

**CARE PLAN FOR A STUDENT WITH DIABETES**

NORRIS PUBLIC SCHOOLS  
25211 S. 68<sup>TH</sup>  
FIRTH, NE 68358

THIS PLAN IS FOR THE SCHOOL  
YEAR FROM \_\_\_\_\_ TO  
\_\_\_\_\_.

**STUDENT'S NAME:** \_\_\_\_\_ Current Grade \_\_\_\_\_

Parent's Phone Number: Home) \_\_\_\_\_ Work) \_\_\_\_\_ Cell) ) \_\_\_\_\_

Physician: \_\_\_\_\_ PH \_\_\_\_\_ FAX \_\_\_\_\_

Diabetic Nurse: \_\_\_\_\_ PH \_\_\_\_\_ FAX \_\_\_\_\_

Other Contact: \_\_\_\_\_ Service Provided: \_\_\_\_\_ PH \_\_\_\_\_

**DIABETES HISTORY:**

When was your child first diagnosed with diabetes? \_\_\_\_\_

Does your child take insulin injections? \_\_\_\_\_ Does your child use an insulin pump? \_\_\_\_\_

Does he or she use any diabetes medications in pill form? \_\_\_\_\_

What have been his/her typical symptoms of low blood sugar? \_\_\_\_\_

At what level does he or she feel low? \_\_\_\_\_ Has your child ever required glucagon? \_\_\_\_\_

How would you describe your child's ability to manage his/her diabetes? \_\_\_\_\_

Last hemoglobin A1c result: \_\_\_\_\_ Date of test: \_\_\_\_\_ A1c Target result: \_\_\_\_\_

Any known complications from diabetes at this time? \_\_\_\_\_

**DAILY MANAGEMENT PLAN FOR DIABETES:**

List supplies that your student will be bringing to school;

\_\_\_\_\_ GLUCOSE METER \_\_\_\_\_ INSULIN (TYPE: \_\_\_\_\_) \_\_\_\_\_ INSULIN PEN \_\_\_\_\_ INSULIN PUMP  
\_\_\_\_\_ PUMP SUPPLIES \_\_\_\_\_ GLUCOSE TABLETS \_\_\_\_\_ GLUCOSE GEL \_\_\_\_\_ GLUCAGON \_\_\_\_\_ KETONE STRIPS  
\_\_\_\_\_ SNACKS ( \_\_\_\_\_ ) \_\_\_\_\_ OTHER ( \_\_\_\_\_ )

What supplies does your child carry during the school day? \_\_\_\_\_

Instructions for the classroom/PE/Athletics/ Fieldtrips: \_\_\_\_\_

Is exercise to be avoided for any of these circumstances?

\_\_\_\_\_ BLOOD SUGAR LEVEL ( \_\_\_\_\_ MG/DL) \_\_\_\_\_ ILLNESS \_\_\_\_\_ SPILLING KETONES INTO URINE  
\_\_\_\_\_ OTHER ( \_\_\_\_\_ )

**Blood Glucose Monitoring and Insulin Plan for School:**

**Goal** is between \_\_\_\_\_mg/dl and \_\_\_\_\_mg/dl. Notify parent if blood glucose is < \_\_\_\_\_mg/dl or > \_\_\_\_\_mg/dl.

Check urine for **ketones** if blood glucose is > \_\_\_\_\_mg/dl.

Does Your Child Test Independently? \_\_\_\_\_ Child needs help with: \_\_\_\_\_

If an insulin pump is used, what is its basal setting or settings during the school day? \_\_\_\_\_

**First Glucose Test Time** : \_\_\_\_\_ Any snack/meal? \_\_\_\_\_ Any insulin? \_\_\_\_\_

Any insulin/carbohydrate ratio at this time? \_\_\_\_\_ Any correction factor? \_\_\_\_\_

**Second Glucose Test Time** : \_\_\_\_\_ Snack/meal? \_\_\_\_\_ Any insulin? \_\_\_\_\_

Any insulin/carbohydrate ratio at this time? \_\_\_\_\_ Any correction factor? \_\_\_\_\_

**Third Glucose Test Time:** \_\_\_\_\_ Snack/meal? \_\_\_\_\_ Any insulin? \_\_\_\_\_

Any insulin/carbohydrate ratio at this time? \_\_\_\_\_ Any correction factor? \_\_\_\_\_

**Any other instructions for glucose testing/snacks/insulin?** \_\_\_\_\_

**DIRECTIONS FOR EMERGENCY CARE AT SCHOOL**

**Can a trained school staff member check your child's blood sugar if he/she shows symptoms of low or high blood sugar and is not able to do the test?** \_\_\_\_\_ **YES** \_\_\_\_\_ **NO**

**Symptoms of low blood sugar:** HEADACHE, TREMORS, COLD SWEAT, HUNGER, IRRITABILITY, NERVOUSNESS, PALE SKIN, CONFUSION, DROWSINESS, WEAKNESS OR FATIGUE, DIZZINESS, TINGLING LIPS, POOR COORDINATION, INABILITY TO CONCENTRATE, SLURRED SPEECH, COMBATIVENESS, UNCOOPERATIVENESS, CONVULSIONS, UNCONSCIOUSNESS

For blood sugar < \_\_\_\_\_mg/dl, do the following: give: \_\_\_\_\_

Retest glucose after \_\_\_\_\_ minutes.

Then if blood sugar is < \_\_\_\_\_mg/dl , give: \_\_\_\_\_

Additional instructions: \_\_\_\_\_

Student can return to class when: \_\_\_\_\_

**Symptoms of high blood sugar:** INCREASED URINATION, INCREASED THIRST, BLURRED VISION, INCREASED HUNGER, FRUITY BREATH, VOMITING, STOMACH PAIN, WEAKNESS, SLEEPINESS, DIFFICULTY BREATHING, COMA

Instructions for high blood sugar: \_\_\_\_\_

**Life-threatening Emergency: CALL 911.** Any glucagons instructions?

**PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

# PARENT/GUARDIAN 'S REQUEST TO PROVIDE MEDICATION AT SCHOOL

NORRIS PUBLIC SCHOOLS, DISTRICT # 160, 25211 S. 68<sup>th</sup> St., Firth, NE 68358

**PARENTS/GUARDIANS, PLEASE READ THIS IMPORTANT INFORMATION:** Your written permission must be on file before your student can be provided medication at school. Your signature below indicates that you understand and agree to the following:

- Your child has received the medication listed below without side effects.
- Medication will be sent to school in the original container with an intact clearly legible label. Medication sent to school in bags or other home packages will be returned home due to safety concerns. Herbals and medications not approved by the FDA will not be given at school. Over-the-counter medications given at doses or frequencies above that of the manufacturer's labeling will be considered prescription medications.
- Student medications must be stored in the school health office. Emergency medications can be an exception. Your child can carry prescription emergency medication with your written permission and that of your physician. With your permission, your child can carry an asthma inhaler, diabetic supplies, an epinephrine pen, or another medication needed for emergency care. In signing permission for your student to self-provide medication, you agree that the school district, its employees and agents are released from any liability for any injury arising from your student's self administration of the medication on school property or at any school-related activity, except in cases of willful or wanton misconduct on the part of the school employee or agent of the district. If your student uses asthma or anaphylaxis medication other than as prescribed, he/she may be subject to disciplinary action by the school, but this action will not restrict immediate access to the medication. If your student self-administers asthma or anaphylaxis medication at school or during a school activity, he/she must report to the school nurse, health aide, or another designated adult in order to receive appropriate follow-up care.
- Your child's medication may be given by a nurse, and unlicensed health aide, or by other school staff members. Unlicensed health aides and staff members who provide medication to students have demonstrated, through training and testing, competency to provide medications, as required by Nebraska laws. A health aide or unlicensed staff member can give medications only by the following routes: oral, inhalation, topical, and instillation into eyes and ears. Special arrangements will need to be made for other routes. A licensed nurse might not be on duty at the school campus and in that circumstance, you will need to be responsible for direction and monitoring of the medication.
- A physician's or other licensed prescriber's written authorization has to be on file at school in order for prescription medication to be provided to your child. This can be in the form of a written prescription or a current pharmacy label attached to the bottle of medication. A school nurse can, if needed, contact the prescribing physician for clarification about medication administration.
- You will need to notify the school, in written form, if there are changes in your child's medications.

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## PARENT/GUARDIAN'S WRITTEN CONSENT: TO BE COMPLETED PRIOR TO MEDICATIONS BEING GIVEN AT SCHOOL

I give permission to Norris Public Schools to provide to \_\_\_\_\_  
Child's Name

the following medication: those listed for use at school on the diabetes care plan, and as directed on the plan. .

Does your student have permission to keep and self-provide any medication, following directions for use as written on the care plan?    \_\_\_\_\_yes    \_\_\_\_\_no

If yes, which medication(s) can he/she self-provide? \_\_\_\_\_.

Parent/guardian's signature \_\_\_\_\_ Date \_\_\_\_\_

**Student's agreement for self-administration:** I agree to use this medication only as prescribed by my doctor and to report to the school nurse, health aide, or a school staff member if I have blood sugar results that fall outside of my parents and physician's parameters, or if I am noticing symptoms of low or high blood sugar.

Student's signature: \_\_\_\_\_ Date \_\_\_\_\_

**PHYSICIAN'S REQUEST FOR PROVISION OF PRESCRIPTION MEDICATIONS AND DIABETES CARE BY SCHOOL PERSONNEL**

NORRIS SCHOOL DISTRICT #160

Elementary 791-0030

Middle School 791-0020

High School 791-0010

The student, whose name is: \_\_\_\_\_, is under my care and must take medication which I have prescribed during the school day.

My prescription for the school day is as follows: (Please include medication name, dose, route, and frequency at school)

**INSULIN:**

**GLUCAGON:**

**Norris Public Schools may follow the instructions for insulin administration, blood glucose testing, ketone testing, diet, exercise, and emergency procedures that I provide to this student's parents and they, in turn, provide to the school.**

The duration of this medication therapy is: **X** for the current school year.  
\_\_\_\_\_ for this time: (\_\_\_\_\_)

Instructions for storage of this medication:

Instructions for reporting adverse reactions:

This student will be able to self-provide this medication. We have discussed how to use this medication correctly, store the medication, and report on the effects of the medication to parents and myself. If applicable, I also authorize the use of syringes or similar medical items.

This student cannot self-provide this medication. I, or my designee, have trained school personnel or approved alternative training as adequate to provide this medication. The plan for administration is appropriate and safe. As applicable, syringes and other similar medical items can be used.

\_\_\_\_\_  
PHYSICIAN OR PRESCRIBER'S SIGNATURE

\_\_\_\_\_  
DATE