Seguin Independent School District
HEALTH SERVICES

Diabetes Management and Treatment Plan
Authorized Health Care Provider's Written Authorization

Student:_____ DOB:_____ School Year:_____ Grade:_____

Diagnosis: Type I_____ Type 2_____ Other:_____ Date of Onset:_____

Teacher:_____ SHARS:_____ ID#: _____

PLEASE FILL IN BLANKS AND CHECK ALL BOXES THAT APPLY

1. PHYSICIANS OPINION OF STUDENT'S COMPETENCE:

☐ Blood glucose testing ☐ Carry supplies for BS monitoring
☐ Testing in classroom ☐ Measuring insulin
☐ Injecting insulin ☐ Self treatment for mild lows
☐ Determining insulin dose
☐ Independently operating insulin pump
☐ Carry supplies for insulin administration
☐ Universal precautions and proper disposal of sharps

2. BLOOD GLUCOSE TESTING:

Desired range _____mg/dl to _____mg/dl
☐ Before AM snack ☐ 2 hours after lunch
☐ Before lunch ☐ 2 hours after correction dose
☐ At student's discretion, except, always for suspected hypoglycemia
☐ No blood glucose testing at school required at this time.

3. MILD HYPOGLYCEMIA INTERVENTION:

☐ BG<70 mg/dl ☐ BG<____mg/dl
Student must NEVER be alone when hypoglycemia is suspected and should be treated on site.
☐ Give 15 gm/CHO or ☐ _____gm of fast-acting glucose
☐ Recheck in: ☐ 15 minutes ☐ _____ minutes

4. SEVERE HYPOGLYCEMIA INTERVENTION:

Seizure, unconscious, unable to swallow:
CALL 911 – Ensure open airway
☐ Ok, to use glucose gel inside cheek if conscious
☐ Glucagon injection IM, if unconscious or seizing
☐0.5mg ☐1mg

5. HYPERGLYCEMIA INTERVENTION:

If BG is greater than _____mg/dl check ketones in urine. Encourage to drink water. If student is ill or vomiting, call parent to pick up student.
For confusion, labored breathing or coma – CALL 911
✓ If BG>_____mg/dl with ketones moderate to large call parent to pick up.
✓ If BG>_____mg/dl with ketones negative to small, child may remain at school if not ill or vomiting.
✓ For above, initiate insulin per sliding scale, ONLY, if more than 2 hours have passed since last insulin dose and encourage sugar free liquids. DO NOT give insulin more frequently than every 2 hours.
✓ If student has a pump, immediately troubleshoot the pump, infusion set and site. Use pump for initial correction dose and recheck blood sugar within one hour to assure adequate delivery of insulin.

6. INSULIN ORDERS: Complete ONLY if insulin is needed at school.

Brand name of insulin:_____
Insulin administration route:
☐ Syringe ☐ Pump ☐ Pen ☐ Other:_____
***Routine administration times**:
☐ Breakfast ☐ AM Snack
☐ Lunch ☐ Other:_____
***Food/bolus insulin dose**:
☐ Insulin to CHO ratio
_____ unit(s) insulin per _____gm CHO or
***Fixed insulin dosing**:
☐ Breakfast dose _____ unit(s) (If given at school)
☐ AM snack dose _____ unit(s)
☐ Lunch dose _____ unit(s)
☐ Other dose _____ unit(s)
***Correction Dose**:
☐ Give _____ unit(s) for every _____mg/dl above ____mg/dl
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
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Blood glucose from _____ to _____=_____ units

7. **MEAL PLAN**:

Meal/snack will be considered mandatory, unless, "at student's discretion" box is checked. Attach orders if breakfast or PM snacks are needed. Timing will be routine school times unless indicated.

Content of meal/snack to be specified by:
☐ Parent ☐ Health Care Provider (attach if necessary)
☐ Student ☐ No snack needed

8. **ILLNESS**:

✓ If student is ill, check ketones and blood glucose.
✓ If ketones are _____ or greater, provide fluids, call parents to pick up.
✓ If ketones and blood glucose are within range, follow standard procedures for an ill child and notify parents.

CONTINUE ON BACK

9. **BUS TRANSPORTATION**:
   - ☐ Blood glucose test NOT required prior to boarding bus.
   - ☐ Test blood glucose 10-20 minutes prior to boarding bus and treat hypoglycemia appropriately.
   - ☐ Notify parent if BS > _____mg/dl or < _____mg/dl

10. Exercise: Complete ONLY if needed.
    Follow hypoglycemia or hyperglycemia and illness protocols when relevant.
    Eat _____ extra grams of CHO for vigorous exercise.
   - ☐ Before
   - ☐ Every 30 minutes during
   - ☐ After exercise
   - ☐ Student may disconnect pump for up to _____ hour(s)
   - ☐ Student may decrease basal rate at their discretion.

11. **OTHER NEEDS**:

_____

_____

_____

_____

_____

_____

_____

_____

Physician's Signature:_____ Print Name: _____

Date:____/____/____ Physician's Phone:_____ Fax: _____

Other Phone Numbers:

Physician's Nurse:_____ Phone: _____ Fax: _____

Dietitian: _____ Phone: _____ Fax: _____

Other Health Care Provider:_____ Phone: _____

As the parent, I understand that I will notify the school immediately if the health status plan of my child changes, change physicians or emergency contact information. I understand that the Unlicensed Diabetic Care Assistant(s) are not liable for civil damages as provided by Section 168.009 of House Bill 984 – Care of Diabetic Students. I also give permission to the school principal and school nurse to communicate with my child's physician and other Health Care Providers listed. This authorization is for the current school year. If changes to this plan occur, I will be required to submit it in writing **with** physician's signature. I understand that all diabetic supplies, snacks, and drinks will be provided by the parent/guardian.

Parent/Legal Guardian Signature:_____ Relationship: _____

Date:____/____/____ Cell:_____ Home:_____ Cell: _____

Special notes/comments: _____

_____

_____

_____

To be completed by Seguin ISD Health Services Staff:

Received by:_____ Date: _____