Lake Central School Corporation

8260 Wicker Avenue St. John, IN 46373
Tel: (219) 365-8507 Fax: (219) 365-6406

website: lcsc.us

Lawrence Veracco, Ph.D.
Superintendent
Sarah Castaneda
Assistant Superintendent
Yolanda Bracey, Ed.D.
Director of Primary Education
Misty Scheuneman
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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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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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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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: _____

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FOR STUDENTS WITH INSULIN PUMPS, cont.

Student Pump Abilities/Skills:	*Needs Assistance*
Count carbohydrates	▢ YES ▢ NO
Bolus correct amount for carbohydrates consumed	▢ YES ▢ NO
Calculate and administer corrective bolus	▢ YES ▢ NO
Calculate and set basal profiles	▢ YES ▢ NO
Calculate and set temporary basal rate	▢ YES ▢ NO
Disconnect pump	▢ YES ▢ NO
Reconnect pump at infusion set	▢ YES ▢ NO
Prepare reservoir and tubing	▢ YES ▢ NO
Insert infusion set	▢ YES ▢ NO
Troubleshoot alarms and malfunctions	▢ YES ▢ NO

MEALS AND SNACKS EATEN AT SCHOOL

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

Meal/Snack	Time	Food content/amount
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):

_____

_____

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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
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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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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 care tasks as outlined by _____'s Diabetes Management and Treatment 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.

(LCSC School Student Enrolled In)

(Student's Name)

Acknowledged and Received By:

_____

Student's Parent/Guardian Signature Date

_____

Student's Parent/Guardian Signature Date

_____

School Nurse/Designated Staff Member Signature Date