Student Health Plan: Diabetes (Independent Management) ☐ Type 1 ☐ Type 2

Student:	_____	**DOB:**	_____	**Home Phone:**	_____
Mother:	_____	Work Phone:	_____	Cell Phone:	_____
Father:	_____	Work Phone:	_____	Cell Phone:	_____
Guardian:	_____	Phone:	_____		
School Nurse:	_____	Phone:	_____		
School:	_____	Grade:	_____	Teacher:	_____
Physician:	_____	Phone:	_____	Fax:	_____
Diabetes Educator:	_____	Phone:	_____		
Hospital of Choice:	_____	504 Plan on file:	☐ Yes ☐ No		

Student is independent with daily diabetes management and self-care

Blood Glucose Monitoring: Student is able to check as needed during the school day.

Target range: ___ mg/dl to ___ mg/dl.

NOTE: ***A comprehensive Individualized Health Plan is kept in the health office.***

Health Concern #1 **Low Blood Glucose (Hypoglycemia)**

Emergency situations may occur with low blood glucose.
Symptoms: shaky, feels low, feels hungry, confused

- Student is treated when blood glucose is below ___ mg/dl or if symptomatic.
- If treated outside the classroom, a responsible person should accompany student to the clinic.
- Follow directions on **Hypoglycemia Flow Chart**.

Health Concern #2 **High Blood Glucose (Hyperglycemia)**

Symptoms: increased thirst, increase in urination, headache, stomachache

- Student is treated when blood glucose is above ___ mg/dl.
- Follow directions on Hyperglycemia Flow Chart.

Call 911 for following

1. Student is unable to cooperate to eat or drink anything.
2. Decreasing alertness or loss of consciousness.
3. Seizure–never put anything into the mouth of a person who is unconscious or having a seizure. Roll student onto side and protect from injury.

NOTE: If Glucagon is prescribed and available, immediately contact delegated staff to administer.

Comments:

Medication at School: Insulin via: ☐ Pump ☐ Syringe ☐ Pen ☐ None
Glucagon: ☐ Yes ☐ No Location in school: _____
Staff delegated to administer Glucagon: _____

Additional Information:

1. **Student is allowed access to fast acting glucose and test blood glucose as needed.**
2. **Student will be allowed to carry a water bottle and have unrestricted bathroom privileges.**
3. **Substitute teachers must be aware of the student's health situation**
4. **Be aware that blood glucose levels can affect ability to concentrate and perform properly on tests.**
5. **Prior to and during timed tests, i.e., CSAPs, have student monitor their blood glucose. If blood glucose out of range during test, treat per care plan. Allow for student to continue taking test when student returns to normal range and asymptomatic.**
6. **Notify Parent(s) when blood glucose below ___ mg/dl or above ___ mg/dl and for emergencies**.

FIELD TRIPS AND SPECIAL EVENTS: Notify parents of all field trips and special events. Supervising staff will review Student Health Plan. Trained and delegated staff will provide necessary interventions for daily management and emergency care. All necessary supplies will accompany student during the trip and may include: blood glucose meter, snack and drinks, fast acting glucose, Glucagon.

As parent/guardian of the above named student, I give my permission to the school nurse and other designated staff to perform and carry out the diabetes tasks as outlined in this School Health Plan and for my child's health care provider to share information with the school nurse for the completion of this plan. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis.

_____	_____	_____	_____
Parent	Date	School Nurse	Date

THOMAS MACLAREN SCHOOL

CONTRACT FOR STUDENTS INDEPENDENTLY MANAGING DIABETES WHILE AT SCHOOL 2018-2019

Student Name _____ Grade" _____

Date of Birth: _____

STUDENT

Student:

- I agree to dispose of any sharps either by keeping them in my kit and disposing at home, or placing them in the sharps container provided at school.
- I agree to notify the school health office is my blood sugar is below _____ mg/dl or above _____mg/dl.
- I agree to keep my diabetic supplies _____ with me OR in the school health office in an accessible secure location (located in _____).
- I agree never to allow any other person to use my diabetic supplies.
- I understand that the freedom to manage my diabetes independently is a privilege and I agree to abide by this contract.

Student Signature _____ Date _____

PARENT / GUARDIAN

Parent/Guardian:

- I agree that my child can self manage his/her diabetes and can recognize when he/she needs to seek the help of a staff member.
- It has been recommended to me that back up supplies be provided to the school health office for emergencies.
- I understand that this contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contingencies.

Parent Signature _____ Date _____

SCHOOL NURSE

School Nurse

- School staff members that have the need to know about the student's conditions and the need to carry his/her need to carry his/her diabetic supplies have been notified..

Nurse signature:_____ Date _____

Thomas MacLaren School

Health Care Provider's Authorization for the Administration of Medication by School Personnel

Dear Parent:

If your child must have medication of any type, including over-the-counter medicine and all homeopathics, given during school hours, you may:

1. Come to the school and administer it to your child at the appropriate time; or
2. Discuss with your health care provider an alternative schedule to administer medications outside of school hours; or
3. Complete, in its entirety, the attached form signed by your health care provider AND
4. Provide the medication in the original labeled pharmacy container which includes the child's name, name of medicine, dosage amount, and instructions for administration. For over-the-counter medication, please provide the medicine in a new, unopened bottle with all labels.

Remember, staff at Thomas MacLaren School may only administer medications at school with the properly completed documentation and the medication in the original, properly labeled container.

Thank you,

Tammie Chasteen, RN, BSN | School Nurse
Phone 719.313.4488 | Secure Fax: 866.587.2608
1702 N. Murray Blvd., Colorado Springs, CO 80915

Students required to take medication(s) prescribed by a physician during regular school days may be assisted by the school nurse or other designated school personnel. Medications may be administered only if the school receives specific written instructions from the physician and parent/guardian of the student.

Authorization to Assist in Administration of Medication

Student: _____ Birthdate:_____ Grade: _____

Purpose of medication: _____ Possible Side Effects: _____

Medication: _____ Dosage: _____ Route: _____

Time of day to be given at school: _____ Start Date: _____ End Date: _____

Asthma Inhaler / Epi-Pen (must also have self-carry contract): This student **MAY**/ **MAY NOT** carry their own Inhaler / Epi-Pen..

Physician Office Number & Fax Number:_____ Physician Signature/Stamp: _____

Parent Request that School Administer Medication

I request that medication be administered to my child by the designated member of the school staff in accordance with the instructions on the Health Care Providers's authorization. Please give my child their medication according to the above authorization,. Any special instructions are noted here: _____

It is understood that the medication is administered solely at the request of, and as an accommodation to, the undersigned parent/guardian. In consideration of the acceptance of the request to perform this service by the school nurse or other designee employed by Thomas MacLaren School, the undersigned parent/guardian hereby agrees to release Thomas MacLaren School and its personnel from any legal claim which they now have or may hereafter have arising out of side effects or other medical consequenc-es of the medication.

I will notify the school **immediately** if the medication is to be changed or terminated, or if we change health care providers.

I hereby give my permission for: (name of student).. _____
to take the above named prescription at school as ordered.

Date:: _____

Parent/Guardian Signature: _____