DIABETES – School Health Plan (SHP) Utah Department of Health	**DIABETES** ☐ Type 1 ☐ Type 2	CACHE COUNTY SCHOOL DISTRICT Nursing & Health Services Phone 435-752-3925 Fax 435-792-7796	**ATTACH STUDENT PHOTO**

STUDENT INFORMATION				
Student:	DOB:	School:	Grade:	School Year:
Parent:	Phone:		Email:	
Physician:	Phone:		Fax:	
School Nurse:	Phone:		Email:	

SECTION 504 PLAN: All students with diabetes should also have a separate Section 504 plan in place to provide accommodations necessary to access their education.

STUDENT DIABETES MANAGEMENT SKILLS	Needs Assistance	Needs Supervision	Independent
Identifying feelings of hypoglycemia			
Checking blood glucose			
Independently counts carbohydrates			
Measuring out insulin			
Entering information into pump			
Administering insulin injection			

CONTINUOUS GLUCOSE MONITORING

☐ Student has a Continuous Glucose Monitoring System: CGM's must have parent signature on CGM Addendum. All CGM readings can be used to make treatment decisions.

Test blood glucose with a meter if apparent disparity between CGM reading and symptoms!

INSULIN DELIVERY: (per healthcare provider. correction doses can be given with meal/snack **ONLY**, unless on a pump.

Method of insulin delivery: ☐ Syringe and Vial ☐ Insulin Pen ☐ Pump

High Blood Glucose Correction Dose for **PUMP ONLY**: If BG over _____ mg/dl, give correction per pump calculation.

Lunch – Student will typically eat:

☐ School Lunch (staff can help with carb counts) ☐ Home Lunch (parent will provide carb counts)

HYPOglycemia – Low Blood Glucose	**HYPERglycemia** – High Blood Glucose	ADDITIONAL INFORMATION
Emergency situations may occur with low blood sugar! Symptoms: shaky, feels low, feels Hungry, confused, other (specify): ☐ Student needs treatment when blood glucose is below _____ ☐ If treated outside the classroom, a responsible person MUST accompany student to the office ☐ If blood glucose is below _____ mg/dl or if symptomatic give _____ grams carbohydrates ☐ Repeat until blood glucose is over _____ mg/dl ☐ Disconnect or suspend pump	Symptoms: Increase thirst, increase need for urination, other (specify): ☐ Student needs treatment when blood glucose is over _____ mg/dl ☐ If blood sugar is over _____ mg/dl contact parent ☐ Allow unrestricted bathroom privileges ☐ Encourage student to drink water or sugar-free drinks **IF VOMITING CALL PARENT IMMEDIATELY!**	•Student must always be allowed access to fast-acting sugar. •student is allowed to carry a water bottle and have unrestricted bathroom privileges. •Student is allowed to test his/her blood glucose when/where needed. •Substitute teachers must be aware of the student's health, but still respecting privacy. CALL 911 IF: •Glucagon is administered •Student is unable to cooperate to eat or drink anything •Decreasing alertness or loss of consciousness •Seizure

NOTIFY PARENT(S)/GUARDIAN WHEN BLOOD GLUCOSE IS BELOW _____ mg/dl OR ABOVE _____ mg/dl

Student:	DOB:	School Year: 23-24

SPECIAL CONSIDERATIONS AND PRECAUTIONS (Snacks, PE, School Parties, Field Trips)

PE

☐ Check BG before PE ☐ 15 gram carb snack before PE ☐ 15 gram carb free snack before PE ☐ Other (specify):

_____ **Do not exercise is BG is below _____ mg/dl or above _____ mg/dl or symptomatic of hyperglycemia.**

SCHOOL PARTIES

☐ No coverage for parties ☐ I:C Ratio ☐ Student to take snack home

Parent will provide alternate snack Other (specify):

FIELD TRIPS

Field trips instructions:

OTHER (specify):

EMERGENCY MEDICATION (See DMMO)

Person to give Glucagon: ☐ School Nurse ☐ Parent ☐ EMS ☐ Volunteer(s) (Specify):

Location of glucagon: _____ Attach volunteer(s) training documentation if applicable.

SIGNATURES

PARENT TO COMPLETE *(as required by UCA 53G-9-504 and 53g-9-506)*

(Parent must sign in both places)

☐ I certify that glucagon has been prescribed for my student.

☐ I request the school identify and train school personnel who volunteer to be trained in the administration of Glucagon.

☐ I authorize the administration of glucagon in an emergency to my student.

☐ I authorize my student to possess or possess and self-administer diabetes medication. I acknowledge that my student is responsible for, and capable of, possessing or possessing and self-administering the diabetes medication.

Parent Signature:	**Date:**

As parent/guardian of the above named student, I give permission for my child's healthcare provider to share information with the school nurse for the completion of this plan. I understand the information contained in this plan will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the School Nurse of any change in the student's health status, care or medication order. If medication is ordered I authorize school staff to administer medication described below to my child. If prescription is changed a new prescriber order must be completed before the school staff can administer the medication. Parents/Guardian are responsible for maintaining necessary supplies, medications and equipment.

Parent Signature:		**Date:**
Emergency Contact:	**Relationship:**	**Phone:**

SCHOOL NURSE (or school office staff, health aide)

Diabetes medication and supplies are kept: ☐ Front Office ☐Health Office ☐ Student Carries ☐ Backpack

☐ Classroom ☐ Other (specify):

This health care plan is to be distributed via PowerSchool or as needed by the front office to all "need to know" staff.

School Nurse Signature:	**Date:**

ADDENDUM: