School Nurse Notified:
☐ Teacher
☐ Office Staff
Office use only

Downey Unified School District
PARENT CONSENT AND PHYSICIAN AUTHORIZATION FOR
DIABETES MANAGEMENT AT SCHOOL AND SCHOOL SPONSORED EVENTS
(ISHP and Procedures will provide details on below)

Pupil _____ DOB _____ School _____ Grade _____

Physician's Written Authorization
Complete all spaces that apply:

1. Blood Glucose Testing: _____Before lunchtime
____Before snack _____ As needed
____ By pupil ____ Needs assistance

2. Routine Care of Severe Hypoglycemia When:
____ Below 70 **or** ____ 70 or below

3. Emergency Care of Severe Hypoglycemia:
_____Cakemake gel: _____If conscious _____If unconscious
_____Glucagon injection: _____0.5 mg _____1 mg
_____Glucose tablets

4. Care of Hyperglycemia When: _____240 or above
_____300 or above _____Other:_____
_____ Exercise contraindicated ____ H2O
Check ketones if BS>_____

5. Insulin at school: _____ Not at this time
_____Routine lunchtime dose (See next column)
_____Correction lunchtime dose (See next column)
(per sliding scale)
_____ Carb Counting____# units per ____CHO servings
At:___morning snack ___lunchtime

6. If insulin At School:
Type of insulin to be used:
___ Novolog ___ Humalog ____Regular ___NPH

7. Dose Preparation:
____Insulin Pen ____Syringe and vial ____Insulin pump
SQ Administration performed by:
____Licensed Nurse ____Pupil
____Needs supervision by staff
____Parent Designee*

8. Dosage (per sliding scale): (up to 15 minutes before lunch)
Blood Glucose from _____ to _____=_____Units
Blood Glucose from _____ to _____=_____Units
Blood Glucose from _____ to _____=_____Units
Blood Glucose from _____ to _____=_____Units
Blood Glucose from _____ to _____=_____Units
Blood Glucose from _____ to _____=_____Units

9. Routine Lunchtime Insulin Dose:
Type of insulin to be given: _____ Time:_____
Insulin dosage:_____ Units

(Parent Designee MUST be a NON-school person designated and trained by parent)

Other Needs (Specify):

PHYSICIAN AUTHORIZATION FOR DIABETES MANAGEMENT IN SCHOOL

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with Education Code Section 49423.5. I understand that unlicensed designated school personnel under the training and supervision provided by the school nurse may perform specialized physical health care services. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization (may be faxed).

Physician's Signature & Stamp _____ Date _____

Address: _____ City_____Zip_____Phone number_____

PARENT CONSENT FOR DIABETES MANAGEMENT IN SCHOOL

We (I), the undersigned, the parent(s)/guardian(s) of the above named pupil, request that the following specialized physical health care service be administered to our (my) child in accordance with Education Code Section 49423.5:
I will:

1. Provide the necessary supplies and equipment
2. Notify the school nurse if there is a change in pupil health status or attending physician
3. Notify the school nurse immediately and provide new consents/ authorizations for any changes in doctor's orders
4. Be provided a copy of my child's completed Individual School Health Care Plan (Upon Request)

I authorize the school nurse to communicate with the physician when necessary.

Parent/Guardian _____ Date _____

Downey Unified School District
Individualized School Healthcare Plan (ISHP)
Management of Diabetes at School and School Sponsored Events
School year_____

Student name: _____ Date of Birth: _____ School:_____
Grade:_____ ID#:_____

Mother/Guardian: _____
Telephone: Home_____
Work_____
Cell_____

Father/guardian: _____
Telephone: Home_____
Work_____
Cell_____

Student's Doctor/Healthcare Provider:
Name: _____
Address: _____
_____
Telephone: _____

Purpose of an ISHP: The purpose of an Individualized School Healthcare Plan (ISHP) is to provide safe management of healthcare needs and services for pupils at school and during school-related activities.

General Information: 1. The school nurse, in collaboration with the student and the student's parent/guardian, healthcare providers, and school team, is responsible for:

a) Development, implementation and revision of the ISHP.
b) The training and supervision of all non-licensed designated personnel who will provide healthcare according to the ISHP standard procedures.

2. ISHP revisions must be directed to the school nurse prior to implementation. All physician changes must have a written physician authorization and written parent consent. Revisions, not requiring physician authorization, may be made with written parent consent.
3. ISHP must be completed annually and whenever necessary to ensure provision of safe care.
4. Parent/guardian is responsible for updating the school of any recent information or changes made to ISHP.
5. If you, as a parent/guardian, find that your child is having problems in school related to his/her physical or mental health problem, please notify the teacher, principal, or the school nurse and they may schedule a meeting to discuss how your child's needs can best be met.

Parent/Guardian Signature:_____ Date:_____

Individualized School Healthcare Plan
School Nurse Assessment
(Completed With Parent)

Pupil:_____ DOB:_____ School: _____Grade:_____ ID # _____

1. **Diagnosis/ Current Status:**
   This student was diagnosed on _____. The target range for maintaining blood glucose is _____mg/dl to _____mg/dl. The most recent Hemoglobin A1C level was _____mg/dl on_____. (Hemoglobin A1C is the lab value for blood glucose control during the previous 6 weeks to 3 months. Ranges are: 6-8(good), 9-10(fair), 11+(poor)).
2. **Other Health Problems:**
   _____
   _____

3. **Diabetic Routines at School Per Parent Request/Consent:**
   Daily School Snacks to be eaten at (times): _____ ____Done independently ____Needs reminder
   Daily Blood Test at (times): _____ _____ _____

   Lunch Eaten at (time): _____ Regardless of schedule changes, field trips, etc.

   Extra snacks: Before exercise____ After exercise____ Other_____

   ____ No exercise if blood glucose test results are below ____mg/dl or above ____mg/dl

   In Event of Field Trip: 1) All diabetic supplies are taken and care is provided according to this Diabetic Management IHSP
   2) Parent must notify School Nurse at least two weeks prior to the field trip to plan for a Qualified Personnel to provide care.
   In Event of Bus Transportation: _____Blood test done before boarding, and if 70 or less, provide care per mild to moderate low blood glucose protocol.
   ___Other:_____
   In Event of Classroom/School Parties: Food treats will be handled as follows
   _____Pupil will eat the treat.
   _____Replace with parent supplied alternative.
   ____Do not eat it, put in baggie and take home with a teacher's note.
   _____Modify the treat as follows:
   _____

Equipment and Supplies <u>Provided by Parent</u>

1. <u>Blood Glucose Meter Kit</u>

Includes meter, testing strips, lancets with device

2. <u>Low Blood Glucose Supplies (5 day Supply)</u>

_____Fast Acting Carbohydrate drinks: At least

Six (6) containers (Apple juice and/or orange juice, regular soda pop,

NOT diet!

_____ Glucagon Kit

_____Glucose Tablets

_____ Gel Cakemate (not frosting)

_____Glucose Gel Products

_____ Prepackaged Snacks: 5-6 servings or more

(Crackers with cheese/peanut butter, Nite bite, etc.)

3. <u>High Blood Glucose Supplies</u>

_____ Ketone test strips/ urine cup

_____ Water Bottle

4. <u>Insulin Supplies</u>

_____ Insulin and syringes

_____ Insulin Pen

5. <u>3 Day Disaster Diabetes Supplies</u>

_____3 Day of nonperishable planned meals

_____ Vials of insulin for daily regime; 6 syringes

_____ Insulin pen with cartridge and needles

6. <u>Extra Insulin Pump Supplies</u> such as:

___ Vial of insulin

___ Spare infusion set, reservoir

___ 6 extra batteries for pump

___ Wallet sized pump programming and alarm cards

___ 3X5 card with pump model, serial number and pump Help Line phone number

Parent's Signature_____ Date _____ School Nurse Signature _____ Date _____

Pupil: _____ D.O.B. _____ Date _____

Physician Authorization and Parent Consent for Insulin Dose During a Disaster

RECOMMENDATIONS
If insulin is available but there is a limited food supply then consider decreasing the usual dose of NPH, Lente, Ultralente or Lantus by 25%. *Regular or rapid-acting insulins may not be needed**.
* Rational: Hypoglycemia will be less likely to occur with these lower insulin doses and mild hyperglycemia for one to three days is acceptable.
Daily/Routine Insulin regimen to follow during a disaster (decrease the following doses if limited food supply):

	Time of Day	Insulin Type	Dosage to be given (Units)
Breakfast			
Lunch			
Dinner			
Bedtime			

OR

Test Blood Sugar every _____ hours with Sliding Scale Coverage as follows:
Type of Insulin _____
Blood glucose from _____ to _____ = _____Units
Blood glucose from _____ to _____ = _____Units
Blood glucose from _____ to _____ = _____Units
Blood glucose from _____ to _____ = _____Units
Blood glucose from _____ to _____ = _____Units

OR
____ Physician's disaster recommendations *attached*

OR
____ No disaster plan recommended at this time

PHYSICIAN/ PROVIDER AUTHORIZATION FOR DIABETES MANAGEMENT IN SCHOOL DURING A DISASTER
My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state law governing school health services (Education Code Section 49423.5). This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization (may be faxed).

Physician Signature & Stamp :_____Date: _____

Address: _____ City _____ Zip _____

Phone number: _____

PARENT/GUARDIAN CONSENT FOR DIABETES MANAGEMENT IN SCHOOL DURING A DISASTER
We (I), the undersigned, the parent(s)/guardian of the above named pupil, request that the above defined insulin doses be given during a disaster for our (my) child in accordance with State laws and regulations.

Parent/guardian signature:_____ Date: _____

Individualized School Healthcare Plan
Procedure for Signs of Low Blood Sugar
Hypoglycemia/Insulin Reaction

Observe for signs of low blood sugar and ask student to describe how he/she feels.
(Student's most common signs/symptoms are checked below)

___Headache	___Confusion	___Loss of coordination	___Irritability or change in mood/behavior	___Feels "low" or not well
___Moist skin, sweating	___Seizures	___Slurred speech	___Blurred vision	___Droopy eyelids
___Pale skin	___Dizziness	___Shakiness	___Crying	___Sleepy
___Weakness, fatigue	___Sudden Hunger	___Numbness of lips/tongue	___Stomachache	___Other:_____

Have student test blood sugar and record results.

If blood sugar is below 70 **OR** **If signs of low blood sugar**	**1. Give one (1) of the following fast acting carbohydrates:** • 4 oz. (1/2 cup) apple juice or orange juice (or regular soda pop) • 3 glucose tablets (chewed thoroughly before swallowing) • Glucose Gel (i.e. ½ tube Insta-Glucose or 1 pkt. Monogel or Glutose) • ½ tube gel Cakemate (19 gm., mini-purse size). **2. Observe for 15 minutes, then check for improvement:** • Student states he feels better and appears better • Blood sugar over 70 per pupil retest 3. **If no improvement, repeat Steps 1 and 2** (second attempt) • **If still no improvement,** repeat again (third attempt) • **If still no improvement after third attempt,** call school nurse and parent 4. **When improved,** have student eat one of the following: • Prepackaged snack if lunch or snack time not due within the hour • Lunch or snack, which ever one is due within the hour • After eating lunch or snack, may resume classroom activities if feeling well; If not feeling well, office to call parent for assistance 5. **Document care** on log
_____	
If blood sugar is 70 or above	**1. If blood sugar is 70 to 240 and student feels OK,** no treatment is indicated **2. If blood sugar is 240 or above,** see procedure for HIGH Blood Sugar **3. If blood sugar 70 or above and the student feels low/ not well,** retest in 15 minutes • **If blood sugar is below 70 after retest,** treat for Low Blood Sugar (See above)

Standard Emergency Procedure for Severe Low Blood Glucose
Hypoglycemia/ Insulin Reaction
Glucose Gel

Essential Steps	Key Points and Precautions
1. Verify signs of severe low blood glucose: Unable to swallow, Unconsciousness, Combative, Uncooperative, Seizures 2. **Place pupil on side or in upright position (if restless/uncooperative) and Have someone call paramedics, school nurse and parent** 3. Place one of the following in cheek pouch closest to ground and massage: • Glucose Gel: __15 gm. Tube Insta-glucose or __15 gm. Monogel or Glucose 4. When pupil is able to swallow, repeat Step 3 and Give sips of regular soda pop (not diet) as tolerated until paramedics arrive.	• Signs could be so severe that pupil is not able to participate in care. • If seizure occurs, follow standard seizure procedure. • Maintain head position to one side to prevent aspiration.

Procedure for Signs of High Blood Sugar
Hyperglycemia

If student is awake and alert:

If Blood Sugar Is:	1. Initiate care as checked below:
___ 240 or Above	___ Give 1-2 glasses of water
___ 300 or Above	2. If blood sugar is greater than ___ ___ Check urine ketones ___ Do not participate in PE or other exercise
___ Parent to be notified if blood sugar is greater than ____	3. If student is feeling OK, send to class
	4. If student is not feeling OK (i.e. dry flushed skin, nausea/ vomiting, rapid breathing, etc.) parent to provide for transportation home and further medical care.
	5. Document care on log

Standard Procedure for Testing Urine Ketones

1. Saturate the test strip with urine by one of the following:
   ___ Pupil to hold test strip directly in urine flow.
   ___ Pupil to urinate in cup, then dip strip into cup of urine.
2. Wait for test strip to develop.
3. Compare color of strip to chart on bottle.
   ___ If results are moderate or large, call parent to take pupil home for observation and/or medical care.
4. Document results on log