JACKSON COUNTY School District

"Raising the Standard"

DIABETES ACTION PLAN

(Editable document)

Directions:

1. **To input data, click on the first blank line, type in information**
2. **Use tab key to advance to the next field**
3. **Check mark fields, use tab to advance to field and use space bar to make check or click in the blank to make a check mark. To de-select an answer, click on the incorrect response to remove.**
4. **Yes/No fields are radio button fields to choose either Yes/No. Use tab to advance to the radio button field and use space bar to select either yes or no. Clicking in the appropriate field will make the selection as well. To de-select an answer, click on the incorrect response to remove.**
5. **When the first page of the form is completed by the parent, print and take to your physician to be completed. This editable form should be completed by the physician at http://www.jcsd.k12.ms.us/tech/onlinereg/diabetesplan.pdf , signed by the physician and parent, and submitted with other registration forms and proof of residency to the appropriate school during registration.**

Student Information: (Text fields, type appropriate response)

Name of student: _____ DOB: _____

Grade: _____ Classroom Teacher/1st Period Teacher: _____

Physical Education Days and Times: _____

Emergency Information:

Parent/Guardian Name: _____ Phone (H) _____

Address: _____ Phone (W) _____

Parent/Guardian Name: _____ Phone (H) _____

Address: _____ Phone (W) _____

Physician's name: _____Telephone: _____

In case of emergency, contact:

1. _____

2. _____

3. _____

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TO BE COMPLETED BY PHYSICIAN: (This is an editable form and may be accessed to be completed at http://www.jcsd.k12.ms.us/tech/onlinereg/diabetesform.pdf)

- **Target range of blood glucose:** _____
- **Specific dietary guidelines** (Text fields. Type appropriate response)
  Meal/snack times:
  Breakfast _____ A.M. snack _____ Lunch _____
  P.M. Snack _____ Dinner _____ Bed _____
- **Blood glucose testing at school (**Radio Button fields, Choose appropriate response)

  This student is able to test his/her own blood glucose? ◯ Yes ◯ No

  Adult supervision required? ◯ Yes ◯ No

  Method to be used (type in answer)

  Type of meter _____

  Test strip required _____

  Routine testing times at school ☐ AM ☐ Noon ☐ PM
  (Check Mark fields above. Choose appropriate response)

  Supplemental testing times: (Check mark fields below. Choose all that apply)

  ☐ before exercise ☐ after exercise

  ☐ before snacks ☐ with symptoms of high/low blood glucose

  Other (type in additional times): _____

- **Insulin at school**

  ☐ not at all ☐ routine lunchtime dose ☐ correction lunchtime dose
  (Check Mark fields. Choose appropriate response)

  If insulin is required at school:

  Brand name and type (type in appropriate response): _____

  _____

TO BE COMPLETED BY PHYSICIAN (Continued):

- **Dose preparation by:** **Form used:**
  (Check mark fields. Choose the appropriate response.)

  ☐ Student ☐ Pre-filled syringe
  ☐ Parent ☐ Insulin pen
  ☐ Parent designee ☐ Insulin pump
  ☐ Licensed nurse

- **Number of SQ or insulin pump units determined by**: (Check mark fields. Choose the appropriate response)

  ☐ Student ☐ Licensed nurse ☐ Parent (telephone request acceptable)

- **Written sliding scale as follows:** (Text fields. Type in the appropriate response)

  Blood glucose from _____ mg/dl to _____ mg/dl = _____ units of insulin

  Blood glucose from _____ mg/dl to _____ mg/dl = _____ units of insulin

  Blood glucose from _____ mg/dl to _____ mg/dl = _____ units of insulin

  Blood glucose from _____ mg/dl to _____ mg/dl = _____ units of insulin

- **SQ or insulin pump insulin administered by**: (Check mark fields. Choose the appropriate response)

  ☐ Student ☐ Parent
  ☐ Parent designee ☐ Licensed nurse
  ☐ Student with staff verification of the number of prescribed insulin units

(all parent designees are trained by the parent and are not employees of the school or district)

TO BE COMPLETED BY PHYSICIAN (Continued):

- **Specific sports/exercise guidelines:** (Radio Button, Check Mark, and Text Fields. Choose or type the appropriate response)

  1. This student may participate in daily PE? ◯ Yes ◯ No
  2. After school sports? ◯ Yes ◯ No
  3. Activity restrictions: ☐ None ☐ Other _____
  4. Exercise should be delayed or avoided if blood glucose is higher than _____ mg/dl or lower than _____mg/dl.

- **Treatment of <u>LOW BLOOD GLUCOSE</u>:** (See signs & symptoms of low blood glucose) Low blood glucose must be treated immediately. An adult must stay with student until all signs and/or symptoms of low blood glucose are gone and blood glucose is 70mg/dl or higher.

  THIS IS AN EMERGENCY. IMMEDIATE TREATMENT IS NEEDED.

  This student's blood sugar is considered low if _____ mg/dl or lower. (Type the appropriate response)

  If the student is **<u>conscious</u>** and able to swallow give one of the following: (Type the appropriate response)

ITEM	AMOUNT
_____	_____
_____	_____

  If the student is **<u>less co-operative</u>** then give one of the following: (Type the appropriate Response)

ITEM	AMOUNT	ROUTE
_____	_____	_____
_____	_____	_____

  If student **<u>begins to lose consciousness</u>** or is having a seizure, school authorities will call 911 and parents immediately.

TO BE COMPLETED BY PHYSICIAN (Continued):

- **Treatment of HIGH BLOOD GLUCOSE** (See signs & symptoms of high blood glucose)
  (Text, Radio Button, and Check Mark fields. Choose or type the appropriate response)

  1. The student is hyperglycemic if blood glucose is above _____ mg/dl.
  2. Are urine ketones to be check at school? ◯ Yes ◯ No
  3. Check urine ketones if glucose is above _____ mg/dl

     ☐ by student independently

     ☐ with assist.

     Notify parents or physician if ketones are positive or when _____

     _____
  4. Additional actions to be taken: (see insulin at school section)

     _____

     _____.

- **In the event of field trips**, all diabetic supplies are taken and care is provided according to the Action Plan (a copy is taken on trip)

- **In the event of classroom/school parties**, food treats will be handled as follows:
  The teacher will replace with parent supplied alternative.

- **3 day disaster diabetes supplies are recommended:**
  (School only response: Supplies that are provided by parents/guardians)

  ☐ vial of insulin, 6 syringes
  ☐ Glucagon kit
  ☐ insulin pen with cartridge and needles
  ☐ ketone strips/plastic cup
  ☐ glucose gel product and glucose tablets
  ☐ snack supply
  ☐ blood glucose testing kit (testing strips lancing device with lancets)

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PARENT CONSENT FOR DIABETES MANAGEMENT IN SCHOOL

The undersigned parent/guardian of the above-named student request that the specialized physical health care service for management of diabetes in school is administered to student. Parent will provide the necessary supplies and equipment, notify school if there is a change in student health status or attending physician and notify the school nurse immediately and provide new consent for any changes in doctor's orders. I authorize the school nurse to communicate with the physician when necessary.

Parent/Guardian Signature _____Date _____

PHYSICIAN CONSENT FOR DIABETES MANAGEMENT IN SCHOOL

My signature below provides authorization for the above written orders. I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision of the school nurse. The authorization is for maximum of one year.

Physician Signature _____ Date _____

Reviewed by School Nurse _____ Date _____

This form should be completed by the physician, signed by the physician and parent, and submitted with other registration forms and proof of residency at the appropriate school during Jackson County School District registration or as soon as possible.

The signed form may be mailed or faxed to your childs school. Please contact the school for address or fax number.