Diabetes Care Plan & Healthcare Provider Order for Student with Diabetes

Mecklenburg County Public Health.

School Name	School Phone #	Fax:	For School Use Only
		(704) 432-2079 (School Health)	**Date Received/Receiver's Signature:** **Medication Received?** ❒ yes ❒ no
Student's Name (Please print.)	**Student's Date of Birth**		**Date Approved/Nurse's Signature** **Entered in EHR?** ❒ yes ❒ no
Parent/Guardian: Please read all pages of the Care Plan and Order. Sign and date the bottom of the first and last pages to show your agreement.			❒ **Student Self Carries** ❒ **Medication in Health Room** ❒ **Medication in Classroom**

Important Information about Medication Administration in CMS Schools

- When possible, medications should be taken before or after school. Administration of non-prescription medications at school is discouraged.
- Written parent/guardian consent and an order from a healthcare provider licensed in North Carolina are required for administering prescription and over-the-counter medications at school (CMS Policy JLCD/Regulation JLCD-R). Contact the school nurse for help if relocating from another state with orders from an out-of-state provider.
- Some medications may not be suitable for a school setting. Additional documentation may be required for some medications (examples: research medications, medications with potential for immediate serious side effects). Contact the school nurse if you have questions.
- Unless changed in writing, this plan will be used for the entire school year within which it was written.
- Medications are given by a nurse or trained CMS staff.
- No medication will be given by a CMS staff person until this authorization has been approved by a school nurse.
- New authorization forms are required at the beginning of every school year, when the dose or directions change, and when a new medication is prescribed. Parents/guardians must supply the medications.
- Each medication must be in the original labeled container from the pharmacy or healthcare provider's office. Some pharmacies will provide an extra container for school use.
- Information about this medication and the student's health may be shared with other school staff or agents of the school to help assure the student's safety and success at school.
- The school nurse may contact the healthcare provider who prescribed the medication and the pharmacy where the prescription was filled to discuss this medication and the student's health.

Healthcare Provider's Name / Address / Phone / Fax (please print or use stamp)	Parent/Guardian Contact Information (please print)	
	Parent/Guardian	
	Phone:	Phone:
	Parent/Guardian	
	Phone:	Phone:

I have read and understand the "Important Information about Medication Administration in CMS Schools" in this action plan. I give permission for my child to receive the medications noted in this plan during school hours. I give permission for the healthcare provider, pharmacist and their staff to provide information to the school nurse about this medication and my child's health. On behalf of my child, I release the Charlotte-Mecklenburg Board of Education, their agents and employees from any and all liability whatsoever that may result from my child taking this medication at school.

Write on line below.

Parent's/Guardian's Name (print) Signature Date

To be completed by a Licensed Healthcare Provider

Student:	DOB:	Valid for Current School Year:	Type 1 □
School:	Grade:	Year of Diagnosis:	Type 2 □

Glucagon

IM Injection: ☐ **0.5 mg** ☐ **1.0 mg** **Nasal Glucagon** ☐ **3 mg**

SQ Injection: ☐ **0.5** mg ☐ **1.0 mg**

CGM

Student with CGM □ YES □ NO

Brand/ Model: _____

CGM set to alarm at: _____(low) ____(high)

NOTE: *CGM results will be confirmed with finger stick prior to making treatment decisions unless an FDA approved CGM is being used.*

Blood Sugar Testing/ Monitoring

Student's BS Target Range: _____mg/dl to _____ mg/dl

Test Blood Sugar (check all that apply):

☐ Before meals ☐ Before snacks ☐ Before exercise ☐ After exercise

✓ Symptoms of low/high BS ☐ 30-45 minutes before dismissal

Insulin Administration

Type of Insulin: _____

Route: ☐ Pen ☐ Syringe ☐ Pump/ Type: _____

TO DETERMINE INSULIN DOSE USE:
□ Correction Scale **or** □ Correction Formula

CORRECTION SCALE: Use only if two hours have passed since last insulin administration. For pump users, only use for pump malfunction.

BS Range	_____mg/dl	Administer	_____ units
BS Range	_____mg/dl	Administer	_____ units
BS Range	_____mg/dl	Administer	_____ units
BS Range	_____mg/dl	Administer	_____ units
BS Range	_____mg/dl	Administer	_____ units
BS Range	_____mg/dl	Administer	_____ units
BS Range	_____mg/dl	Administer	_____ units
BS Range	_____mg/dl	Administer	_____ units
BS Range	_____mg/dl	Administer	_____ units
BS Range	_____mg/dl	Administer	_____ units

☐ **Parent/guardian authorized to increase/decrease correction scale within_____units of insulin**

CORRECTION FORMULA:

Use when Blood Sugar greater than _____ mg/dl.

Target Blood Sugar: _____	Correction Factor/ Sensitivity: _____

A = Correction Insulin is
(Blood Sugar – Target) ÷ Correction Factor

B = Carbohydrate/ Food Insulin is
(grams of carbs intake ÷ carbohydrate ratio)

Total Insulin Dose = A + B

□ Round up □ Round down □ ½ unit dosing

Carbohydrate Ratio

Breakfast	Lunch	Snacks
____ unit per _____grams of carbs _____	**____ unit per _____grams of carbs**	**____ unit per _____grams of carbs**

*****Insulin will be given before meals unless the following box is checked for after meals ☐**

- Pump settings are established by the student's healthcare provider and should not be changed by school staff
- Contact parent/guardian and/or healthcare provider with any concerns about pump functioning/failure/error messages, as well as insertion site concerns including redness or soreness at site

Student's Ability to Self- Manage Diabetes Care

Student is independent in all aspects of care
□ **YES** □ **NO**

Student needs assistance with the following:

□ Testing blood sugar □ Verification of blood sugar reading □ Treating mild hypoglycemia
□ Administering insulin □ Verification of insulin dose □ Changing pump site
□ Testing urine ketones □ Changing CGM

Signatures

Healthcare Provider: **Date:**	**Parent/ Legal Guardian:** **Date:**
Reviewed by School Nurse: **Date:**	

Care Plan for Student with Diabetes

Name:	DOB:	Valid Current School Year:	Type 1 □
School:	Grade:	Year Diagnosed:	Type 2 □

Parent/ Legal Guardian's Contact Information

Name:	Contact Number:
Name:	Contact Number:

Trained Diabetes Care Team Members

Name:	Name:
Name:	Name:

IF THE STUDENT IS SENT TO THE HEALTH ROOM, THEY MUST BE ACCOMPANIED BY AN ESCORT

HYPOGLYCEMIA: BLOOD SUGAR LESS THAN 80 mg/dl

Signs and symptoms of hypoglycemia:

- ● Dizziness
- ● Hunger
- ● Headache
- ● Shaking
- ● Blurry vision
- ● Loss of consciousness
- ● Behavior changes
- ● Anxiety
- ● Pallor
- ● Seizure
- ● Weakness/fatigue
- ● Other_____

1. Test blood sugar (BS) with any complaint/symptom, if blood glucose meter not available, treat symptoms.
2. For blood sugar less than 80 mg/dl: Treat IMMEDIATELY with 15-gram fast acting carbohydrate snack (juice, glucose tab, etc.) and recheck every 15 minutes until above 80mg/dl. SUSPEND INSULIN PUMP AND NOTIFY PARENT/GUARDIAN.
3. If unable to drink juice: Administer glucose gel or cake icing to inside of cheek. Recheck and retreat every 15 minutes until BS >80 mg/dl. NOTIFY PARENT/GUARDIAN.
4. Once BS is >80mg/dl and if it is going to be more than 1 hr. until the next meal or snack, give an additional 15 grams complex carbohydrate snack (i.e. cheese and crackers, granola bar, trail mix) to sustain BS.
5. DO NOT cover carbohydrates that were used to bring BS up to within target range and snack given to sustain BS with insulin. Once blood sugar level is within target range, blood sugar should not be re-checked and treated within the following 2 hours, unless student has symptoms of a low BS.
6. If unconscious, convulsing, unable or unwilling to take glucose gel or juice: Administer Glucagon and call 911, position student on side in case of vomiting, then notify parent/guardian.

HYPERGLYCEMIA: BLOOD SUGAR GREATER THAN 300 mg/dl

Signs and symptoms of hyperglycemia:

- ● Increased Thirst
- ● Hunger
- ● Irritability
- ● Nausea/Vomiting
- ● Frequent urination
- ● Fatigue
- ● Double vision
- ● Abdominal pain

1. Check blood sugar.
2. If blood sugar is over 300 mg/dl and at least 2 hours from last insulin dose, give insulin per sliding scale or bolus via pump.
3. Check urine ketones. If ketones are present, call parents. STUDENT SHOULD NOT EXERCISE.
4. Give 8-16 oz. of water per hr.
5. Recheck blood sugar in 2 hours and treat with sliding scale insulin, as needed. **** See below for pump.***
6. When student is having symptoms of nausea and vomiting, student will be released from school to parent/guardian.

*** When student has insulin pump**:

If BS is greater than 300 mg/dl with ketones or 2 consecutive unexplained BS's greater than 300 mg/dl (with or without ketones), may indicate a malfunction in the pump. Student may require insulin via injection and/or new infusion site. PARENT/GUARDIAN MUST BE NOTIFIED.

School Nurse Signature:	
***Parent/Legal Guardian Signature:**	

***Parent/ Legal Guardian:** By signing, I understand that all procedures will be implemented in accordance with state laws and regulations and may be performed by an unlicensed school personnel under the training and supervision provided by the school nurse.