



HEALTH SERVICES

Irving Independent School District

Diabetes Management and Treatment Plan

Annual Health Service Prescription - Provider/Parent Authorization for Diabetic Care

*This form is to be renewed annually.

Student: _____ Birth Date: ____/____/____ Date of Plan: ____/____/____

Prescribed in-school medication or procedures may be administered by a school nurse or a non-health professional designee of the principal.

TO BE COMPLETED BY PROVIDER:

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. MEDICATIONS:

- 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:
[] Fixed dose: _____ units plus insulin correction scale; OR
[] Insulin to Carbohydrate Ratio: 1 unit insulin per _____ grams carbohydrate plus insulin correction scale
• Insulin Correction Scale
Blood glucose below _____ = no additional insulin
Blood glucose from _____ to _____ = _____ unit(s) insulin subcutaneously
Blood glucose from _____ to _____ = _____ unit(s) insulin subcutaneously
Blood glucose from _____ to _____ = _____ unit(s) insulin subcutaneously
Blood glucose over _____ = _____ unit(s) insulin subcutaneously
(Notify parent if blood glucose is over _____.)
• Oral Diabetes medication: _____ Dose _____ Time _____
• Student is to eat lunch following pre-lunch blood test and required medication.
• 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 personnel.

3. PRECAUTIONS:

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

- Hypoglycemia: Signs of hypoglycemia include trembling, sweating, shaking, pale, weak, dizzy, sleepy, lethargic, confusion, coma, or seizures.
• Hyperglycemia: Signs include frequency of urination, excessive thirst and positive urinary ketones.

4. 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. Nutrition-rich carbohydrate foods are encouraged.

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 in section 2. Use basic rounding rules for inexact CHO amounts.
• 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 provider permission to provide self-care? Yes No
- This student has been provided instruction/supervision in recognizing sign/symptoms of hypoglycemia. Yes No
- This student is capable of performing self-glucose monitoring and administering his/her own insulin injection/insulin pump care including using universal precautions and proper disposal of sharps. Yes No
- This student requires the assistance of a designated adult. Yes No
- This student requires the supervision of a designated adult. Yes No
- This student is completely independent and does not require supervision or assistance of an adult. Yes No

I understand that IISD reserves the right to require that medications and supplies be kept in the clinic if in the school nurse’s judgment, the student cannot or will not carry the medication/supplies in a safe manner and/or properly use them.

5. GUIDELINES FOR RESPONDING TO BLOOD GLUCOSE TEST RESULTS

- **If glucose is BELOW _____:** (hypoglycemia or low blood sugar)
 1. Give child 15 grams carbohydrate if child is alert and able to swallow.
(Examples include but are not limited to: 6 lifesavers; 4 ounces of juice; 6 ounces of regular soda; 3-4 glucose tabs)
 2. Allow child to rest for 10 – 15 minutes, and retest glucose.
 3. If glucose is above _____, allow student to proceed with scheduled meal, class or snack.
 4. If symptoms persist (or blood glucose remains below _____), repeat 1 and 2.
 5. If symptoms still persist, notify parent and keep child in clinic.
- **If blood glucose is BELOW _____ and the child is unconscious or seizing:**
 1. Call emergency medical services.
 2. Rub a small amount of glucose gel (or cake frosting) on child’s gums and oral mucosa.
 3. If available, inject Glucagon _____mg. SQ.
 4. Notify parent.
- **If blood glucose is FROM _____ to _____: Follow usual meal plan and activities** (unless otherwise directed by insulin correction scale for insulin administration)
- **If blood glucose is OVER _____:**
 1. If within 30 minutes prior to lunch, follow insulin/medication orders from page 1. Nurse or unlicensed diabetes care assistant to be called if student unable to administer correction dose of insulin per student’s sliding scale orders.
 2. Student checks urine ketones.
 - If Ketones are negative or small:** Encourage water until ketones are negative.
 - If Ketones are moderate or large:**
 - Student should remain in clinic for monitoring.
 - Notify parent for pick up.
 - Encourage student to drink 8-10oz of water (or other carbohydrate-free liquid) every 20 minutes until ketones are negative; allow access to restroom.
 - If student remains at school, retest glucose and ketones every 2 hours or until ketones are negative.
 3. Student not to participate in PE or other forms of exercise if blood sugar is above 250 and ketones are present.
 4. If student develops nausea/vomiting, rapid breathing, and/or fruity odor to the breath, call 911, the nurse and the parents.
 5. Notify parent if blood glucose is over _____ to update parent and discuss management plan.

Provider signature _____ Date _____
 Clinic/facility _____ Phone _____ Fax _____
 Diabetes Nurse Educator: Name _____ Phone _____
 Clinical Dietitian: Name _____ Phone _____

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 understand that it is my responsibility to provide the necessary equipment and supplies in order for the above healthcare service to be performed at school by district personnel. 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 healthcare providers.

Signature _____ Date: _____ Relationship to student: _____
 Phone (Hm) _____ (Wk) _____ (Cell) _____