WAYNE COUNTY PUBLIC SCHOOLS
DIABETES HEALTH CARE/EMERGENCY PLAN

Student's Name: _________________________________ ID# _____________________________ Date of Birth: ___________________________

School: ____ Grade: ____ Homeroom Teacher: ____

Parent/Guardian #1:____ Address: ____

Telephone Numbers: ___________________________ (Home) ____________________________ (Work) ___________________________ (Cell)

Parent/Guardian #2:____ Address: ____

Telephone Numbers: ___________________________ (Home) ____________________________ (Work) ___________________________ (Cell)

Other Emergency Contact: ____ Relationship: ____

Telephone Numbers: ___________________________ (Home) ____________________________ (Work) ___________________________ (Cell)

Trained Diabetes Care Providers: (1) ____ (2) ____

Name of Physician Treating Student for Diabetes: ____ Telephone: _________________________

Other Physician: ____ Telephone: _________________________

Effective Dates for Plan: ____________________ to ______________________ Bus #/Transportation: __________________________________

This student has been diagnosed with Diabetes. During school, the following will be necessary:
Target Blood Sugar Range from __________ to ____________.

Insulin Administration **Type of Insulin** ________________________________

_____ Call parent to administer insulin
_____ Student may self administer with pen or syringe
_____ Student requires adult supervision (observing student and verifying insulin dose)
_____ Student requires administration by school staff
(School Nurse will train 2 staff to draw up and give injections.)

INSULIN INJECTIONS		
Does student know how to:		
Give own injections?	Yes	No
Determine correct insulin dose?	Yes	No
Draw up correct insulin dose?	Yes	No
Handle and dispose of needles safely?	Yes	No

Carbohydrate Counting:

____ No Carbohydrate Counting

____ Units per _____ grams of Carbs

At Meals only _____

For meals and Snacks _____

Scheduled Insulin:

Breakfast _____ units

Lunch _____ units

Snacks _____ units

Sliding Scale:

If blood sugar is:

______________ give _________ units

______________ give _________ units

______________ give _________ units

______________ give _________ units

______________ give _________ units

Sliding scale (referred to as correction insulin) may not be given more frequently than every 3 to 4 hours due to the risk of causing a low blood sugar.

Insulin Pumps:

Target Blood Sugar = __________

Insulin Sensitivity Factor: __________

$$\frac{\text{Current Blood sugar - Target Blood sugar}}{\text{Insulin Sensitivity Factor}}$$

Equals # units

All calculations MUST be verified and go through the bolus wizard or EZ bolus in the pump.

*Insulin may be given anytime carbs are eaten EXCEPT when treating a low blood sugar.
Special Instructions: ____

____

_____ **Blood Glucose Monitoring** **Meter is to be kept**: ______ with student _______ other: ____________________________________

_____ Before Meals _____ Before snacks _____ Signs or Symptoms of Low/High Blood sugar _____ other

_____ Student can perform own test. _____ Staff must perform test. _____ Student must be supervised.

***Notify Parents if blood sugar is below ___________ or above ___________.**

Parent's Initials: __________ Date: ___________________ Provider's Initials: __________ Date: ___________________

_____ **Nutrition (Diet)** Snack will be kept by: _____ student _____ office _____other (specify):________________________________

_____ Student should eat breakfast/take insulin at home
_____ Student may eat breakfast at school
_____ Student may bring lunch or eat school lunch
_____ Student needs to eat a snack at school Time(s): __________ a.m. __________ p.m.
_____ Before or after PE (Time___________)

_____ **Exercise**

_____ No restrictions _____ Restrictions Do not exercise if blood sugar is below ________ or above ________

_____ Give snack before exercise _____ Other: ____

WCPS DIABETES EMERGENCY HEALTH CARE PLAN

***Symptoms of low blood sugar (hypoglycemia)**: hunger, sweating, tremors, inability to concentrate, irritability, dizziness, pallor, crying, confusion, poor coordination, headache, nervousness.*

***Symptoms of high blood sugar (hyperglycemia)**: increased thirst, increased urination, hunger, blurred vision, abdominal pain, nausea.*

EMERGENCY ACTION PLAN:

A. Insulin Reaction (low blood sugar)

If student is **unresponsive,** unable to swallow, or unconscious, **CALL 911:**

- **Call 911**
- **Give fast acting sugar-like cake gel, glucose gel, syrup. Lay child on his/her side. Place sugar substance inside child's cheek and massage the outside of the cheek. Never place sugar in the back of throat.**
- **Administer glucagon per MD orders.**
- Notify parents

If student is **responsive**:

Have student check blood sugar if possible. *Stay with student*. **Do not send down the hall unattended.**

If blood sugar is low (below __________) or if student is unable to self-test, give source of instant sugar ½ cup fruit juice, 4 oz. regular soda, one small tube of cake gel or glucose gel, 3 glucose tablets, or other source of sugar. Recheck blood sugar in 15 minutes. CALL PARENT.

B. High Blood sugar –
Allow bathroom breaks as needed and sugar free drinks. Notify Parent. Follow sliding scale insulin.

I have reviewed the health/emergency plan and approve it:

Physician signature: _______________________________ Date: ______________________

PARENT'S PERMISSION AND RELEASE OF MEDICAL INFORMATION

I am the parent/legal guardian of ____ (student). I give my consent for the employees of the Wayne County Public School system to follow the plan and use the designated medications on my child in accordance with the instructions above. I understand that I am to provide the school with supplies, snacks, equipment, etc. to follow the plan. It is my responsibility to have the health care provider approve/amend the plan. I will keep the school informed if changes are made at a future time. I hereby acknowledge that I have read, understand, and support the Health/Emergency Plan. I release the school system and its employees from liability connected with administering this plan.

*Parent/Guardian signature: _______________________________ Telephone: __________________________ Date: ______________________
***Must have Parent and Physician signatures prior to implementing plan.**

RELEASE OF MEDICAL INFORMATION

I hereby authorize my child's health care provider to release to the school nurse, principal, or other authorized school personnel, specific confidential, medical information contained in my child's record regarding diabetes. Only school staff delivering health care services to my child in school will use this information.

Parent/Guardian signature: ______________________________ Date: ______________________