Anchorage School District

DIABETES CARE PLAN (PUMP)

STUDENT PHOTO

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH (MM/DD/YYYY)
SCHOOL	SCHOOL FAX		GRADE

EFFECTIVE DATE: End Date:

DIABETES HEALTHCARE PROVIDER INFORMATION

Name: Phone #: Fax #:

Monitor Blood Glucose – test ... (reference Hypo/Hyperglycemia treatment protocol for BG < 70 and BG ≥ 250)

☒ If student has symptoms of high or low blood glucose

Breakfast: ☒ Before ☐ After Exercise/PE/gym/recess: ☒ Before ☐ After

Lunch: ☒ Before ☐ After ☐ Before leaving school

Snack: ☐ Before ☐ After ☐ Other : _____

Where to test: ☐ Classroom ☒ Health office ☐ Other: _____

☒ **Without moving student if has low blood glucose symptoms**

Continuous Glucose Monitoring: Type of CGM: _____

Student may use reading from CGM for: ☐ Insulin dosing ☐ End of day check ☐ Before activity check

Perform a finger stick: ☐ Blood glucose is rapidly changing when dosing insulin ☐ To confirm hypoglycemia

☐ Hyperglycemia ☐ Calibrations ☐ Other: _____

Insulin Pump Information: Type of pump: _____

Insulin Type: ☒ Rapid-acting (Insulin Lispro/Insulin Aspart/FIASP) ☐ Other: _____

Basal rates during school: See insulin pump as rates may vary

Verify pump for: ☐ Automode ☐ Basal IQ ☐ Control IQ ☐ Suspend Before Low ☐ Other:_____

☒ Insulin dosing per pump recommendations

BLOOD GLUCOSE CORRECTION

☒ USE THE FOLLOWING PARAMETERS TO CALCULATE CORRECTION DOSE

Target blood glucose: _____ mg/dL **Insulin sensitivity factor:** _____

$$\frac{\textbf{(Current Blood Glucose – Target Blood Glucose)}}{\textbf{Insulin Sensitivity factor}} = \_\_\_\_\_ \textbf{ Units of Insulin}$$

When to give correctional insulin: ☐ Before breakfast ☐ Before lunch ☐ Per pump ☐ Other: _____

☒ All BG/SG results to be entered into pump to determine bolus dose.

Do not give correction dose more than once every 3 hours.

CARBOHYDRATE COVERAGE

☒ If BG <70 before a meal, treat with carbohydrate per Hypoglycemia Treatment Protocol.

Meal Insulin: ☒ Before eating ☐ After eating

☒ USE THE FOLLOWING PARAMETERS TO CALCULATE CARBOHYDRATE COVERAGE DOSE

Time: _____ 1 unit of insulin per _____ grams of carbohydrate

Time: _____ 1 unit of insulin per _____ grams of carbohydrate

Time: _____ 1 unit of insulin per _____ grams of carbohydrate

Time: _____ 1 unit of insulin per _____ grams of carbohydrate

$$\frac{\textbf{Total Gram of Carbohydrates to Be Eaten}}{\textbf{Insulin-to-Carbohydrate Ratio}} = \_\_\_\_\_ \textbf{ Units of Insulin}$$

When to give carbohydrate coverage insulin:

☒ With all carbohydrate intake ☐ Breakfast ☐ Lunch ☐ Snack ☐ Special Occasions ☐ Other: per pump

MEDICATION	Frequency	DOSE	ROUTE	NOTES
☐Tresiba or insulin glargine	Once daily at _____	_____ units	Subcutaneous	Injection to be witnessed or performed by the nurse or trained person.
☐PRN Baqsimi*	PRN Severe Hypoglycemia	☐ 3 mg	Intranasal	
☐PRN Glucagon*	PRN Severe Hypoglycemia	☐ 1 mg ☐ 0.5 mg	IM or SC Injection	Administration site (buttocks, arm, or thigh) by the nurse or trained person.
☐PRN Gvoke*	PRN Severe Hypoglycemia	☐ 1 mg ☐ 0.5 mg	IM or SC Injection	Administration site (buttocks, arm, or thigh) by the nurse or trained person.

*** You may use either Baqsimi or Gvoke to treat severe hypoglycemia. You would not use both in a single event.**

Exercise and Sports with Pump

- A quick-acting source of glucose such as glucose tabs or sugar-containing juice should be available at the site of physical activity or sports.
- Do not exercise with moderate to large ketones per Hyperglycemia Algorithm for Blood Glucose Results.

☐ Temp Basal Decrease: ☐ (____% or ___units for ____ minutes) ☐ duration of exercise
☐ Activate Temp Target: ☐ Duration of exercise ☐ Start_____ minutes before ☐ End _____ minutes after exercise.
☐ May disconnect from the pump for exercise to last no more than 2 hours.
☒ Student should monitor blood glucose hourly.
☐ Student should eat _____ grams of carbohydrates:
☐ Before ☐ Every 30 minutes during ☐ Every 60 minutes during ☐ After vigorous activity
☒ If pre-exercise blood glucose is **less than 70 mg/dL**, student can participate in physical activity once blood glucose is corrected and **above 120 mg/dL**.
☒ If pre-exercise blood glucose is **less than 120 mg/dL**, student can participate in physical activity once they consume a **15 gram** snack with protein.
☐ If student is to exercise right after lunch, student should subtract _____ gm from their carbohydrate count

Parent/Guardian Authority to Adjust Insulin Dose

Dose adjustment allowed up to 20 % higher or lower ☐ Yes ☐ No

Pump settings should not be changed by school staff (unless under direction of diabetes doctor).

☐ Place pump on suspend when blood glucose is less than 70 mg/dl and re-activate it when blood glucose is at least 85 mg/dl. (Do not override auto mode/basal IQ)

If infusion set comes out or needs to be changed:
☒ Change set at school OR ☒ Insulin via syringe every 3 hours

HCP Assessment of Student's Diabetes Management Skills:

Skill	Independent	Needs Supervision*	Cannot do	**Notes**
Check blood glucose	☐	☐	☐	
Count carbohydrates	☐	☐	☐	
Calculate insulin dose	☐	☐	☐	
Injection	☐	☐	☐	
Troubleshoot CGM alarms	☐	☐	☐	
Set Temp basal/Temp target	☐	☐	☐	
Change infusion set	☐	☐	☐	

*The RN or other trained staff are expected to observe for accuracy & completion of the skill if "needs supervision"

-For blood glucose ≥ 250 mg/dL, repeat blood glucose check in 2 hours. If blood glucose remains ≥250 mg/dL, check urine ketones and refer to Hyperglycemia Treatment Protocol.
-Check ketones with signs of illness including abdominal pain, upset stomach and vomiting.
-For blood glucose less than 70 mg/dL, refer to Hypoglycemia Treatment Protocol.

Other health concerns:

Notes

HEALTHCARE PROVIDER
Electronically signed or signed by: Date:

Student Name: **Allergies:**

STUDENT'S NAME:

Student's usual LOW blood glucose symptoms:

_ Shaky or jittery	_ Uncoordinated
_ Sweaty	_ Irritable, nervous
_ Hungry	_ Argumentative
_ Pale	_ Combative
_ Headache	_ Changed personality
_ Blurry vision	_ Changed behavior
_ Sleepy	_ Unable to concentrate
_ Dizzy	_ Weak, lethargic

ALGORITHMS FOR BLOOD GLUCOSE RESULTS

CHECK BLOOD GLUCOSE

Student's usual HIGH blood glucose symptoms:

Hyperglycemia	*Emergency levels*
_ Increased thirst, dry mouth	_ Extreme thirst
_ Frequent or increased urination	_ Nausea, vomiting
_ Change in appetite, nausea	_ Severe abdominal pain
_ Blurry vision	_ Fruity breath
_ Fatigue	_ Heavy breathing, shortness of breath
Other	_ Increasing sleepiness, lethargy

BELOW 70

1. Give 15 gm fast-acting carbohydrate
2. Observe for 15 minutes then retest blood glucose.
   a. If less than 70, repeat 15 gm carbohydrate and retest in 15 min.
   b. If over 70 and not eating a meal within an hour, give carbohydrate and protein snack without insulin coverage.
3. Notify school nurse and parent if no improvement.
4. Student should not exercise.

CALL 911 if student becomes unconscious, seizures or is unable to swallow

- Turn student on side to ensure open airway
- Give glucagon as ordered. Keep student in recovery position on side.
- If on insulin pump, either place it in 'suspend' or stop mode, disconnect it at the pigtail or clip, or cut tubing. If pump was removed, send it with EMS to the hospital.
- Notify school nurse, parent and HCP
- Wait 15 minutes; if no response, repeat glucagon.
  - If responsive, offer juice. Wait 15 minutes and give protein & carbohydrate snack.

70 – 90

1. If prior to exercise or immediately following strenuous activity and **NO** meal/snack is planned within 30 minutes, give 15 gm carbohydrate and protein snack.

2. If **NOT** exercise-related and student is symptomatic, observe and recheck in 15 minutes.

3. If **NOT** exercise-related and is NOT symptomatic, return to class.

15 GM FAST-ACTING CARBOHYDRATE =

- ½ c. juice
- 3-4 glucose tablets
- Tube of glucose **gel**
- ½ c. regular (not diet) soda
- 6-7 small sugar candies (to chew)
- 1 c. skim milk

Do not give chocolate

91-125

Student may eat before exercising or recess.

126-250

No action needed.

ABOVE 250

STUDENT TREATED BY **INJECTION**

1. Use correction scale or formula at lunch or every 2-3 hours
2. Check ketones if symptoms or if blood glucose>250 twice in a row:
   a. If ketones are *absent or small*, encourage exercise and water
   b. If ketones moderate or large:
      - No exercise; give water
      - Add units of insulin per orders
3. Notify school nurse and parent
4. **Provide free, unrestricted access to water and the restroom.**

STUDENT TREATED BY **PUMP**

1. If 2-3 hours since last bolus, treat with correction bolus via pump. Re-check in 2- 3 hrs. Trouble shoot pump function.
   - Check for redness at site, tubing for kinks or air bubble, insulin supply
2. If blood glucose still ≥ 250 mg/dl and not explained, check ketones:
   a. If ketones are *absent or small*, encourage exercise and water
   b. If ketones moderate or large:
      - Give insulin correction dose per orders **via syringe**.
      - No exercise; encourage water
3. Change infusion set or continue insulin injections every 2-3 hours via syringe.
4. Notify school nurse and parent
5. **Provide free, unrestricted access to water and the restroom.**

CALL 911 if the student vomits, becomes lethargic and/or has labored breathing.
Notify school nurse, parent and HCP.

EXERCISE AND SPORTS

✓ Assure has quick access to water for hydration, fast-acting carbohydrates, snacks and monitoring equipment.
✓ Student should not exercise if blood glucose level is below 70 mg/dl or if has moderate to large ketones.

Never send a child with suspected low blood glucose *anywhere* alone.

PARENT / GUARDIAN AUTHORIZATION

I request that the medication(s) and diabetes care outlined on this plan be given to my child. **I will provide needed medications or supplies for care in school.**

Employees and agents of the Anchorage School District ("ASD") strive to provide treatment consistent with the appropriate standard of care, but are not infallible. I agree to release, defend, indemnify, and hold harmless ASD from any liability for the risks or results of the care, which may include INJURY, ILLNESS, or DEATH, or the manner in which it is administered, including for NEGLIGENCE. I will notify ASD immediately if the medications or protocols change. I give permission for the exchange or release of health information between the medical provider listed above and ASD as part of the provision of my child's care. I agree for the nurse to share health information with ASD staff on a need-to-know basis for my child's safety and to foster academic success.

I understand that ANY remaining diabetes care supplies will be disposed of at the end of the school year, unless I pick up the remaining supplies by the last school day, as indicated on the ASD school year calendar.

PARENT / GUARDIAN NAME (PRINTED)	RELATIONSHIP TO CHILD	TELEPHONE NUMBER
PARENT / GUARDIAN (SIGNATURE)		DATE

NURSE PLAN REVIEW

I have reviewed the *Diabetic Care Plan* for accuracy and ensure that all required fields and signatures are completed before providing care to a student. I approve of the agreement arranged between the physician, parent, nurse, and student for the management of the student's health needs. I will conduct training with school staff, as needed, to ensure the safety and well-being of the student in the school setting.

NURSE NAME (PRINTED)	
NURSE SIGNATURE	DATE

ANCHORAGE SCHOOL DISTRICT

MEDICATION ADMINISTRATION: PARENTAL AUTHORIZATION FOR SCHOOL STAFF TO ADMINISTER

(for Non-Delegable Medication)

Student_____**Birthdate**_____**Grade** _____

Parent/Guardian _____**Contact** _____

BACKGROUND. All students attending public schools must have access to health care during the school day and for school sponsored activities, if necessary, to enable the student to participate fully in the school program. The federal laws include the Americans with Disabilities Act, Individuals with Disabilities Education Act (IDEA), and Section 504 of the Rehabilitation Act of 1973.

The Alaska Board of Nursing does not authorize registered nurses to delegate certain medications to unlicensed assistance personnel. Examples include but are not limited to: **injectable** medications, medications via gastrostomy tube and "as needed" **controlled substances**. However, parental delegation of these medications, when a school nurse is not available to administer them, is allowed in 12 AAC 44.975, Exclusions (2) under "other legal authority." In an Alaska Board of Nursing advisory opinion dated 4-2-12, the ***Medication Administration in the School Setting Delegation Decision Tree*** was adopted as a plan to allow parents to delegate to school staff with nurse involvement in training and follow up. The trained school staff must provide care for the student consistent with the Individualized Healthcare Plan (IHP) prepared by the nurse based on healthcare provider instructions and parent input.

PARENT AUTHORIZATION. I, the parent/legal guardian, understand that in the absence of the school nurse, other trained Anchorage School District ("ASD") personnel may administer this medication. Employees and agents of ASD strive to provide treatment consistent with appropriate standard of care, but are not infallible. I agree to release, defend, indemnify, and hold harmless ASD from any liability for the risks or results of the care, which may include INJURY, ILLNESS, or DEATH, or the manner in which it is administered, including NEGLIGENCE. I will notify the school immediately if the medication is changed. I give permission for the exchange or release of health information between the medical provider for this care and ASD as part of the provision of my child's care. I agree for the nurse to share health infomration with ASD employees and agents on a need-to-know basis for my child's safety and to foster academic success.

As a parent or guardian of _____, I hereby acknowledge that I have read and understand this form and agree to its content. I have authorized the nurse to train school staff using a standardized curriculum to administer the medication(s) (below) to my child according my child's IHP when the school nurse is not available.

☐ I **attended** the training session(s) provided to the school staff identified above, agree that the content was appropriate for medication administration to my child.

☐ I **did not attend** the training session(s) provided to the school staff identified above but have reviewed the curriculum and agree that the content is appropriate for medication administration to my child.

Name(s) of school staff authorized to be trained to administer_____to my child.
Name of Medication(s)

1._____ **2.** _____ **3.**_____

_____ _____ _____ _____
Parent signature ***Date*** ***Home phone*** ***Cell phone***

PLEASE SIGN AND RETURN THIS FORM TO YOUR SCHOOL OFFICE - if no form is on file, it will be assumed that authorization for parental delegation has not been granted and there will be no trained school staff assigned to your child.