor) ***give this amount***

****** OR ******

*c Correction dose scale

blood glucose_____to_____mg/dL, give _____units of insulin

blood glucose_____to_____mg/dL, give _____units of insulin

blood glucose_____to_____mg/dL, give _____units of insulin

******OR******

*Administer correction dose of insuin if they are on a pump following pump guidelines

Notify parent/fuardians if blood glucose is over _____mg/dL.

Give extra water or non-sugar containing drinks (not fruit juices): _____ounces per hour.

Allow free and unrestricted access to the restrooms.

Recheck blood glucose every 2 hours to determine if decreasing to target range of _____mg/dL.

Restrict participation in phusical activity if blood glucose is greater than _____mg/dL.

Ketones:

Check: *Urine *Blood for Ketones every _____hour(s) when blood glucose level is above _____mg/dL

If Ketones present are Moderate to Large, **call parent/guardian for immediate pick up.**

Treatment for Severe Hyperglycemia

Have someone call 911!

DO NOT LEAVE STUDENT ALONE!

Administer correction dose of insulin per above orders

Encourage student to drink water

Call parent/guardians/emergency contacts

Document on incident report form

PARENT TO COMPLETE

As Parent/Guardian of the named student:

* I give permission for my child's Health Care Provider to release/share information with the District Nurse for the completion of this plan of care and to exchange health information and records.
* I understand the information contained in this plan will be shared with school staff on a need-to-know basis.
* I give permission to the District Nurse and other designated staff to follow this Emergency Care Plan and administer medication as directed.
* I agree to release, indemnify, and hold harmless the District Nurse and other designated staff from lawsuits, claim expense, demand or action, etc., against them for helping my child with allergy treatment, provided the personnel are following physician instruction as written in the emergency action plan above.
* I understand I am responsible for maintaining necessary supplies, medication, and equipment.
* My child and I understand there are serious consequences for sharing any medication with others.
* I understand I am responsible to notify the District Nurse of any change in my child's health status, care, or medication order. If the prescription on the medication order is changed, I understand a new DMMP, Medication Request Form, and Emergency Care Plan Form must be completed before the school staff can administer the medication.
* I understand that if any emergency medication is administered at school, EMS will be notified for evaluation, monitoring, and possible further treatment.
* I understand that if my child is given emergency medication, he/she may not remain at school unless I can be present to monitor him/her for adverse reactions. I understand that trained school employee volunteers can only monitor him/her until I arrive or EMS arrive. I understand that if I want my child to remain in school after receiving emergency medication, I will have to stay with him/her at school.

Parent Name:	**Phone:**
Parent Signature:	**Date:**
HEALTHCARE PROVIDER TO COMPLETE - Please read, check one of the options, and sign below	
This student is under my care. This Emergency Action Plan reflects my plan of care.	
◯ It is **medically appropriate** for the student to **self-carry and self-administer** diabetes medication when able and appropriate, and be in possession of diabetes medication, testing supplies, and snacks at all times. ***** This student has been trained and has demonstrated proper medication administration procedure.***	
◯ It is **medically appropriate** for the student to **self-carry** diabetes medication, testing supplies, and snacks, but **NOT to self-administer** medication. Please have the designated school personnel administer this student's medication.	
◯ It is **NOT medically appropriate** for the student to **self-carry or self-administer** medication. Please have the designated school personnel maintain the medication, testing supplies, and snacks and administer the medication.	
Healthcare Provider Name (print):	**Phone:**
Healthcare Provider Signature:	**Date:**
District Nurse:	**Date:**