PORTLAND CHRISTIAN SCHOOL

Diabetes Individual Health Care Plan

Student Name:_____ Date of Birth:_____
Grade:_____ School Year:_____

Treating Physician:_____ Phone #:_____

[ ] Type 1 Diabetes [ ] Type 2 Diabetes [ ] Other condition requiring blood glucose monitoring

HYPOGLYCEMIA MANAGEMENT (LOW BLOOD SUGAR)

Location of Glucagon: [ ] Health Room/Office [ ] 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 ride the bus, leave campus, or drive if blood sugar is less than _____
6. Notify parent/guardian if student does not respond to treatment

EMERGENCY PLAN OF ACTION

1. If student is able to follow commands, offer sips of juice, milk, soft drink with sugar.

2. If student is unconscious, unresponsive or has a seizure, CALL EMS/911, notify appropriate school personnel, and administer Glucagon into muscle of upper arm.

3. Position student on their side in the recovery position, due to potential of vomiting. Monitor airway.

4. Contact Parent/Guardian or emergency contact. (If EMS is called, PCS employee must accompany student to medical facility if parent is not available.

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. Can student correct a high blood sugar with insulin other than at lunch? [ ] No [ ] Yes*
   *directive_____
2. Does student check ketones at school? [ ] No [ ] Yes* (call parent if ketones present) *See Ketone supplementation formula under insulin therapy
3. If blood sugar is greater than_____, do not participate in PE, exercise or sports
4. Student is not to drive if blood sugar is greater than _____. Notify parent. (High School student only)

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INSULIN THERAPY

Insulin type:_____
Insulin Delivery Device: [ ] Insulin Pen [ ] Insulin pump [ ] Syringe

Insulin to be administered: [ ] Before lunch [ ] After lunch

If low prior to lunch, administer insulin after meal: [ ] Yes [ ] No

Low blood sugar correction prior to lunch if applicable:_____

Insulin-to-carbohydrate ration (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 _____

Use Ketone Supplementation formula: [ ] Yes* [ ] No

*Give additional insulin as follows: Small amount = _____units; moderate amount = _____units;
Large amount = _____ units

****NOTE: DO NOT CORRECT FOR KETONES MORE OFTEN THAN EVERY 4 HOURS. ***

SNACKS

Does the student require a scheduled snack during the day? [ ] Yes* [ ] No [ ] As needed *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

Specific directives regarding PE or exercise:_____

Does your student participate/plan to participate in after school activities in which staff/coaches supervising your student would require Glucagon training?_____

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DISEASE MANGEMENT SKILLS (to be completed by physician or healthcare provider)

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 draw up correct dose of insulin (if not using pump)? [ ] Yes [ ] No
If has pump, is student independent in insulin pump function (giving correct dose of insulin, re-insertion and troubleshooting problems? [ ] Yes [ ] No
Has student demonstrated use of blood glucose monitoring equipment, including meter, lancet device, test strips, test sites to ensure accurate readings to manage disease? [ ] Yes [ ] No
Does the student have your permission to carry diabetes management supplies including Glucagon kit, insulin, and sharps? [ ] Yes [ ] No
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

PHYSICIAN SIGNATURE AND CONTACT INFORMATION

A Physician 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 personnel from Portland Christian School.

_____ _____

Physician Signature Date

_____ _____ _____

Physician Printed Name Phone # Fax #

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PARENT/GUARDIAN CONTACT AND RELEASE OF INFORMATION

****PARENTS WILL PROVIDE ALL DIABETIC CARE SUPPLIES INCLUDING: INSULIN (IF NOT USING PUMP), SNACKS, JUICE, BLOOD GLUCOSE METER, LANCETS AND LANCET DEVICE, EMERGENCY GLUCOSE, GLUCAGON AND ANY OTHER SUPPLIES NEEDED.**

I hereby give my consent for medical records and reports to be shared with Portland Christian School and for the treating physician to discuss my child's medical condition referenced above with school personnel to assist then 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 may not be 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. The undersigned hereby consents to the intervention of the employee under these circumstances.

Additionally, the undersigned agrees to hold Portland Christian School, its members, employees, and the intervening staff 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 from any claim resulting from self-administration of medication per state law.

*It is the responsibility of the parent/guardian to notify school personnel regarding changes in contact information or changes in the plan of care.

_____	_____	_____
Parent/Guardian signature	Date	Daytime Phone #
_____	_____	_____
Parent/Guardian signature	Date	Daytime Phone #

TO BE COMPLETED BY SCHOOL PERSONNEL

Form reviewed and received by:_____ Date:_____

School Year:_____

Glucagon received:_____ Expires:_____

Insulin kept in Health Room: [ ] Yes [ ] No