Steger School District 194
Administration Center • 3753 Park Avenue • Steger, Illinois 60475
(708) 753-4300 *Phone* • (708) 755-9512 *Fax* • www.sd194.org

Diabetes Packet

To ensure all students, staff, and stakeholders learn and grow together as a community

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Care of Students with Diabetes:

Steger School District 194 will address the needs of students with diabetes who attend its schools. The District will not deny a student access to any school or school related activities on the basis that a student has diabetes and will not restrict the assignment of a student with diabetes to a particular school on the basis that the school does not have a full time nurse. The District will comply with the requirements of the Individuals with Disabilities Education Act, Section 504 of the Rehabilitation Act of 1973 and the Care of Students with Diabetes Act

If your child has diabetes and requires assistance with managing this condition while at school and school functions, a Diabetes Care Plan must be submitted to the school principal.

Parents/guardians are responsible for and must:

1. Inform the school in a timely manner of any change which needs to be made to the Diabetes Care Plan on file with the school for their child.
2. Inform the school in a timely manner of any changes to their emergency contact numbers or contact numbers of health care providers.
3. Sign the Diabetes Care Plan.
4. Grant consent for and authorize designated School District representatives to communicate directly with the health care provider whose instructions are included in the Diabetes Care Plan.

For further information, please contact the Building Principal.

Diabetes Medical Management Plan (DMMP)

This plan should be completed by the student's personal diabetes health care team, including the parents/guardian. It should be reviewed with relevant school staff and copies should be kept in a place that can be accessed easily by the school nurse, trained diabetes personnel, and other authorized personnel.

Date of Plan: _____ This plan is valid for the current school year: _____ - ____

Student's Name: _____ Date of Birth: _____

Date of Diabetes Diagnosis: _____ ❑ type 1 ❑ type 2 ❑ Other_____

School: _____ School Phone Number: _____

Grade: _____ Homeroom Teacher: _____

School Nurse: _____ Phone:_____

CONTACT INFORMATION

Mother/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell: _____

Email Address: _____

Father/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell: _____

Email Address: _____

Student's Physician/Health Care Provider: _____

Address: _____

Telephone:_____

Email Address: _____ Emergency Number: _____

Other Emergency Contacts:

Name: _____ Relationship:_____

Telephone: Home _____ Work _____ Cell: _____

CHECKING BLOOD GLUCOSE

Target range of blood glucose: ☐ 70–130 mg/dL ☐ 70–180 mg/dL

☐ Other: _____

Check blood glucose level: ☐ Before lunch ☐ _____ Hours after lunch

☐ 2 hours after a correction dose ☐ Mid-morning ☐ Before PE ☐ After PE

☐ Before dismissal ☐ Other:_____

☐ As needed for signs/symptoms of low or high blood glucose

☐ As needed for signs/symptoms of illness

Preferred site of testing: ☐ Fingertip ☐ Forearm ☐ Thigh ☐ Other: _____

Brand/Model of blood glucose meter:_____

Note: The fingertip should always be used to check blood glucose level if hypoglycemia is suspected.

Student's self-care blood glucose checking skills:

☐ Independently checks own blood glucose

☐ May check blood glucose with supervision

☐ Requires school nurse or trained diabetes personnel to check blood glucose

Continuous Glucose Monitor (CGM): ☐ Yes ☐ No

Brand/Model: _____ Alarms set for: ☐ (low) and ☐ (high)

Note: Confirm CGM results with blood glucose meter check before taking action on sensor blood glucose level. If student has symptoms or signs of hypoglycemia, check fingertip blood glucose level regardless of CGM.

HYPOGLYCEMIA TREATMENT

Student's usual symptoms of hypoglycemia (list below):

_____

_____

If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than _____mg/dL, give a quick-acting glucose product equal to _____ grams of carbohydrate.

Recheck blood glucose in 10–15 minutes and repeat treatment if blood glucose level is less than _____ mg/dL.

Additional treatment: _____

HYPOGLYCEMIA TREATMENT (Continued)

Follow physical activity and sports orders (see page 7).

- If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movements), give:
- Glucagon: ❑ 1 mg ❑ 1/2 mg Route: ❑ SC ❑ IM
- Site for glucagon injection: ❑ arm ❑ thigh ❑ Other:_____
- Call 911 (Emergency Medical Services) and the student's parents/guardian.
- Contact student's health care provider.

HYPERGLYCEMIA TREATMENT

Student's usual symptoms of hyperglycemia (list below):

_____

_____

Check ❑ Urine ❑ Blood for ketones every _____hours when blood glucose levels are above _____mg/dL.

For blood glucose greater than _____mg/dL AND at least _____hours since last insulin dose, give correction dose of insulin (see orders below).

For insulin pump users: see additional information for student with insulin pump.

Give extra water and/or non-sugar-containing drinks (not fruit juices): _____ounces per hour.

Additional treatment for ketones: _____

Follow physical activity and sports orders (see page 7).

- Notify parents/guardian of onset of hyperglycemia.
- If the student has symptoms of a hyperglycemia emergency, including dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy, or depressed level of consciousness: Call 911 (Emergency Medical Services) and the student's parents/guardian.
- Contact student's health care provider.

INSULIN THERAPY

Insulin delivery device: ❑ syringe ❑ insulin pen ❑ insulin pump

Type of insulin therapy at school:

❑ Adjustable Insulin Therapy
❑ Fixed Insulin Therapy
❑ No insulin

Adjustable Insulin Therapy

- **Carbohydrate Coverage/Correction Dose:**
  Name of insulin: _____
- **Carbohydrate Coverage:**
  Insulin-to-Carbohydrate Ratio:
  Lunch: 1 unit of insulin per _____ grams of carbohydrate
  Snack: 1 unit of insulin per _____ grams of carbohydrate

Carbohydrate Dose Calculation Example

$$\frac{\textit{Grams of carbohydrate in meal}}{\textit{Insulin-to-carbohydrate ratio}} = \_\_\_\_\_ \text{ units of insulin}$$

- **Correction Dose:**

Blood Glucose Correction Factor/Insulin Sensitivity Factor = _____
Target blood glucose = _____ mg/dL

Correction Dose Calculation Example

$$\frac{\textit{Actual Blood Glucose–Target Blood Glucose}}{\textit{Blood Glucose Correction Factor/Insulin Sensitivity Factor}} = \_\_\_\_\_ \text{ units of insulin}$$

Correction dose scale (use instead of calculation above to determine insulin correction dose):

Blood glucose _____ to _____ mg/dL give _____units
Blood glucose _____ to _____ mg/dL give _____units
Blood glucose _____ to _____ mg/dL give _____units
Blood glucose _____ to _____ mg/dL give _____units

INSULIN THERAPY (Continued)

When to give insulin:

Lunch

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____mg/dL and ____ hours since last insulin dose.

☐ Other: _____

Snack

☐ No coverage for snack

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____mg/dL and ____ hours since last insulin dose.

☐ Other: _____

☐ Correction dose only:

For blood glucose greater than _____mg/dL AND at least _____ hours since last insulin dose.

☐ Other: _____

Fixed Insulin Therapy

Name of insulin: _____

☐ ____ Units of insulin given pre-lunch daily

☐ ____ Units of insulin given pre-snack daily

☐ Other: _____

Parental Authorization to Adjust Insulin Dose:

☐ Yes ☐ No Parents/guardian authorization should be obtained before administering a correction dose.

☐ Yes ☐ No Parents/guardian are authorized to increase or decrease correction dose scale within the following range: +/- _____ units of insulin.

☐ Yes ☐ No Parents/guardian are authorized to increase or decrease insulin-to-carbohydrate ratio within the following range: _____ units per prescribed grams of carbohydrate, +/- ___ grams of carbohydrate.

☐ Yes ☐ No Parents/guardian are authorized to increase or decrease fixed insulin dose within the following range: +/- _____ units of insulin.

INSULIN THERAPY (Continued)

Student's self-care insulin administration skills:

- ☐ Yes ☐ No Independently calculates and gives own injections
- ☐ Yes ☐ No May calculate/give own injections with supervision
- ☐ Yes ☐ No Requires school nurse or trained diabetes personnel to calculate/give injections

ADDITIONAL INFORMATION FOR STUDENT WITH INSULIN PUMP

Brand/Model of pump: _____ Type of insulin in pump: _____

Basal rates during school: _____

Type of infusion set: _____

☐ For blood glucose greater than _____ mg/dL that has not decreased within _____ hours after correction, consider pump failure or infusion site failure. Notify parents/guardian.

☐ For infusion site failure: Insert new infusion set and/or replace reservoir.

☐ For suspected pump failure: suspend or remove pump and give insulin by syringe or pen.

Physical Activity

May disconnect from pump for sports activities ☐ Yes ☐ No

Set a temporary basal rate ☐ Yes ☐ No _____% temporary basal for _____ hours

Suspend pump use ☐ Yes ☐ No

Student's self-care pump skills:	**Independent?**	
Count carbohydrates	☐ Yes	☐ No
Bolus correct amount for carbohydrates consumed	☐ Yes	☐ No
Calculate and administer correction bolus	☐ Yes	☐ No
Calculate and set basal profiles	☐ Yes	☐ No
Calculate and set temporary basal rate	☐ Yes	☐ No
Change batteries	☐ Yes	☐ No
Disconnect pump	☐ Yes	☐ No
Reconnect pump to infusion set	☐ Yes	☐ No
Prepare reservoir and tubing	☐ Yes	☐ No
Insert infusion set	☐ Yes	☐ No
Troubleshoot alarms and malfunctions	☐ Yes	☐ No

OTHER DIABETES MEDICATIONS

Name: _____ Dose: _____ Route: _____ Times given: ____
Name: _____ Dose: _____ Route: _____ Times given: ____

MEAL PLAN

Meal/Snack	Time	Carbohydrate Content (grams)
Breakfast	_____	_____ to_____
Mid-morning snack	_____	_____ to_____
Lunch	_____	_____ to_____
Mid-afternoon snack	_____	_____ to_____

Other times to give snacks and content/amount:_____

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

Special event/party food permitted: ☐ Parents/guardian discretion
☐ Student discretion

Student's self-care nutrition skills:

☐ Yes ☐ No Independently counts carbohydrates
☐ Yes ☐ No May count carbohydrates with supervision
☐ Yes ☐ No Requires school nurse/trained diabetes personnel to count carbohydrates

PHYSICAL ACTIVITY AND SPORTS

A quick-acting source of glucose such as ☐ glucose tabs and/or ☐ sugar-containing juice must be available at the site of physical education activities and sports.

Student should eat ☐ 15 grams ☐ 30 grams of carbohydrate ☐ other_____
☐ before ☐ every 30 minutes during ☐ after vigorous physical activity
☐ other _____

If most recent blood glucose is less than _____ mg/dL, student can participate in physical activity when blood glucose is corrected and above _____ mg/dL.

Avoid physical activity when blood glucose is greater than _____ mg/dL or if urine/blood ketones are moderate to large.

(Additional information for student on insulin pump is in the insulin section on page 6.)

DISASTER PLAN

To prepare for an unplanned disaster or emergency (72 HOURS), obtain emergency supply kit from parent/guardian.

☐ Continue to follow orders contained in this DMMP.

☐ Additional insulin orders as follows: _____

☐ Other: _____

SIGNATURES

This Diabetes Medical Management Plan has been approved by:

_____

Student's Physician/Health Care Provider Date

I, (parent/guardian:) _____ give permission to the school nurse or another qualified health care professional or trained diabetes personnel of (school:) _____ to perform and carry out the diabetes care tasks as outlined in (student:) _____'s Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified health care professional to contact my child's physician/health care provider.

_____

Acknowledged and received by:

_____

Student's Parent/Guardian Date

_____

Student's Parent/Guardian Date

_____

School Nurse/Other Qualified Health Care Personnel Date

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MEDICATION AUTHORIZATION FORM

STUDENT NAME _____ BIRTHDATE _____

ADDRESS _____ PHONE NUMBER _____

SCHOOL _____ GRADE _____

EMERGENCY CONTACT NAME AND PHONE NUMBER _____

I. TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN

I, _____, parent or guardian of _____ am primarily responsible for administering medication to my child. However, in a medical emergency or if necessary for the critical health and well-being of my child, I hereby authorize Steger School District 194, and its employees and agents, on my behalf and in my stead, to administer to my child or to allow my child to self-administer while under the supervision of the employees and agents of District 194, lawfully prescribed medication in the manner described below. I acknowledge that it may be necessary for the administration of medication to my child and treatment of my child's condition to be performed by an individual other than the school nurse and specifically consent to such practices. I will notify the school in writing if the medication is discontinued and will obtain a written order from the physician if the medication dosage or treatment is changed. I understand that this medication authorization is only effective for the _____ school year and will need to be renewed each subsequent school year.

I further acknowledge and agree that, when the lawfully prescribed medication is so administered, I waive any claims I might have against Steger School District 194, its employees and agents, arising out of the administration or self-administration of said medication, regardless of whether the authorization for self-administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice nurse. In addition, I agree to indemnify and hold harmless Steger School District 194, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration or self-administration of said medication, except a claim based on willful or wanton conduct, regardless of whether the authorization or self-administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice registered nurse.

Parent/Guardian Print Name _____ Date _____

Parent/Guardian Signature _____ Date _____

II. TO BE COMPLETED BY THE STUDENT'S LISCENSED PRESCRIBER

(Except for a Student Self-Administering Asthma Medication, see Section III Below)

Diagnosis: _____ Name of Medication: _____
Dosage: _____ Route of Administration: _____
Time/Circumstances when Medication Should be Administered: _____
Side Effects:_____
Date of Prescription: _____ Discontinuation Date: _____

TURN PAGE OVER & COMPLETE 2ND PAGE

Self-Administration of Epinephrine: _____Yes _____ No. The student listed above has a life threatening allergy that medically necessitates the immediate administration of epinephrine followed by emergency medical attention. I have determined that it is medically necessary for this child to carry an epinephrine auto-injector. The student has been instructed in the self-administration of the medication listed above and is capable of administering the medication independently. The student understands the need for the medication and the necessity to notify a staff member and the health office immediately following the self-administration of the epinephrine auto-injector.

Self-Administration of Diabetes Medication: _____ Yes _____ No. The student listed above has been diagnosed with diabetes. I have determined that it is medically necessary for this child to possess his/her diabetes medication and the equipment and supplies necessary to monitor and treat his/her diabetic condition pursuant to his/her Diabetes Care Plan. The student has been instructed in the self-administration of the medication listed above and use of his/her diabetes supplies and equipment and is capable of doing this independently. The student understands the need for the medication and the necessity of reporting to school personnel any unusual side effects.

I may be reached at the following phone number in the event of a reaction to the medication or an emergency.

_____	_____	
Phone Number of Physician	Signature of Physician	Date
_____	_____	
Address of Physician	Print Name of Physician	Date

III. FOR STUDENT SELF-ADMINISTERING ASTHMA MEDICATION ONLY

TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN

Diagnosis: _____ Name of Medication: _____

Dosage: _____ Route of Administration: _____

Time/Circumstances when Medication Should be Administered: _____

Side Effects: _____

Date of Prescription: _____ Discontinuation Date: _____

Self-Administration of Asthma Medication: _____Yes _____ No. My child has been diagnosed with asthma and has been prescribed asthma medication by a qualified health care professional. I hereby authorize my child to carry his/her asthma medication and to self-administer his/her medication as prescribed by his/her physician. My child's physician has instructed my child in the self-administration of his/her medication and has indicated that my child is capable of doing this independently. My child understands the need for the medication and the necessity of reporting to school personnel any unusual side effects. I have provided the school an extra supply of his/her medication with a prescription label for use in the event that he/she forgets to bring his/her asthma medication to school on a particular day.

Parent/Guardian Print Name _____ Date _____

Parent/Guardian Signature _____ Date _____