YOUR STUDENT'S DIABETES CARE IN THE SCHOOL SETTING

April 2022

Dear Parents/Guardians,

This packet includes the forms needed for Elizabeth School District personnel to manage your student's diabetes in the school setting. This packet includes the following forms:

1. **Please provide *ONE* of the following:**

- Provider Orders for Students on Injections and/or Oral Medications (to be complete by a medical provider)
- Provider Orders for Students on Insulin Pumps (to be complete by a medical provider)
- If your student is seen at Barbara Davis, they provide their own paperwork for schools (to be completed by a medical provider)

2. **Individualized Health Care Plan: Diabetes in the School Setting** (completed out by parent) – This helps us to better care for your student with diabetes. We would like to know if your student has a pump, CGM, when blood glucose is checked throughout the day, where supplies are kept for secondary students, if your student is able to participate in class parties etc. In addition, the Emergency Action Plan provides school personnel instructions so that they may intervene during an emergency.

   Please Note: The Emergency Action Plan is now part of the Individualized Health Care Plan**.** If not completed by a parent, the district nurse will complete it based on your student's medical provider orders and the most current "Standards of Care for Diabetes Management in the School Setting**"**

If you and your student's medical provider believe your **middle or high school student** is able to independently manage his/her own diabetes at school, please also provide the form below:

3. **Diabetes Self-Management Agreement** (to be completed by parent & student))

If your student is managing his/her diabetes independently, it is **strongly recommended** that your student have rapid sugar sources (juice, glucose tabs, cake frosting, candy etc.), extra supplies, and **GLUCAGON** in the school health office.

Please submit all forms to your student's school health office before the start of school.

Please note that these forms are need to be renewed yearly. If your student's care changes, revised provider orders (See number 1) will need to be provided.

If you have questions, please feel free to contact the Health Technician at your student's school or the District Nurse (303-646-6730)

Sincerely,

Lori Clark RN/BSN Elizabeth School District Nurse

Health Care Provider Orders for Student with Diabetes on Injections/Oral Medication

To be completed by the Health Care Provider and used in conjunction with the Standards of Care for Diabetes Management in the School Setting – Colorado
www.coloradokidswithdiabetes.org

Student:	DOB:	School:	Grade:
Physician/Provider:		Phone:	
Diabetes Educator:		Phone:	

TARGET RANGE – Blood Glucose:	**mg/dl TO mg/dl**			
☐< 5y.o. 80-200mg/dl	☐ 5 – 8 y.o 80-200mg/dl	☐ 9-11y.o 70-180mg/dl	☐ 12-18y.o. 70-150mg/dl	☐ >18y.o. 70-130mg/dl
Notification to Parents: Low < *target range* and High > 300 mg/dl or ***Other:*** less than____ **mg/dl** and			greater than: ____ **mg/dl**	
☐ Continuous glucose monitoring Type: _____ *Follow* ***Collaborative Guidelines for CGM/iCGM*** **(www.coloradokidswithdiabetes.org)**				

Hypoglycemia: Follow *Standards of Care for Diabetes Management in the School Setting – Colorado*, unless otherwise indicated here:

____

For *Severe Symptoms:* Call 911 & Administer: ☐**Glucagon Injection Dose:** **mg Intramuscular in**
OR ☐BAQSIMI nasal spray 1 device (3mg) in one nostril

Hyperglycemia: Follow *Standards of Care for Diabetes Management in the School Setting – Colorado*, unless otherwise indicated here:

____

Ketone Testing: *per Standards of Care for Diabetes Management in the School Setting – Colorado* OR Other: | Other:

When to Check Blood Glucose: *For provision of student safety while limiting disruption to learning*
✓**Always for signs & symptoms of low/high blood glucose, when does not feel well and/or behavior concerns**
✓**Check before meals and as mutually agreed upon by parent and school nurse**
☐ **Other:**

Blood Glucose Correction & Insulin Dosage using Rapid Acting/Short Acting Insulin Type: *Injections should be given subcutaneously & rotated*

Lunchtime Correction: Give ☐ Prior to lunch ☐ Immediately after lunch ☐ Split ½ before lunch & ½ after lunch ☐ Other :

☐**Insulin** Dosing Attached

☐**Sensitivity/Correction Factor:** ____ unit insulin for every ____ mg/dl above _____ starting at ____ mg/dl

Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer:	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer:	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer:	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer:	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer:	**units**	☐ Check ketones
Blood Glucose Range:	**mg/dl to**	**mg/dl**	Administer:	**units**	☐ Check ketones

☐ Parent/guardian authorized to increase or decrease sliding scale +/- 2 units of insulin per *Standards of Care for Diabetes Management in the School Setting – Colorado*

When hyperglycemia occurs other than at lunchtime:
☐ If it has been greater than **3 hours** since the last dose of insulin, the student may be given insulin via injection using the indicated correction factor on the provider orders **if approved by the school nurse and parent is notified.**
☐ **Con**tact Health Care Provider for One-time order

Carbohydrates and Insulin Dosage: ☐ **Breakfast** ☐**Snack** ☐**Lunch** ☐**Other:**
(To be given in conjunction with the correction dose as indicated)

Insulin to Carbohydrate Ratio: _____**unit(s)** for every _____ **grams** of carbohydrate to be eaten ☐Dosing Attached

☐ Parent/guardian authorized to increase or decrease insulin to carb ratio 1 unit +/- 5 grams of carbohydrates

☐ **Oral Medication:** ____ ____ mg Time: ____

☐ **NPH Insulin** Dose: ____units SQ Time: ____

Student's Self Care: ☐No supervision ☐Full supervision, ☐Requires some supervision: ability level to be determined by school nurse and parent unless otherwise indicated here:

Additional Information:

Signatures: My signature below provides authorization for the written orders above and exchange of health information to assist the school nurse an Individualized Health Plan. I understand that all procedures will be implemented in accordance with state laws and regulations and may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This order is for a maximum of one year.

Physician: _____ Date: _____

Parent: _____ Date: _____

School Nurse: _____ Date: _____

Health Care Provider Orders for Student with Diabetes on Insulin Pump

To be completed by the Health Care Provider and used in conjunction with the Standards of Care for Diabetes Management in the School Setting
www.coloradokidswithdiabetes.org

Student:	DOB:	School:	Grade:
Physician/Provider:			Phone:
Diabetes Educator:			Phone:

TARGET RANGE – Blood Glucose:	**mg/dl TO mg/dl**			
☐< 5y.o. 80-200mg/dl	☐ 5 – 8 y.o 80-200mg/dl	☐ 9-11y.o 70-180mg/dl	☐ 12-18y.o. 70-150mg/dl	☐ >18y.o. 70-130mg/dl
Notification to Parents: Low < *target range* and High > 300 mg/dl or ***Other:*** less than____ **mg/dl** and			greater than:____ **mg/dl**	
☐ Continuous glucose monitoring Type: _____ *Follow* ***Collaborative*** **Guidelines for CGM/iCGM (www.coloradokidswithdiabetes.org)**				

Hypoglycemia: Follow *Standards of Care for Diabetes Management in the School Setting – Colorado*, unless otherwise indicated here:
____

For *Severe Symptoms:* Call 911, Disconnect Pump, Administer: ☐**Glucagon Injection Dose:** **mg Intramuscular in**
OR ☐BAQSIMI nasal spray 1 device (3mg) in one nostril

Hyperglycemia: Follow *Standards of Care for Diabetes Management in the School Setting – Colorado*, unless otherwise indicated here:
____

Ketone Testing: *per Standards of Care for Diabetes Management in the School Setting – Colorado* OR Other:

When to Check Blood Glucose: *For provision of student safety while limiting disruption to learning*
✓**Check always for signs & symptoms of low/high blood glucose, when does not feel well and/or behavior concerns**
✓**Check before meals and as mutually agreed upon by parent and school nurse**
☐ **Other:**

Insulin Pump: *Follow Standards of Care for Diabetes Management in the School Setting – Colorado.* Pump settings are established by the student's healthcare provider and should not be changed by the school staff. All setting changes to be made at home or by student providing self care as indicated on IHP.

- Internal safety features for the insulin pump should be active at all times while the student is at school - (Alarms set conservatively).

Insulin Pump Brand: ____	Type of Insulin in pump____
Correction Bolus: Provide Correction bolus per pump calculator. All BG levels should be entered into the pump for administration of pump-calculated corrections unless otherwise indicated on the provider orders.	
☐**Sensitivity/Correction Factor:**	____ unit insulin for every ____mg/dl above target BG range starting at ____**mg/dl**
☐ **Insulin**Dosing Attached	
☐ If blood glucose is ***less than*** ___ ***mg/dl,*** wait to give meal bolus until after meal. Other: ____	

When Hyperglycemia occurs other than at lunchtime:
☐ If it has been greater than **3 hours** since the last dose of insulin, the student may be given insulin via injection using the indicated correction factor on the provider orders **if approved by the school nurse and parent is notified.**
☐ **Con**tact Health Care Provider for One-time order

Carbohydrates and Insulin Dosage per pump: ☐ **Breakfast** ☐**Snack** ☐**Lunch** ☐**Other:** ☐ **Insulin** Dosing Attached
Insulin to Carbohydrate Ratio: _____**unit(s)** for every _____ **grams** of carbohydrate to be eaten
Bolus for carbohydrates should occur immediately ☐ Prior to lunch/snack ☐After lunch/snack ☐ Split ½ before lunch & ½ after lunch ☐ Other: _____
☐ Parent/guardian authorized to increase or decrease insulin to carb ratio 1 unit +/- 5 grams of carbohydrates

Pump Malfunctions: Disconnect pump when malfunctioning
If pump calculator is operational then the insulin dosing should be calculated by using the pump bolus calculator and then insulin given by injection
If pump calculator is not operational: ☐ School Nurse or Parent to give insulin according to Insulin to Carbohydrate Ratio and/or Correction Factor
☐ Call Parent and Health Care Provider (for orders)

Student's Self Care: ☐No supervision ☐Full supervision, ☐Requires some supervision: ability level to be determined by school nurse and parent unless otherwise indicated here:

Additional Information:

Signatures: My signature below provides authorization for the written orders above and exchange of health information to assist the school nurse an Individualized Health Plan. I understand that all procedures will be implemented in accordance with state laws and regulations and may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This order is for a maximum of one year.

Physician: _____ Date: _____
Parent: _____ Date: _____
School Nurse: _____ Date: _____

Individualized Health Plan: Diabetes in School Setting

Student Name: **Birthday:** **Grade**

HCP orders: No* ☐ Yes: ☐ & Date of orders: Date of Plan:

* If no Provider orders only Emergency Care can be provided please include Emergency care plan on page 2 and 3..

Family and Emergency Contact Information:
Parent/Guardian: Preferred Contact Info:
Parent/Guardian: Preferred Contact Info:

Physician: **Work#:**
School Nurse: **Work #:**
Diabetes Resource Nurse: **Contact Info:**

**May attach photo for identification if needed* (May print summary sheet from student electronic record)*
Health Concern: Type 1 Diabetes: ☐ Type 2 Diabetes: ☐ Other: ☐ Date of Diagnosis:

Target Range: mg/dl to mg/dl
Notify Parents if values below **mg/dl or above** **mg/dl**

Addendums: Medication Insulin Plan ☐ Self-Management Agreement ☐ Pump Addendum ☐ CGM Addendum ☐

Medications: Insulin type:
Delivery Device: Pen ☐ Syringe & vial ☐ InPen ☐ **Pump Brand and Model:**

Student's Self Care: *(Ability level to be determined by School Nurse and Parent with input from Provider)*

- Self- Managed: NO: ☐ YES: ☐ *
  If Yes attach required *Agreement for Student's Self- Management and include Emergency Action Plan

Student's Self Care *(ability level to be determined by School Nurse and Parent with input from Health Care Provider.)*

- Supervised Care: Trained personnel must perform diabetes care: YES ☐ NO ☐
- Trained Personnel must supervise insulin administration and BG monitoring: YES ☐ NO ☐
- Student can administer insulin: YES ☐ NO ☐

Required Glucose Monitoring at School:

- Student can carry supplies and test where needed and when needed ☐
- **Blood Glucose Meter:** Yes ☐ No ☐
  Preferred place to check Blood Glucose: Health room ☐ Classroom ☐ Other:
- **Continuous Glucose Monitor:** Yes ☐ Model: No ☐
  CGM alarms set for BG/BS Low: __mg/dl High BG/BS: ___ mg/dl

When to Check Blood Glucose:
As needed for signs/symptoms of low/high blood glucose and/or student does not feel well ☐
Before School Program: ☐ Before Snack: ☐ Mid-morning: ☐ After School Program/Activity: ☐
Before Lunch: ☐ Before Recess: ☐ Before PE: ☐ After PE: ☐ School Dismissal ☐
Other:
Anytime symptoms don't match CGM value do fingerstick for BG. ☐

Supporting Students with Diabetes:

1. Student is allowed to test blood glucose as needed anywhere in the school setting
2. Student may self-carry fast acting sugar source as well as store fast acting sugar source in the classroom
3. Student with diabetes who ride the bus should always carry a fast-acting sugar source
4. Student will be allowed to carry a water bottle and have unrestricted bathroom privileges.
5. Substitute teachers will be aware of the student's health concerns and necessary interventions
6. Student is allowed access to cell phone at all times when utilized for diabetes care.

Student Name: **Birthday** **Grade**

Emergency Medication: *For Severe Hypoglycemia

- Glucagon Dosage mg **INTRAMUSCULAR** injection
- Gvoke Dosage mg Route **Subcutaneous** Prefilled syringe: Arm ☐ Thigh ☐ Abdomen ☐
- Nasal Glucagon (Baqsimi) Dosage 3mg Intranasal ☐
- **If none then call 911 and if given call 911**

LOW Blood Sugar (Hypoglycemia) Management

If Symptoms – Take Action: Check blood glucose/sensor glucose if possible. Treat if below mg/dl

- Always treat if in doubt or if blood sugar is unavailable.
- Never leave unattended.
- Always send to clinic accompanied by responsible person.
- Check BG/SG when CGM alarms or when student is symptomatic.
- If blood glucose/sensor glucose in range but student symptomatic, may contact parent or provide a **solid carb snack** (cheese and crackers, ½ granola bar).
- With insulin pump, DO NOT enter carbs for fast acting sugar used to treat low.

MILD SYMPTOMS: Hunger, shaky irritable, dizzy, anxious, sweating, crying, pale, spacey, tired, drowsy, personality change, other:

Mild Treatment:

- **Treat** by giving up to grams of fast acting sugar such as **Glucose Tabs**, **Juice Box/Capri Pouch**, regular soda, 2-3 Smarties candy rolls.
- Wait 10-15 minutes, child should be observed during this time.
- Recheck BG/SG.
- **Retreat** if BG/SG still under mg/dl or if symptoms persist.
- Once BG/SG mg/dl or higher, provide a up to a **15 gram** (or gram per parent) **solid carb snack** OR escort to lunch if lunchtime.
- **Lows MUST be treated before student goes to lunch.**
- Dose for lunch carbs after eating lunch.
- Notify Parent and RN.

MODERATE SYMPTOMS Confusion, Slurred speech, Poor coordination, Behavior changes, Unable to focus to eat or drink

Moderate Treatment:

- **Treat** with Glucose Gel or Icing keeping head elevated, squeeze gel between cheek and gums, encourage child to swallow.
- Wait 10-15 minutes; child should be observed during this time.
- **Recheck** BG/SG and if below mg/dl and symptoms persist, retreat until BG/SG above mg/dl.
- Once BG/SG mg/dl or higher, provide a **10-15 gram** (or per parent **solid carb snack** OR escort student to lunch if lunchtime.
- **Lows MUST be treated before student goes to lunch.**
- Dose for lunch carbs after eating lunch.
- Notify Parent and RN.

SEVERE SYMPTOMS Seizure, Loss of consciousness

Severe Low Treatment:

- **Administer Emergency medication/Call 911**
- Position student on side.
- Disconnect pump or peel off insertion site like a band-aid.
- If trained / delegated staff available: Administer

Emergency Medication

- Stay with student until 911 arrives
- Once student responds to glucagon and able to sit up, treat with glucose gel. When fully alert offer sips of juice.
- Notify Parent and RN.

High Blood Glucose (Hyperglycemia) Management

Student Name: **Birthday** **Grade**

If Symptoms – Take Action: Check blood/sensor glucose; if above or > mg/dl

- Encourage to drink water
- Contact parent/guardian
- Allow access to water and restrooms
- Other:

MILD SYMPTOMS

Thirst, headache, abdominal discomfort, nausea, increased urination and/or lethargy.

Treatment:

- Encourage to drink water or diet pop (caffeine free): 1 ounce water/year of age/per hour
- When hyperglycemia occurs other than lunchtime – contact school nurse and parent to determine correction procedure per provider orders or one-time orders.
- Provide blood/sensor glucose correction as indicated in provider orders or per pump.
- ***Recheck in 2 hours for students on pump.***
- **Reminder:** Students taking insulin injections should not be given a correction dosage more than every 3 hours unless directed by provider orders.
- Note: If on a pump insulin may need to be given by injection contact school nurse and parent.

See Standards of Care.

Access Standards of Care for Diabetes Management in the School Setting and Contact School Nurse

Hyperglycemia:

If Blood/Sensor Glucose is over > **twice** in a row and greater than 2 hours apart:

- **Check** urine/blood ketones - if **moderate to large or if blood ketones are greater than 1.0 mmol, call parent & school nurse immediately!**
- **If student has labored breathing, change in mental status and/or may be dehydrated- call 911**

Contact the school nurse for Exercise Restrictions and School Attendance per Standards.

(Reference: STANDARDS OF CARE FOR DIABETES MANAGEMENT IN THE SCHOOL SETTING for more information - www.coloradokidswithdiabetes.org

*If student has moderate to large ketones or blood ketones ≥ 1.0 mmol **and** student has labored breathing, change in mental status or may be dehydrated - **call 911**.

Additional Information

Student Name: **Birthday** **Grade**

Student's Schedule:				
Lunch:	PE:	Recess:	Snack: AM	PM
Location of snacks:		Location Eaten:		

Exercise and Sports:	
Check BG/SG prior to activity Yes ☐ No ☐ Snack prior to PE ☐ only if BG/SG < Snack prior to Recess ☐ only if BG/SG < Snack after Recess ☐	#Snack Carbohydrates:

Class School Parties or Events with Food: *(Check all that apply)*

In the event of a Class Party – may eat the treat and insulin dosage per Provider Orders ☐
Student able to determine whether to eat the treat ☐
Replace with parent supplied treat ☐ May NOT eat the treat ☐
Contact Parent Prior to event for instructions ☐

Classroom Emergency Preparedness:

Snack/Water in specials classrooms (provided by parent) ex: art, computer lab, library, music etc

Standardized Academic Testing Procedures:

*504/IEP Form on File: Yes ☐ No ☐

- School Staff to notify Parents and School Nurse of upcoming standardized testing in order to create a plan for Blood Glucose monitoring.

*Acceptable Standardized Testing BG/SG range without symptoms:

FIELD TRIP INFORMATION AND SPECIAL EVENTS:

- Notify parent and school nurse in advance so proper training can be accomplished
- Adult staff must be trained and responsible for student's needs on field trip
- Extra snacks BG meter, copy of health plan, glucagon, insulin & emergency supplies must accompany student on field trip if at school.
- Adult (s) accompanying student on a field trip will be notified of student's health accommodations on a need to know basis

In general, there are no restrictions on activity except in these cases:
Student should not exercise if blood glucose is >300 and ketones are > small, or until hypoglycemia/hyperglycemia is resolved.
Reference *Standards of Care and Notify School Nurse*

A source of fast-acting glucose & glucagon should be available in case of hypoglycemia.
Special instructions: Click or tap here to enter text.

Staff Trained	**Monitor BG/SG & treat hypo/hyperglycemia**	**Give Insulin**	**Give Glucagon**
Name	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Name	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Name	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Name	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Further Instructions:

Student Name: **Birthday** **Grade**

I understand that:

- Medication orders are valid for this school year only and need to be renewed at the beginning of each school year.
- New Physician Orders are needed when there are any changes in the care orders. (e.g. at quarterly clinic visits)
- Medication orders will become part of my child's permanent school health record.
- Medications must be in original container and labeled to match physician's order for school use including field trips.
- I have the responsibility for notifying the school nurse of any changes in Medication or care orders.
- I give permission to the school nurse to share information with appropriate school staff relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.
- I give permission to the school nurse to contact the above health care provider for information relevant to the prescribed medication administration, provider orders, and related student health information appropriate for my child's health and safety.
- I give my permission to the school nurse and designated staff to perform and carry out the diabetes tasks as outlined in this Individualized Health Plan (IHP).
- I understand that the information contained in this plan will be shared with school staff on a need-to-know basis.
- Parent/Guardian & student are responsible for maintaining necessary supplies, snacks, blood glucose meter, medications and other equipment.

Parent Name:	Parent Signature:	Date:
School Nurse:	School Nurse Signature:	Date:

Nursing Care Services:

ICD-10 Code:

Specific Task: *(Example BG testing, administering insulin, treatment of hypoglycemia/hyperglycemia)*

Scope: (*What is the related service that is needed for the student?)*

Duration: *(How long does the service take? (minute or hours/per instance)*

Frequency: *(How many times does it need to be done per day or is the service as needed)*

Elizabeth SCHOOL DISTRICT

DIABETES SELF-MANAGEMENT AGREEMENT

20___ - 20___

Student Name: _____ DOB: _____ School:_____

STUDENT: (Please initial each statement after reading)

____ I agree to dispose of sharps either by keeping them in my kit and disposing of them at home or placing them in the sharps container at school.

____ I will notify the school health office if my blood sugar is below ____mg/dl or above ____mg/dl.

____ I plan to keep my diabetic supplies: ____ with me ____ in the school health office.

____ I understand that the freedom to manage my diabetes independently is a privilege, and I agree to abide by this agreement.

_____ _____
Student Signature Date

PARENT/GUARDIAN: (Please initial each statement after reading)

____ I agree to provide my child's healthcare provider's orders to the school health office.

____ I agree that my child is able to self-manage his/her diabetes and can recognize when to seek help from a staff member.

____ My child has been instructed in and understands his/her diabetic self-management.

____ My child's healthcare provider has confirmed that he/she is able to independently manage his/her own diabetes care.

____ I am aware that it is strongly recommended that back-up supplies be provided to the health office for emergencies.

____ I understand that this agreement is in effect for the current school year.

____ I understand that the district or school nurse may impose reasonable limitations or restrictions on my child's possession and self- administration of diabetic medications relative to his/her age, maturity level, and other relevant considerations.

____ I understand that the school administration may revoke permission to possess and self-administer diabetes medication at school at any point during the school year if it is determined that my child has abused the privilege to self-manage their diabetes care or is not safely and effectively managing their care.

____ I give permission for the district or school nurse or designee to contact my child's healthcare provider regarding my child's diabetes care at school.

____ I agree to exempt and release the Elizabeth School District, its directors, officers, employees, volunteers, and agents from any and all liability, claims, demands or actions arising out of any damage, loss, or injury that my child or I/we sustain arising out of my child's self-management of his or her diabetes.

_____ _____
Parent/Guardian Signature Date

_____ _____
District Nurse Signature Date