

Diabetes Health Care Plan for Insulin Administration via Syringe or Pen

School: _____

Start Date: _____ End Date: _____

Name: _____ Grade/ Homeroom: _____ Teacher: _____

Transportation: Bus Car Van Type 1 Type 2

Parent/ Guardian Contact: Call in order of preference

Name	Telephone Number	Relationship
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1. _____
2. _____
3. _____

Prescriber Name _____ Phone _____ Fax _____

Blood Glucose Monitoring: Meter Location _____ Student permitted to carry meter and check in classroom Yes No

BG= Blood Glucose SG= Sensor Glucose

Testing Time Before Breakfast/Lunch 1-2 hours after lunch Before/after snack Before/after exercise Before recess
 Before bus ride/walking home **Always** check when student is feeling high, low and during illness Other _____

Snacks: Please allow a _____ gram snack at _____ before/after exercise, if needed.

Snacks are provided by parent /guardian and are located in _____

Treatment for Hypoglycemia/Low Blood Sugar

If student is showing signs of hypoglycemia or if BG/SG is below _____ mg/dl

Treat with _____ grams of quick-acting glucose:

__oz juice or ___ glucose tablets or Glucose Gel or Other _____

Retest blood sugar every 15 minutes, repeat treatment until blood sugar level is above target ___mg/dl

If no meal or snack within the hour give a 15-gram snack

If student unconscious or having a seizure (severe hypoglycemia): Call 911 and then parents

Give Glucagon: Amount of Glucagon to be administered: _____ (0.5 or 1 mg) IM, SC **OR** Baqsimi 3 mg intranasally

Notify parent/guardian for blood sugar below _____ mg/dl

Treatment for Hyperglycemia /High Blood Sugar

If student showing signs of high blood sugar or if blood sugar is above _____ mg/dl

Allow free access to water and bathroom

Check ketones for blood sugar over 250 mg/dl, Notify parent/guardian if ketones are **moderate to large**

Notify parent/guardian for blood sugar over _____ mg/dl

Student does not have to be sent home for trace/small urine ketones

See insulin correction scale (next page)

Call 911 and parent/guardian for hyperglycemia emergency. Symptoms may include nausea & vomiting, heavy breathing, severe abdominal pain, chest pain, increased sleepiness or lethargy, or loss of consciousness.

Document all blood sugars and treatment

Signs of Low Blood Sugar

personality change, feels funny, irritability, inattentiveness, tingling sensations headache, hunger, clammy skin, dizziness, drowsiness, slurred speech, seeing double, pale face, shallow fast breathing, fainting

Name: _____

Orders for Insulin Administration

Insulin is administered via: Vial/Syringe Insulin Pen Not taking insulin at school

Can student draw up correct dose, determine correct amount and give own injections?

Yes No Needs supervision (describe) _____

Insulin Type: _____ Student permitted to carry insulin & supplies: Yes No

Calculation of Insulin Dose: A+B=C

A. Insulin to Carbohydrate Ratio: 1 unit of Insulin per _____ grams of carbohydrate

Give _____ units for _____ grams
 Give _____ units for _____ grams
 Give _____ units for _____ grams
 Give _____ units for _____ grams

OR

$\frac{\text{Carbohydrates To Eat}}{\text{Carbohydrate Ratio}} = \text{Units of Insulin (A)}$

B. Correction Factor: _____ unit/s of insulin for every _____ over _____ mg/dl
Target BG

If BG/SG is _____ to _____ mg/dl Give _____ units
 If BG/SG is _____ to _____ mg/dl Give _____ units
 If BG/SG is _____ to _____ mg/dl Give _____ units
 If BG/SG is _____ to _____ mg/dl Give _____ units
 If BG/SG is _____ to _____ mg/dl Give _____ units
 If BG/SG is _____ to _____ mg/dl Give _____ units
 If BG/SG is _____ to _____ mg/dl Give _____ units

OR

$\frac{\text{Current BG/SG} - \text{Target BG}}{\text{Amount to Correct}} = \text{Units of Insulin (B)}$
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C. Mealtime Insulin dose = A + B

Other: _____

Give mealtime dose: before meals immediately after meals If blood glucose is less than 100mg/dl give after eating

Parental authorization should be obtained before administering a correction dose for high blood glucose level (excluding meal time)

Parents are authorized to adjust the insulin dosage +/- by _____ units for the following reasons:

Increase/Decrease Carbohydrate Increase/Decrease Activity Parties Other _____

Student self-care task	Independent	
Blood Glucose Monitoring	Yes	No
Carbohydrate Counting	Yes	No
Selection of snacks and meals	Yes	No
Insulin Dose calculation	Yes	No
Insulin injection Administration	Yes	No
Treatment for mild hypoglycemia	Yes	No
Test Urine/Blood for Ketones	Yes	No

Authorization for the Release of Information:

I hereby give permission for _____ (school) to exchange specific, confidential medical information with _____ (Diabetes healthcare provider) on my child _____, to develop more effective ways of providing for the healthcare needs of my child at school _____

Prescriber Signature _____ Date _____

Parent Signature _____ Date _____

I received a copy of the 504 Procedural Safeguards for the current school year. _____

Parent/Guardian Signature



Reviewed by
Drs Carly Wilbur & Jamie Wood
10/2019

SECTION 504 PARENT/CHILD RIGHTS AND PROCEDURAL SAFEGUARDS

1. Your child has a right to take part in and receive benefits from public education programs without discrimination based on a disability.
2. You have the right to receive written notice prior to any action by the district in regard to the identification, evaluation, or placement of your child.
3. Your child has a right to an evaluation prior to the development of an initial § 504 plan and any subsequent significant change in placement. Your child is eligible for a free appropriate public education under § 504 of The Rehabilitation Act of 1973 if the § 504 Team determines that your child has a physical or mental impairment that substantially limits one or more major life activities, including the provision of regular or special education and related aids and services that are designed to meet the individual educational needs of the student as adequately as the needs of students without disabilities are met and that are based upon adherence to Section 504's procedural requirements. Major life activities include, but are not limited to, caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, eating, sleeping, standing, lifting, bending, reading, concentrating, thinking, communicating, working, and learning, or the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, or endocrine functions.
4. The district shall consider information from a variety of sources, including (as appropriate) but not limited to aptitude and achievement tests, teacher recommendations, physical condition, social and cultural background, adaptive behavior, medical reports, student grades, progress reports, parent observations, anecdotal reports, and test scores when making eligibility, educational, and placement decisions under § 504.
5. Eligibility decisions must be made by a group of persons knowledgeable about your child, the meaning of the evaluation data, and the placement options.
6. If eligible as disabled under § 504, your child has a right to periodic reevaluations, generally every three years, before your child's placement is terminated or significantly changed, and if otherwise determined to be necessary.
7. Your child has the right to a free appropriate public education ("FAPE"), meaning the provision of education and related services without cost to the person with a disability or his or her parents or guardians except for those fees that are imposed equally on non-disabled students or their parents.
8. Your child has a right to access facilities, services, and activities that are comparable to those provided for non-disabled students.
9. You have the right to examine educational records of your child and obtain copies at a reasonable cost.
10. With respect to actions regarding the identification, evaluation, or educational placement of your child under Section 504, you have the right to notice, an opportunity to examine relevant records, an impartial hearing with opportunity for participation by you and representation by counsel, and a review procedure.
11. If you wish to challenge the actions of the district's § 504 Team in regard to your child's identification, evaluation, or educational placement, you should file a written grievance with the district's § 504 Compliance Officer, Tebra Page, at Solon City School District, 33800 Inwood Road, Solon, Ohio 44139, within 10 calendar days from the time you received written notice of the § 504 Team's action(s). A hearing will be scheduled before an impartial hearing officer selected and appointed by the district and you will be notified in writing of the date, time, and place for the hearing.
12. If you disagree with the decision of the impartial hearing officer appointed by the district, you have a right to a review of that decision by a court of competent jurisdiction.
13. You have a right to file a complaint with the United States Department of Education Office for Civil Rights (OCR) at any time. OCR may be contacted at 600 Superior Avenue, East, Suite 750, Cleveland, Ohio 44114-2611.

Cari Root

Name

33800 Inwood Road

Address

Solon, Ohio 44139

City, State, and Zip

Solon City

School District

Director of Pupil Personnel

Title

(440) 349-6258

Telephone

cariroot@solonboe.org

E-mail