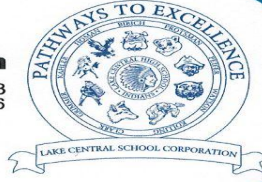


**Lake Central School Corporation**

8260 Wicker Avenue  
Tel: (219) 365-8507

Saint John, IN 46373  
Fax: (219) 365-6406



**Lawrence Veracco, Ph.D.**  
*Superintendent*  
**Terry Mucha**  
*Director of Human Resources*  
**Yolanda Bracey**  
*Director of Primary Education*  
**Sarah Castaneda**  
*Director of Secondary Education*  
**Rebecca Gromala**  
*Director of Student Services*

To:

Parent/Guardian of: \_\_\_\_\_

Upon diagnosis as well as the beginning of each school year, we need to have a current letter from your student's doctor regarding treatment for their diabetes. This information is required for the student's health records to enable us to best assist in the proper management of their condition as well as in the event of an emergency situation at school.

Please provide us with the current parameters from the physician for your student's diabetes treatment. Please include:

- Insulin orders
- Frequency of glucose monitoring
- Sliding scale orders
- Carbohydrate meal counts (if restricted)
- At what level to check for ketones
- Parameters for riding the bus

If your student uses an insulin pump, please indicate:

- Basal rate
- Meal bolus
- Correction bolus

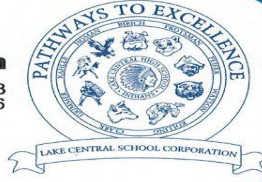
Also enclosed is the Indiana state law that must be signed each year.

Thank you very much for taking care of this at your earliest convenience. If you have any questions, please contact your student's school nurse.

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House Bill No. 1116, Chapter 5 Care of Students with Diabetes, Sec. 7 states:

A diabetes management and treatment plan must be prepared and implemented for a student with diabetes whose parent seeks care for the student's diabetes while the student is at school or participating in a school activity.

The plan must be developed by:

- (1) The student's parent or guardian; and
- (2) The licensed physician or licensed health care practitioner responsible for the student's diabetes treatment.

A diabetes management and treatment plan must:

- (1) Identify the health care services the student may receive at school;
- (2) Evaluate the student's:
  - (a) Ability to manage; and
  - (b) Level of understanding of the student's diabetes; and
- (3) Be signed by the student's parent and the licensed physician or licensed health care practitioner responsible for the student's diabetes treatment.
  - (a) The parent of a student who seeks care for the student's diabetes while the student is at school or participating in a school activity shall submit a copy of the student's diabetes management and treatment plan to the school.

The plan must be submitted to and be reviewed by the school:

- (1) Before or at the beginning of the school year;
- (2) At the time the student enrolls, if the student is enrolled in school after the beginning of the school year; or
- (3) As soon as practicable following a diagnosis of diabetes for the student.

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

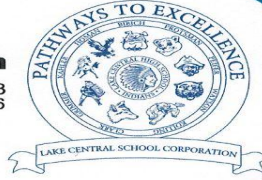
Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**DIABETIC SUPPLIES FOR SCHOOL**

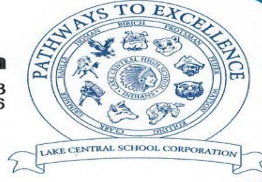
May include, but not limited to the following:

1. Blood glucose monitor
2. Test strips
3. Batteries for glucose monitor
4. Lancing device
5. Lancets
6. Ketone testing strips
7. Glucagon (with accompanied physician order)
8. Source of fast-acting carbohydrate for treatment of hypoglycemia
9. Any routine snacks
10. Glucose tablets - or - cake icing/gel
11. Water bottles
12. Alcohol swabs (if needed)
13. Insulin syringe (if needed)
14. Insulin pen needles (if needed)

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**DIABETES HEALTH CARE PLAN**

STUDENT NAME: \_\_\_\_\_

SCHOOL: \_\_\_\_\_ SCHOOL YEAR: \_\_\_\_\_

1. The school nurse(s) and/or parent will inform each staff member having involvement with the student about his/her condition.
2. All staff and personnel will be educated in meeting the needs of a diabetic student and recognize the signs of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar).
3. The student with diabetes will be given a pass to leave any class, at any time, if he/she needs to use the bathroom or needs a drink of water.
4. A companion will accompany the student if he/she needs to go to the nurse's office when not feeling well. Staff will notify the Nurse that the student is not feeling well and is on his/her way to the Nurse's office. **NEVER SEND A STUDENT WITH ACTUAL - OR - SUSPECTED - LOW BLOOD SUGAR ANYWHERE ALONE!**
5. It is the parent's responsibility to alert the NURSE if their child has been experiencing Blood Glucose results at home that are atypical.
6. Information on the student's Diabetes Health Plan will be included in all Substitute Teacher Plans. These teachers must be aware of his/her medical needs (bathroom, drinking, testing, snacking in class, going to the nurse) and any pertinent accommodations.
7. It is the parent's responsibility to notify the Nurse if Medical treatment changes. The parents must educate the Nurse in any new treatment, supplies, or situation.
8. Medical supplies will be kept in the Nurse's office. It is the parent's responsibility to make sure that these supplies are adequate in quantity and not expired. These include: Blood glucose monitor, test strips, batteries for glucose monitor, lancing device, lancets, ketone strips, glucagons, source of fast-acting carb for treatment of hypoglycemia, any routine snacks, glucose tablets, or instant glucose.
9. All school personnel will permit the student with diabetes to eat a snack in the classroom or whenever he/she is (including but not limited to classrooms, gym, auditorium, playground, field trips, and bus).
10. The student's blood glucose monitor and fast-acting sugar sources and snack must accompany the teacher on all field trips. A diabetes trained staff member must accompany this student on any field trip unless his/her parents are able and wishes to attend.
11. For physical education calls, the student with diabetes will be given adequate time to have a snack before class, without consequence. The student should participate fully in physical education classes and sports. Physical education instructors and sports coaches must be able to recognize and assist with the treatment of hypoglycemia.
12. The student should NOT participate in physical activity if ketones are moderate or large.

**GLUCAGON - EMERGENCY TREATMENT**

- A. If the student with diabetes is unconscious or having a seizure, he/she will need an injection of Glucagon.
- B. If Glucagon is administered, immediately dial 911 and contact the parents.
- C. If no one is available to administer Glucagon, instant glucose should be placed inside the student's mouth (between cheek and gum) and 911 should be called.
- D. Glucagon and Dr's order must be brought to the Nurse's office.

Physician Name \_\_\_\_\_ Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

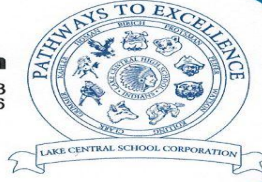
Parent Name \_\_\_\_\_ Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Nurse Name \_\_\_\_\_ Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_

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*Director of Student Services*

Date of Plan: \_\_\_\_\_

**Diabetes Management and Treatment Plan for School**

Effective Dates: \_\_\_\_\_

*This plan should be completed by the student's personal health care team and parents/guardian. It should be received by the school nurse, who will develop the Individualized Health Plan (IHP).*

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

Physical Condition:  Diabetes Type 1  Diabetes Type 2

Insurance #: \_\_\_\_\_ Primary Cardholder: \_\_\_\_\_

**CONTACT INFORMATION**

**Mother/Guardian:** \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**Father/Guardian:** \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**Student's Doctor/Licensed Health Care Practitioner**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Emergency Number: \_\_\_\_\_

**Other Emergency Contact(s):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**Other Emergency Contact(s):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**Notify parents/guardians or emergency contact in the following situations:**

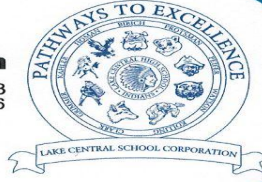
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Date of Plan: \_\_\_\_\_

**Diabetes Management and Treatment Plan for School**

Effective Dates: \_\_\_\_\_

**BLOOD GLUCOSE MONITORING**

Target range for blood glucose is:  70-150       70-180       other \_\_\_\_\_

Usual times to check blood glucose: \_\_\_\_\_

Times to do extra blood glucose checks (check all that apply):

- Before exercise
- After exercise
- When student exhibits symptoms of hyperglycemia
- When student exhibits symptoms of hypoglycemia
- Other: (explain): \_\_\_\_\_

Can the student perform own blood glucose checks?     YES  NO

Exceptions: \_\_\_\_\_

Type of blood glucose meter student uses: \_\_\_\_\_

**FOR STUDENTS TAKING ORAL DIABETES MEDICATIONS**

Medication: \_\_\_\_\_ Timing: \_\_\_\_\_

Other Medication: \_\_\_\_\_ Timing: \_\_\_\_\_

Other Medication: \_\_\_\_\_ Timing: \_\_\_\_\_

**INSULIN**

Base dose: (check type of rapid/short acting insulin used):

- Humalog       Novolog       Regular Insulin

\_\_\_\_\_ dose **OR** \_\_\_\_\_ dose/ \_\_\_\_\_ grams carbohydrates

Use of other insulin: (check type) and time \_\_\_\_\_

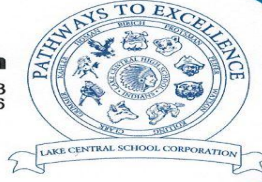
- Intermediate       NPH       Lente
- \_\_\_\_\_ dose      \_\_\_\_\_ dose      \_\_\_\_\_ dose

**OR**

- Basal       Lantus       Ultralente
- \_\_\_\_\_ dose      \_\_\_\_\_ dose      \_\_\_\_\_ dose

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Date of Plan: \_\_\_\_\_

## Diabetes Management and Treatment Plan for School

Effective Dates: \_\_\_\_\_

### INSULIN CORRECTION DOSES

Physical orders should be obtained for administering a correction dose for high blood glucose levels.

YES  NO

\_\_\_\_\_ if blood glucose is \_\_\_\_\_ to \_\_\_\_\_ mg/dl

\_\_\_\_\_ if blood glucose is \_\_\_\_\_ to \_\_\_\_\_ mg/dl

\_\_\_\_\_ if blood glucose is \_\_\_\_\_ to \_\_\_\_\_ mg/dl

\_\_\_\_\_ if blood glucose is \_\_\_\_\_ to \_\_\_\_\_ mg/dl

\_\_\_\_\_ if blood glucose is \_\_\_\_\_ to \_\_\_\_\_ mg/dl

Can the student give own injections?  YES  NO

Can the student determine the correct amount of insulin?  YES  NO

Can the student draw the correct dose of insulin?  YES  NO

### FOR STUDENTS WITH INSULIN PUMPS

Type of pump: \_\_\_\_\_

Basal rates: \_\_\_\_\_ 12am to \_\_\_\_\_

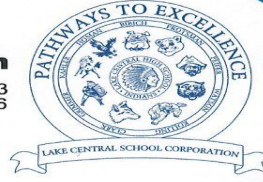
\_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ to \_\_\_\_\_

Type of insulin in pump: \_\_\_\_\_

Type of infusion set: \_\_\_\_\_

Insulin/carbohydrate ratio: \_\_\_\_\_ Correction Factor: \_\_\_\_\_



Date of Plan: \_\_\_\_\_

## Diabetes Management and Treatment Plan for School

Effective Dates: \_\_\_\_\_

### **FOR STUDENTS WITH INSULIN PUMPS, cont.**

***Student Pump Abilities/Skills:***

***Needs Assistance***

- |   |  |
|---|--|
| Count carbohydrates                             | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Bolus correct amount for carbohydrates consumed | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Calculate and administer corrective bolus       | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Calculate and set basal profiles                | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Calculate and set temporary basal rate          | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Disconnect pump                                 | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Reconnect pump at infusion set                  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Prepare reservoir and tubing                    | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Insert infusion set                             | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Troubleshoot alarms and malfunctions            | <input type="checkbox"/> YES <input type="checkbox"/> NO |

### **MEALS AND SNACKS EATEN AT SCHOOL**

Is the student independent in carbohydrate calculations and management?  YES  NO

<u>Meal/Snack</u>	<u>Time</u>	<u>Food content/amount</u>
Breakfast	_____	_____
Mid-morning Snack	_____	_____
Lunch	_____	_____
Mid-afternoon Snack	_____	_____
Dinner	_____	_____

Snack before exercise?  YES  NO      After?  YES  NO

Other times to give snacks and content/amount: \_\_\_\_\_

Preferred snack foods: \_\_\_\_\_

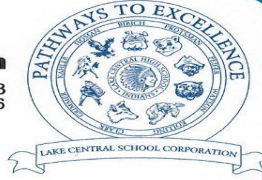
Foods to avoid, if any: \_\_\_\_\_

Instructions for when food is provided to the class (e.g. part of a class party or food sampling event):

\_\_\_\_\_

\_\_\_\_\_





Date of Plan: \_\_\_\_\_

## Diabetes Management and Treatment Plan for School

Effective Dates: \_\_\_\_\_

### EXERCISE and SPORTS

A fast-acting carbohydrate, such as \_\_\_\_\_, should be available at the site of exercise or sports.

Restrictions on activity, if any: \_\_\_\_\_

Student should not exercise if blood glucose level is below \_\_\_\_\_ mg/dl or above \_\_\_\_\_ mg/dl  
- **OR** - if moderate to large ketones or blood ketones of \_\_\_\_\_ mmol/L are present.

### BUS RIDER PARAMETERS

Student's blood glucose level range for riding bus:

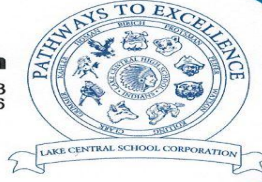
70-150       70-180       other \_\_\_\_\_

### SUPPLIES TO BE LEFT AT SCHOOL

- \_\_\_\_\_ Blood glucose monitor
- \_\_\_\_\_ Test strips
- \_\_\_\_\_ Batteries for glucose monitor
- \_\_\_\_\_ Lancing device
- \_\_\_\_\_ Lancets
- \_\_\_\_\_ Ketone testing strips
- \_\_\_\_\_ Glucagon (with accompanied physician order)
- \_\_\_\_\_ Source of fast-acting carbohydrate for treatment of hypoglycemia
- \_\_\_\_\_ Any routine snacks
- \_\_\_\_\_ Glucose tablets - or - cake icing/gel
- \_\_\_\_\_ Water bottles
- \_\_\_\_\_ Alcohol swabs (if needed)
- \_\_\_\_\_ Insulin syringe (if needed)
- \_\_\_\_\_ Insulin pen needles (if needed)

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Date of Plan: \_\_\_\_\_

## Diabetes Management and Treatment Plan for School

Effective Dates: \_\_\_\_\_

### HYPOGLYCEMIA (LOW BLOOD GLUCOSE)

Usual symptoms of hypoglycemia: \_\_\_\_\_

\_\_\_\_\_

Treatment of hypoglycemia: \_\_\_\_\_

\_\_\_\_\_

Glucagon should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow.

Route \_\_\_\_\_ Dosage \_\_\_\_\_ Site for Glucagon injection:  arm  
 thigh  
 other \_\_\_\_\_

If Glucagon is required, administer it promptly. Turn student on side. Then, call 911 (or other emergency assistance), school nurse and the parents/guardian, if designated.

### HYPERGLYCEMIA (HIGH BLOOD GLUCOSE)

Usual symptoms of hyperglycemia: \_\_\_\_\_

\_\_\_\_\_

Treatment of hyperglycemia: \_\_\_\_\_

\_\_\_\_\_

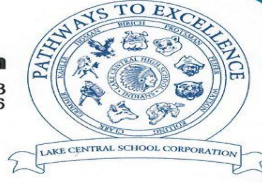
Blood or urine should be checked for ketones when blood glucose levels are above:

\_\_\_\_\_ mg/dl

Treatment for ketones: \_\_\_\_\_

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*Director of Student Services*

Date of Plan: \_\_\_\_\_

## Diabetes Management and Treatment Plan for School

Effective Dates: \_\_\_\_\_

### SIGNATURES

**This Diabetes Management and Treatment Plan has been approved by:**

\_\_\_\_\_  
Student's Physician/Health Care Provider Signature

\_\_\_\_\_  
Date

I give permission to the school nurse, trained diabetes personnel, and other designated staff

members of \_\_\_\_\_ School to perform and carry out the diabetes  
(LCSC School Student Enrolled In)

care tasks as outlined by \_\_\_\_\_'s Diabetes Management and Treatment  
(Student's Name)

Plan. I, also, consent to the release of the information contained in this Diabetes Medical Management Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

**Acknowledged and Received By:**

\_\_\_\_\_  
Student's Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student's Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
School Nurse/Designated Staff Member Signature

\_\_\_\_\_  
Date