COLLEGE STATION INDEPENDENT SCHOOL DISTRICT
Diabetes Management and Treatment Plan
*Annual Health Service Prescription - Physician/Parent Authorization for Diabetic Care

*This form is to be renewed at the beginning of the school year: DATE OF PLAN _____

Student: _____ Birth date: _____

TO BE COMPLETED BY PHYSICIAN:

Please respond to the following questions based on your records and knowledge of the student.

1. Procedures: (parent to provide supplies for procedures):

Test blood glucose before lunch and as needed for signs/symptoms of hypoglycemia.

Test urine ketones when blood glucose is hyperglycemic, and/or when child is ill.

2. Medication: (Child may ___ may not ___ prepare/administer insulin injection).

Rapid Acting Insulin [Regular/Humalog/NovoLog] given subcutaneously prior to lunchtime (within 30 minutes prior to lunch) based on the following guidelines:

a. Fixed dose: _____units plus insulin correction scale*; OR*

b. Insulin to Carbohydrate Ratio: 1 unit insulin per _____ grams carbohydrate plus insulin correction scale

Insulin Correction Scale Use Pump Wizard

Blood glucose below _____ = no additional insulin

Blood glucose from _____ to _____=____ unit(s) insulin subcutaneously; through pump

Blood glucose from _____ to _____=____ unit(s) insulin subcutaneously; through pump

Blood glucose from _____ to _____=____ unit(s) insulin subcutaneously; through pump

Blood glucose over _____=____ unit(s) insulin subcutaneously; through pump

(Notify parent if blood glucose is over _____.)

c. Oral Diabetes medication: _____ Dose _____ Time _____

d.. Student is to eat lunch following pre-lunch blood test and required medication.

e. Parent/family instructed in diabetes self-management. Parent may _____ may not _____ adjust pre-lunch insulin dosage by up to 10% every 4 to 5 days as indicated by glucose trends. **Parent will communicate changes to school health services personnel.**

4. Precautions:

Refer to the physician's orders for Guidelines for Responding to Blood Glucose Test Results on the following page:

a. **Hypoglycemia:** Signs of hypoglycemia include hunger, trembling, headache, sweating, shaking, pale, weak, dizzy, sleepy, lethargic, confusion, coma, or seizures.

b. Hyperglycemia: Signs include frequency of urination, excessive thirst and positive urinary ketones, nausea.

5. Meal Plan:

The *Constant Carbohydrate Diet* emphasizes consistency in the number of grams of carbohydrate eaten from day to day at each meal or snack. Proteins and fats are "free foods" in that they have minimal effect on the blood glucose level. The child and parent can chose the carbohydrate product that they wish to use for meals or snacks. **Parent will communicate meal plan changes to school personnel.**

Breakfast _____ grams at _____ (time) Mid AM snack _____grams at _____ (time)

Lunch _____ grams at _____ (time) Mid PM snack _____ grams at _____ (time).

The *Insulin to Carbohydrate Ratio Meal Plan* allows a variable amount of carbohydrate to be eaten at any meal or snack, but requires appropriate insulin to balance the carbohydrate. The ratio is listed above at # 2-b.

Does this student have an insulin pump? Yes ___ No ___. If yes, please attach student's pump guidelines.

FOR DIABETIC SELF-CARE ONLY

Does this student have physician permission to provide self-care? Yes_____ No_____

This student has been provided instruction/supervision in recognizing signs/symptoms of hypoglycemia and is capable of doing self-glucose monitoring and his/her own insulin injections/insulin pump care, including using universal precautions and proper disposal of sharps? Yes___ No___

This student requires the **supervision** of a designated adult ____ this student requires the **assistance** of a designated adult ___

Physician portion continued on following page

GUIDELINES FOR RESPONDING TO BLOOD GLUCOSE TEST RESULTS

1. **If glucose is BELOW _____:** (hypoglycemia or low blood sugar)
   A. Give child 15 grams carbohydrate, i.e.:
   6 lifesavers — 6 ounces of regular soda
   4 ounces of juice — 3 – 4 glucose tabs
   B. Allow child to rest for 10 – 15 minutes, and retest glucose.
   C. If glucose is above _____, allow student to proceed with scheduled meal, class or snack.
   D. If symptoms persist (or blood glucose remains below _____), repeat A and B.
   E. If symptoms still persist, notify parent and keep child in clinic.

2. **If blood glucose is BELOW _____ and the child is unconscious or seizing:**
   A. Call emergency medical services.
   B. Rub a small amount of glucose gel (or cake frosting) on child's gums and oral mucosa.
   C. If available, inject Glucagon _____mg. SQ.
   D. Notify parent.

3. **If blood glucose is FROM _____ to _____: Follow usual meal plan and activities** (unless otherwise directed by insulin correction scale for insulin administration)

4. **If blood glucose is OVER _____:**
   A. If within 30 minutes prior to lunch, nurse or unlicensed diabetes care assistant to be called if student unable to administer correction dose of insulin per student's sliding scale orders.
   B. Student checks urine ketones.
   <u>If Ketones are negative or small</u>
   - Encourage water until ketones are negative.

   <u>If Ketones are moderate or large:</u>
   - Student should remain in clinic for monitoring.
   - Notify parent for pick up.
   - Give 1-2 glasses of water every hour.
   - If student remains at school, retest glucose and ketones every 2-3 hours or until ketones are negative.

   C. Student not to participate in PE or other forms of exercise if blood sugar is above 250 and ketones are present.
   D. If student develops nausea/vomiting, rapid breathing, and/or fruity odor to the breath, call 911, the nurse and the parents.

Physician signature _____Date _____

Clinic/facility _____Phone_____ Fax_____

Nurse or Certified Diabetes Educator: Name _____Phone_____

Clinical Dietitian: Name _____ Phone _____

Please attach Physician's or Clinic's Business Card

TO BE COMPLETED BY THE PARENT:

We (I) the undersigned, the parents/guardians of _____ request that the above Diabetes Management and Treatment Plan be implemented for our (my) child. Delivery of this form to the school nurse constitutes my participation in developing this Plan, and is my consent to implement this Plan. I will notify the school immediately if the health status of my child changes, if I change physicians or emergency contact information, or if the procedure is canceled or changes in any way. Information concerning my child's diabetes health management may be shared with/obtained from the diabetes health care providers.

Signature_____ Relationship _____

Date _____ Phone (Hm) _____ (Wk) _____

Revised January 8, 2008