Pupils Services Department
Specialized Physical Health Care Services

Diabetic Management Checklist

The purpose of this check list is to assist the school nurse in preparing a safe appropriate school environment for the student in need of Specialized Physical Health Care Services (SPHCS). SPHCS are procedures that require physician's orders, parent/guardian consents, etc. **Nurses may NOT perform SPHCS with physician's orders. In the event the child starts school (which should not happen) prior to the nurse receiving current physician orders, the parent/guardian must come to school to perform the needed SPHCS.**

REQUIRED FORMS

_____ **1. Parent Consent and Physician Authorization**
Both parent and physician signatures are required.

Physician's orders must be renewed annually and/or in the event of a change in student's condition warranting new orders.

A copy of the district's procedure (appropriate for the service provided), will be attached so that is available for the physician to review and write orders accordingly.

_____ **2. Parent/Guardian Request for Having SPHCS Provided**
This form is required annually.

_____ **3. Algorithms for Blood Glucose Results**
This form is required annually.

_____ **4. Individualized School Healthcare Plan (ISHP)**
This form is required annually.

_____ **5. Medical Alert Notice**
Please update information annually.

Parent Consent and Authorized Health Care Provider Authorization for Management of Diabetes at School and School Sponsored Events

Individualized School Healthcare Plan (ISHP) and Procedures Will Provide Details for Implementation

(ATTACH "ALGORITHMS FOR BLOOD GLUCOSE RESULTS")

Pupil_____ DOB _____ School _____ Grade ____

PHYSICIAN'S WRITTEN AUTHORIZATION: PLEASE INITIAL AND CHECK ALL BOXES THAT APPLY

1. Blood Glucose testing:

❑ Before meals ❑ As needed

❑ By pupil ❑ Needs assistance/monitoring

2. Snacks: ❑ None ❑ Morning ❑ Afternoon

❑ Independent ❑ Needs reminder

❑ Needs verification

3. Treat low blood sugar below _____ as follows:

Standard procedure attached ❑ Modified ❑ OK

❑ Self treatment of mild lows ❑ Needs assistance

❑ Notify physician for blood sugar below _____

4. Emergency care of severe hypoglycemia

❑ Glucose gel: ❑ Conscious ❑ Unconscious

❑ Glucagon Injection: ❑ 0.5 mg ❑ 1 mg.

❑ Notify Physician when _____

5. Treat high blood sugar above _____ as follows:

Standard procedure attached ❑ Modified ❑ OK

❑ Record reading only, take no action.

❑ Notify Parent ❑Immediately ❑Written notice only

❑ Increase water intake

❑ Give extra Insulin (order on next column)

❑ Withhold or ❑ Encourage exercise

❑ Check ketones when blood sugar is above _____

6. Hemoglobin A_{1c} _____mg/dl on_____

(date)

7. If Insulin Regimen At School:

Brand name and Type: _____

Equipment Used:

❑ Syringe ❑Insulin pen ❑ Insulin pump

Physician's Insulin Orders for School Administration

_____

_____

_____

Sliding Scale

Blood Glucose from _____ to _____ = _____ Units

Blood Glucose from _____ to _____ = _____ Units

Blood Glucose from _____ to _____ = _____ Units

Blood Glucose from _____ to _____ = _____ Units

In your opinion, is student independent in both determining dose and self-administering insulin?

❑ Yes ❑ No

8. Insulin Pump Regimen At School:

Snack bolus ratio _____

Blood sugar correction bolus _____

Lunch bolus ratio _____

9. Daily Carb Intake Regime Counting

Breakfast _____ # of carbs

Snack _____ # of carbs

Lunch _____ # of carbs

Snack _____ # of carbs

Dinner _____ # of carbs

Snack _____ # of carbs

Physician's Initial _____

(Signatures <u>required</u> on back of this form)

PLEASE SEE ATTACHED FOR STANDARD PROCEDURE AND COMMENT SECTION

Parent Consent for Management of Diabetes at School

Pupil_____ DOB _____ School_____ Grade____

We(I), the undersigned, the parent(s)/guardian(s) of the above named pupil, request that the above specialized physical health care service for Management of Diabetes in school be administered to our (my) child in accordance with Education Code Section 49423.5 . **I will:**

1. Provide the necessary supplies and equipment.
2. Notify the school nurse if there is a change in pupil health status or attending physician.
3. Notify the school nurse immediately and provide new consent for any changes in doctor's orders.

I authorize the school nurse to communicate with the physician when necessary.

I understand that I will be provided a copy of my child's completed Individual School Healthcare Plan (ISHP).

Parent/Guardian Signature_____ Date_____

Authorized Physician for Management of Diabetes at School

My signature below provides authorization for the above written orders. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization (may be faxed).

☐ I request that the School Nurse provide me with a copy of the completed Individualized School Healthcare Plan (ISHP).

☐ I have instructed _____ in the proper way to use his/her **medications**.
(Child's Name)

It is my professional opinion that this student be allowed to carry and administer such **medications** by himself/herself. **Physician Initial** _____

Physician Name_____ Physician Signature_____ Date_____
(Print)

Address_____ City_____ Zip_____

Phone # _____ FAX # _____

For School District Personnel

_____ _____
Reviewed by School Nurse (Signature) (Date)

_____ _____
Reviewed by Principal (Signature) (Date)

Adapted January 29, 2003, from P.E.D.S./Padre Foundation

Algorithms For Blood Glucose Results

STUDENTS PHOTO

Check Blood Glucose

Below 70

1. Give fast acting sugar source*.
2. Observe for 10 minutes.
3. Retest blood glucose, if less than 70 repeat sugar source. If over 70 give carbohydrate and protein snack (e.g. crackers and cheese) or if within one hour to next meal feed early.
4. Notify school nurse if two or more episodes in one week.

If Student Becomes Unconscious, Seizures, Or Is Unable To Swallow:

1. Call 911.
2. Turn student on side to ensure open airway.
3. Give glucose gel and glucagon if ordered.
4. Notify school nurse and parents.

70-240

1. If student feels OK, may resume school activities.
2. If the student does not feel OK, retest blood glucose immediately.
   - If 80 or below, treat for "below 70".
   - If 81 or above, consult immediately with school nurse.

Above 240

Check ketones (if ordered)

Student Feels Ok – Ketones Neg. –Sm.

1. Give 1-2 glasses of water every hour.
2. Give Insulin. Exercise if ordered per ISHP.
3. Notify parents if small ketones are present.
4. Notify school nurse if two or more episodes in one week.

Student Does Not Feel OK - Ketones Mod.-Large

1. Consult immediately with school nurse. Notify parents.
2. Provide 1-2 glasses of water every hour.

If at any time student vomits, becomes lethargic, and/or has labored breathing CALL 911

Fast Acting Sugar Sources

- 15 gm Glucose tablets
- 15 gm. Glucose gel
- 1/3 c. sugared soda
- 1/2 c. orange juice
- 1/2 c. apple juice
- 1/2 c. grape juice
- 1 tube Cakemate gel (19 gm.)
- 3 tsp. sugar (in water)

Student's Name:
School:
School Nurse:
Nurse contact number:
Parent's ph. Number:
Alternate ER number:

Individualized School Healthcare Plan (ISHP)
For Management of Diabetes at School & School Sponsored Events
Completed With Parent and Pupil

Pupil	DOB School Grade
Diabetic Routines at School Per Parent Request/ Consent	Daily Snacks: Time(s) _____ Location for testing _____ ___ Done independently ___ Needs reminder ___ Needs daily compliance verification
	• Extra Snacks: ___ Before exercise ___ After exercise ___ _____ gms. CHO every 30 minutes during vigorous exercise ___ Needs daily compliance verification
	• Daily Blood Test: Time(s) _____ Location for testing _____ ___ By pupil independently ___ Adult verifies results ___ Needs assistance (specify)_____
	• Exercise: ___ None if blood glucose test results are below _____ mg/dl or above_____ mg/dl
	• Lunch Eaten At (time) _____ Regardless of schedule changes, field trips, disaster, etc. ___ Needs daily verification of meal eaten
	• In Event of Field Trips, all diabetic supplies are taken and care is provided according to this ISHP (a copy is taken on trip) **The School Nurse Must Be Notified Two Weeks Before The Field Trip To Plan For Qualified Personal To Provide Procedures**
	• In Event of Classroom/School Parties, food treats will be handled as follows: ___ Pupil will eat the treat. ___ Replace with parent supplied alternative. ___ Put in baggie and take home with teacher note. ___ Modify the treat as follows:
	• In Event of Bus Transportation: ___ Blood test given 10 to 20 minutes before boarding, and, if 70 or less, provide care per Procedure For Mild to Moderate Low Blood Glucose and call parent to provide transportation home. ___ Blood test not required. ___Other_____
	• Scheduled After-School Activities: _____
Other	(Specify):_____

Individualized School Healthcare Plan (ISHP)
For Management of Diabetes at School
Completed With Parent and Pupil

Pupil	DOB	School	Grade

Equipment And Supplies

Provided By Parent

Daily Snacks (for AM/PM snack times) Specify:

_____

Extra Snacks (for before, after, and/or during exercise) Specify:

_____

Blood Glucose Meter Kit
(Includes meter, testing strips, lancing device with lancet, cotton balls, spot bandages)

Brand/Model: _____

Low Blood Glucose Supplies, (5 day supply)

___ **Fast Acting Carbohydrate Drinks:** (Apple juice and/or orange juice, sugared soda pop-NOT diet), at least 6 containers.

___ Glucose Tablets, 1 package or more.

___ Glucose Gel Products (Insta-Glucose, Monogel or Glutose/25-31 gms.), 2 or more.

___ Gel Cakemate (not frosting), (19 gm.,mini-purse size), 2 or more.

Note: Not used in Emergency Procedure For Severe Low Blood Sugar.

___ Prepackaged Snacks (such as crackers with cheese or peanut butter, nite bite, etc.), 5 - 6 servings or more.

High Blood Glucose Supplies

___ Ketone Test Strips/Bottle

___ Urine cup

___ Water bottle

Note: Timing device may be wall clock or watch worn by pupil or personnel.

Provided By Parent (Continued)

Insulin Supplies

___ Insulin pen

___ Pre-filled syringes (labeled per dose)

___ Insulin and syringes

___ Extra pump supplies such as:

___ Vial of insulin, syringes

___ Pump syringe and tubing/needle

___ Batteries and Tape

___ Sof-Serter

Insulin supplies storage locaion:

_____

Emergency Supplies

___ **Glucagon kit** stored:

_____

___ **3 day disaster food supply stored:**

_____

3 Day Disaster Diabetes Supplies

___ Vial of insulin; 6 syringes

___ Insulin pen with cartridge and needles

___ Blood glucose testing kit (testing strips, lancing device with lancets)

___ Glucose gel product and glucose tablets

___ Glucagon kit

___ Food supply (include daily meal) plan) stored as follows:

_____

___ Ketone strips/plastic cup

School will include a copy of the ISHP for management of Diabetes Management with the Disaster Supplies. Stored as follows: _____

_____

Other Supplies, Specify:.

Standard Procedure for High Blood Glucose
Hyperglycemia

Pupil:	DOB:	School:	Grade:
Equipment and Supplies	1. Blood glucose meter kit 2. **(If Indicated)** Ketone test strips/bottle	3. **(If Indicated)** Clean jar or urine cup 4. **(If Indicated)** Insulin supplies	

Essential Steps	Key Points & Precautions
1. Verify, according to test results, a high blood glucose as follows: __ 240 or above __ 300 or above __ Other (specify):_____	
2. **Initiate care as checked below:** • **Give 1 - 2 glasses of water** every hour. • **Notify parent** of blood glucose test results when _____or above. __ Check urine ketones (see directions below) check blood ketones if blood glucose is greater than: __ 300 __ Other (Specify) _____ **Do NOT participate** in PE or other forms of exercise if blood glucose is above _____, or if ketones are present. __ **If 60 minutes or less** before lunchtime, administer correction dose of insulin per Physical orders. (See Physician Authorization for Management of Diabetes and Insulin Administration at School) __ **Other** (specify):_____	Pupil must not exercise if Ketones are present. A water bottle can be provided to encourage fluids. A correction dose of insulin may be given at mealtime or bedtime for control of blood glucose above 240 to 300.
3. **If pupil is feeling OK,** resume classroom activities with parent approval.	
4. **If pupil develops** nausea/vomiting and/or rapid breathing, **call paramedics, school nurse and parent** immediately.	
5. **Document care** on Procedure Log.	

Standard Procedure for Testing Urine Ketones

Essential Steps	Key Points & Precautions
1. Saturate the test strip with urine by one of the following: __ Pupil to hold test strip in urine flow. __ Pupil to urinate in cup/jar, then strip is dipped into urine. 2. Wait for test strip to develop per directions on test strip bottle. 3. Compare color of strip to chart on bottle. Results will be read as negative, small, moderate, or large. • If results are moderate or large, call parent to take pupil home for observation and/or medical care.	If assisting the pupil, wear disposable gloves during this procedure.
4. Record results on Procedure Log.	