# Little Chute Area School District
# Health Services
# DIABETES

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**The district will accept diabetic plans issued by the child's medical provider, such as the Children's Hospital of Wisconsin Diabetes Management Plan.**

## STUDENT INFORMATION

| | | |
|---|---|---|
| **STUDENTS NAME**: | **DOB**: | **GRADE:** |
| **SCHOOL ATTENDING**: | **BUS STUDENT**: *YES* *NO* | |

## DIABETES INFORMATION

**MARK THE TYPE OF DIABETES:**

☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Other: _____

**DOES YOUR CHILD WEAR A CGM DEVICE AT SCHOOL?**

☐ Yes - What type?_____ ☐ No

**DOES YOUR CHILD USE INSULIN AT SCHOOL?**

☐ Yes ☐ No

**IF YES, MARK THE TYPE OF INSULIN:**

☐ Pen ☐ Syringe ☐ Medtronic 670/770G
☐ Omnipod ☐ Omnipod DASH ☐ Omnipod 5
☐ Tanden (Control IQ) ☐ Tandem (Basal IQ) ☐ Other: _____

**IS YOUR CHILD ABLE TO MANAGE THEIR DIABETES INDEPENDENTLY?**

☐ Yes ☐ No

**DOES YOUR CHILD GIVE THEIR OWN INSULIN INJECTION?**

☐ Yes ☐ No

**MARK THE MEALS YOUR CHILD RECEIVES AT SCHOOL:**

☐ Breakfast ☐ Lunch

**DOES YOUR CHILD HAVE SNACKS AT SCHOOL?**

☐ Yes ☐ No

**DOES YOUR CHILD DOSE INSULIN BEFORE OR AFTER EATING MEALS OR SNACKS?**

☐ Yes ☐ No

## SCHOOL MEDICATION DOSAGE INFORMATION

### *INSULIN DOSING FOR MDI ONLY (INSULIN PEN OR SYRINGE):*

**MARK HOW TO DETERMINE A DOSE AT MEALTIME:** ☐ Blueloop ☐ Dosing Chart ☐ Calculation at a meal

**COMPLETE THIS SECTION ONLY FOR DOSE CALCULATIONS AT A MEAL:**

**BREAKFAST:** 1.0 unit for _____ grams **AM SNACK:** 1.0 unit for _____ grams

**LUNCH:** 1.0 unit for _____ grams **PM SNACK:** 1.0 unit for _____ grams

**What blood sugar level at a meal do you give extra insulin?** Over _____ mg/dL

**ABOVE WHAT BLOOD SUGAR LEVEL SHOULD A CORRECTION DOSE OF INSULIN BE GIVEN AT NON-MEALTIME AT SCHOOL?** _____ MG/DL

**HOW DO YOU DETERMINE THE AMOUNT?**

☐ Calculated correction dose ☐ First column of dose chart ☐ Blueloop

**MARK ANY OF THE FOLLOWING SKILLS YOUR CHILD CAN DO:**

☐ No skills
☐ Calculate insulin dose
☐ Set up own pen or syringe
☐ Count carbohydrates

### *INSULIN DOSING ORDERS FOR INSULIN PUMPS ONLY:*

**ABOVE WHAT BLOOD SUGAR LEVEL SHOULD A CORRECTION DOSE OF INSULIN BE GIVEN AT NON-MEALTIME AT SCHOOL?** _____ MG/DL

**MARK ANY OF THE FOLLOWING SKILLS YOUR CHILD CAN DO:**

☐ No skills
☐ Bolus correct amount
☐ Insert new set Disconnect pump
☐ Perform temp basal starts activity/exercise mode
☐ For pump failure: Draw up insulin and inject
☐ Change infusion set/prepare reservoir tubing
☐ Count carbohydrates
☐ Reconnect pump
☐ Troubleshoot alarms

☐ ***Disconnect for:*** ☐ Vigorous sports ☐ Showers ☐ Other:

## TREATMENT PLAN

### *TREATMENT OF LOW BLOOD SUGAR:*

**CHECKING BLOOD SUGAR:**

- Treat blood sugar if under _____ mg/dL or if using GMC, if the sensor reads “LO” without a glucose meter.
- Give _____ grams of fast-acting carbohydrates.
- Recheck blood sugar in 15 minutes.
- If blood sugar is still under _____ mg/dL, give another _____ grams of fast-acting carbs.
- Repeat until blood sugar is above desired treatment amount.

**GLUCAGON ADMINISTRATION:**

☐ Administer Glucagon if student is: confused/unable to follow commands, unable to swallow, unable to awaken (unconscious), or having seizure or convulsion.

***Glucagon Dose:*** ☐ 0.5 mg ☐ 1.0 mg

If student uses an insulin pump and exhibits symptoms of severe low blood glucose, in addition to giving Glucagon:

☐ Disconnect tubing from students ☐ Suspend insulin pump ☐ Other:_____

## *TREATMENT OF HIGH BLOOD SUGAR:*

**CHECKING BLOOD SUGAR *(Check all that apply)*:**

- ☐ Provide correction/supplemental dose of insulin as listed above
- ☐ If blood glucose is _____ mg/dL and it has been greater than 2 hours since last meal, check urine ketones
- ☐ Blood glucose >/= _____ mg/dL without ketones recheck blood level in 2 hours
- ☐ Blood glucose >/= _____ mg/dL with ketones (***check below***)

***Trace/Small Procedure:***

- ☐ Allow free bathroom access
- ☐ Recheck blood glucose level in 2 hours
- ☐ Other: _____
- ☐ Encourage water and/or other sugar-free fluids
- ☐ Recheck ketones in 2 hours

***Moderate/Large Procedure:***

- ☐ Allow free bathroom access
- ☐ Call parents/guardians
- ☐ Other: _____
- ☐ Encourage water and/or other sugar-free fluids
- ☐ Arrange for students to be taken home and/or see their healthcare provider.

## AUTHORIZATION

### *PARENT/GUARDIAN MEDICATION CONSENT*

I hereby give permission to designated trained school personnel to give medications to my child during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed. I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medication(s) administration and possible adverse effects of the medication. I further agree to hold the Little Chute Area School District and LCASD employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school. I agree to notify the school at the termination of this request or when any changes in the above orders are necessary.

I understand, as the parent/guardian, I am responsible to assure that backup rescue medication is available to my child after school hours and traveling to/from and during school-sponsored events. Students' health information is shared via emails, copies of health plans and/or staff meetings with grade level teachers, coaches, bus companies, office staff and other pertinent LCASD staff.

**By signing below you agree you have reviewed this health plan for your child and that the health plan is correct and/or you have made the appropriate changes on this form to make the plan correct.**

| | |
|---|---|
| **EMERGENCY CONTACT:** | **RELATIONSHIP TO STUDENT:** |
| **(H) PHONE:** | **(C) PHONE:** |
| **PARENT/GUARDIAN SIGNATURE:** | **DATE:** |
| **PHYSICIANS NAME:** | **PHONE:** |
| **PHYSICIAN SIGNATURE:** | **DATE:** |

**Principal's Initials:** _____ **Date:** _____