HEALTH SERVICES
Richardson Independent School District

Diabetes Management and Treatment Plan

Annual Health Service Prescription - Provider/Parent Authorization for Diabetic Care
*This form is to be renewed annually.

Student: _____ Birth Date: ____/____/_____ Date of Plan: _____/_____/_____

Prescribed in-school medication or procedures may be administered by a school nurse or a non-health professional designee of the principal.

TO BE COMPLETED BY PROVIDER:
Please respond to the following questions based on your records and knowledge of the student.

1. PROCEDURES: (parent to provide supplies for procedures):

- Test blood glucose before lunch and as needed for signs/symptoms of hypoglycemia.
- Test urine ketones when blood glucose is hyperglycemic, and/or when child is ill.

2. MEDICATIONS:

- Child ☐ may ☐ may not prepare/administer insulin injection.
- **Rapid Acting Insulin [Regular/Humalog/Novolog]** given subcutaneously prior to lunchtime (<u>within 30 minutes prior to lunch</u>) based on the following guidelines:

  ☐ Fixed dose: _____units plus insulin correction scale*; OR*

  ☐ Insulin to Carbohydrate Ratio: 1 unit insulin per _____ grams carbohydrate plus insulin correction scale

- **<u>Insulin Correction Scale</u>**

  Blood glucose below _____ = no additional insulin
  Blood glucose from _____ to _____=____ unit(s) insulin subcutaneously
  Blood glucose from _____ to _____=____ unit(s) insulin subcutaneously
  Blood glucose from _____ to _____=____ unit(s) insulin subcutaneously
  Blood glucose over _____=____ unit(s) insulin subcutaneously
  (Notify parent if blood glucose is over _____.)

- Oral Diabetes medication: _____ Dose _____ Time _____
- Student is to eat lunch following pre-lunch blood test and required medication.
- Parent/family instructed in diabetes self-management. Parent ☐ may ☐ may not adjust pre-lunch insulin dosage by up to 10% every 4 to 5 days as indicated by glucose trends. **Parent will communicate changes to school personnel.**

3. PRECAUTIONS:

Refer to the provider's orders for <u>Guidelines for Responding to Blood Glucose Test Results</u> on the following page:

- **Hypoglycemia:** Signs of hypoglycemia include trembling, sweating, shaking, pale, weak, dizzy, sleepy, lethargic, confusion, coma, or seizures.
- **Hyperglycemia:** Signs include frequency of urination, excessive thirst and positive urinary ketones.

4. MEAL PLAN:

- ☐ The *Constant Carbohydrate Diet* emphasizes consistency in the number of grams of carbohydrate eaten from day to day at each meal or snack. Proteins and fats are "free foods" in that they have minimal effect on the blood glucose level. The child and parent can chose the carbohydrate product that they wish to use for meals or snacks. **Parent will communicate meal plan changes to school personnel.** Nutrition-rich carbohydrate foods are encouraged.

  Breakfast _____ grams at _____(time) Mid AM snack _____grams at _____(time)
  Lunch _____ grams at _____(time) Mid PM snack _____ grams at _____(time)

- ☐ The *Insulin to Carbohydrate Ratio Meal Plan* allows a variable amount of carbohydrate to be eaten at any meal or snack, but requires appropriate insulin to balance the carbohydrate. The ratio is listed above in section 2. Use basic rounding rules for inexact CHO amounts.
- Does this student have an insulin pump? ☐ Yes ☐ No If yes, please attach student's pump guidelines.

FOR DIABETIC SELF-CARE ONLY

Does this student have provider permission to provide self-care? …… ☐ Yes ☐ No

This student has been provided instruction/supervision in recognizing sign/symptoms of hypoglycemia. ……... ☐ Yes ☐ No

This student is capable of performing self-glucose monitoring and administering his/her own insulin injection/insulin pump care including using universal precautions and proper disposal of sharps. ……...…….. ☐ Yes ☐ No

This student requires the assistance of a designated adult. ……..…….. ☐ Yes ☐ No

This student requires the supervision of a designated adult. …… ☐ Yes ☐ No

This student is completely independent and does not require supervision or assistance of an adult. ……...… ☐ Yes ☐ No

I understand that RISD reserves the right to require that medications and supplies be kept in the clinic if in the school nurse's judgment, the student cannot or will not carry the medication/supplies in a safe manner and/or properly use them.

5. GUIDELINES FOR RESPONDING TO BLOOD GLUCOSE TEST RESULTS

- **If glucose is BELOW _____:** (hypoglycemia or low blood sugar)
  1. Give child 15 grams carbohydrate if child is alert and able to swallow.
     (Examples include but are not limited to: 6 lifesavers; 4 ounces of juice; 6 ounces of regular soda; 3-4 glucose tabs)
  2. Allow child to rest for 10 – 15 minutes, and retest glucose.
  3. If glucose is above _____, allow student to proceed with scheduled meal, class or snack.
  4. If symptoms persist (or blood glucose remains below _____), repeat 1 and 2.
  5. If symptoms still persist, notify parent and keep child in clinic.

- **If blood glucose is BELOW _____ and the child is unconscious or seizing:**
  1. Call emergency medical services.
  2. Rub a small amount of glucose gel (or cake frosting) on child's gums and oral mucosa.
  3. If available, inject Glucagon _____mg. SQ.
  4. Notify parent.

- **If blood glucose is FROM _____ to _____: Follow usual meal plan and activities** (unless otherwise directed by insulin correction scale for insulin administration)

- **If blood glucose is OVER _____:**
  1. If within 30 minutes prior to lunch, follow insulin/medication orders from page 1. Nurse or unlicensed diabetes care assistant to be called if student unable to administer correction dose of insulin per student's sliding scale orders.
  2. Student checks urine ketones.
     <u>If Ketones are negative or small:</u> Encourage water until ketones are negative.
     <u>If Ketones are moderate or large:</u>
     - Student should remain in clinic for monitoring.
     - Notify parent for pick up.
     - Encourage student to drink 8-10oz of water (or other carbohydrate-free liquid) every 20 minutes until ketones are negative; allow access to restroom.
     - If student remains at school, retest glucose and ketones every 2 hours or until ketones are negative.
  3. Student not to participate in PE or other forms of exercise if blood sugar is above 250 and ketones are present.
  4. If student develops nausea/vomiting, rapid breathing, and/or fruity odor to the breath, call 911, the nurse and the parents.
  5. Notify parent if blood glucose is over _____ to update parent and discuss management plan.

Provider signature _____Date _____

Clinic/facility _____Phone_____ Fax_____

Diabetes Nurse Educator: Name _____ Phone _____

Clinical Dietitian: Name _____ Phone _____

TO BE COMPLETED BY THE PARENT:

We (I) the undersigned, the parents/guardians of _____ request that the above Diabetes Management and Treatment Plan be implemented for our (my) child. Delivery of this form to the school nurse constitutes my participation in developing this Plan, and is my consent to implement this Plan. I understand that it is my responsibility to provide the necessary equipment and supplies in order for the above healthcare service to be performed at school by district personnel. I will notify the school immediately if the health status of my child changes, if I change physicians or emergency contact information, or if the procedure is canceled or changes in any way. Information concerning my child's diabetes health management may be shared with/obtained from the diabetes healthcare providers.

Signature_____ Date:_____ Relationship to student: _____

Phone (Hm)_____ (Wk)_____ (Cell) _____

HEALTH SERVICES
Richardson Independent School District

Diabetes Health History Parent Questionnaire

Please complete all questions. This information is essential for the school nurse and school staff in determining your student's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact the school nurse.

Student Name: _____ Date of Birth: ___/___/___

School: _____ Grade: _____

Emergency Contact Information		Primary #:	Alternate #:
Parent/Guardian:			
Parent/Guardian:			
Other:			

DIABETES HISTORY

- When was your child diagnosed with diabetes? _____
- Do other family members have diabetes? ☐ NO ☐ YES: _____
- Does your child have any complications of diabetes such as skin infections or dry skin, vision problems, tingling, pain, numbness, or weakness in hands or feet, kidney problems, or elevated blood pressure? ..... ☐ YES ☐ NO
  If YES, please describe:
- What was the child's most recent HgbA1C level? Date:
  - Is this a typical level for your child? ☐ Yes ☐ No: _____
- How independent is the student in managing his/her diabetes at home? **Check the boxes for activities that the student is able to perform with minimal or no supervision**. ☐ Meal selection & eating planned carbs ☐ Checking blood sugar ☐ Checking ketones ☐ Insulin dose calculation ☐ Insulin administration ☐ Recognizing & treating symptoms of high/low blood sugar ☐ Managing carbs related to exercise/athletics

MEALS

- Will the student be eating breakfast at school? ..... ☐ YES ☐ NO
- Will the student require snacks during the school day? ..... ☐ YES ☐ NO
  Please note all snacks must be included in the doctor's orders. Parents must provide all snacks.
- Will the student be bringing their lunch from home or eating in the cafeteria? ..... ☐ Home ☐ Cafeteria ☐ Both

AFTER SCHOOL CARE

- Will the student be riding the bus? ..... ☐ YES ☐ NO
- Where will the student go after school? ..... ☐ Home ☐ xPlore ☐ Daycare
- Will the student be participating in any extracurricular or after school activities? ..... ☐ YES ☐ NO
  If YES, please describe: _____

ACADEMICS

- Has the student had any past academic or attendance concerns? ..... ☐ YES ☐ NO
  If YES, please describe:

PSYCHOSOCIAL

- Please describe the student's living situation and family dynamics.
- Do you have any concerns regarding the student's coping skills or self-esteem related to diabetes? ..... ☐ YES ☐ NO
  If YES, please describe: _____

ADDITIONAL MEASURES/CONSIDERATIONS

- In addition to the prescribed treatment by the doctor, is there anything else the student uses or does to help manage his/her diabetes? ..... ☐ YES ☐ NO
  If YES, please describe: _____
- Are there any religious practices or preferences that may influence diabetes management while at school? ..... ☐ YES ☐ NO
  If YES, please describe: _____

HEALTH SERVICES

Parent & Student Responsibilities & Acknowledgements Related to Management of Diabetes at School

*this form to be renewed annually

Parent/Guardian:

I understand it is my responsibility to:

- Provide medical documentation and orders for treatment of diabetes and update with any changes.
- Communicate directly with the school nurse, preferably by phone, email, or in person.
- Communicate atypical blood glucose results at home with school nurse, as appropriate.
- Inform the school nurse of new equipment or other diabetic supplies, special situations, or treatments changes, and provide education of such if needed.
- Provide all necessary diabetic supplies (including glucometer, testing strips, lancing devices and lancets, ketone strips, insulin, syringes, glucose tablets or fast acting sugar source, snack, and any other equipment/food/drinks deemed necessary) and replace these items upon expiration or when supply is low per the school's notification.
- Provide current working phone numbers at all times.
- Collaborate with the school team to implement and evaluate the student's IHP and 504 plan (if applicable).

I understand that medical alert identification (such as a bracelet or necklace) is strongly encouraged to alert others to my child's diabetes in the event of an emergency.

Regarding the use **of continuous glucose monitors (CGM)**: I understand, acknowledge, and agree to the following:

- Neither law nor policy requires the Richardson ISD (RISD) to access or monitor my child's CGM or continuously monitor my child's glucose in any manner.
- RISD school personnel will not monitor my child's CGM data on any district-issued or personal staff device.
- All medical treatment provided by RISD school personnel to my child for diabetes-related symptoms shall be made only after an FDA-approved finger stick and not for any reason related to my child's CGM device that is not FDA-approved for treatment.
- CGM-based treatment decisions may be made using a device that is FDA-approved for treatment as indicated on the child's diabetes medical management plan. I understand that school personnel will check a finger stick blood glucose to confirm the glucose level in situations where they are not confident of CGM readings.
- I understand that medications containing acetaminophen (Tylenol) can give false high CGM readings and it is my responsibility to notify the school nurse when my child has received acetaminophen (Tylenol).
- I understand that my child's CGM requires wireless internet service and that the RISD is not responsible for any lapse in wireless internet service or any wireless "connection" issues of any kind.
- I understand that I am solely responsible for the maintenance and upkeep of my child's CGM, including, but not limited to, ensuring proper functioning of the CGM and that any and all software and/or program updates have been completed, and that the RISD is not responsible for any functioning issues that may occur with my child's CGM and will not use CGM readings for treatment if the device is not properly maintained and calibrated.

Parent Name & Signature: _____ **Date:** _____

Student:

I understand it is my responsibility to:

- Come to clinic before lunch for blood glucose testing and insulin administration (unless authorized by provider, parent, and RISD to provide self-care outside of the clinic).
- Understand the signs and symptoms of hypo- and hyperglycemia within reason for student's age.
- When experiencing signs or symptoms of hypo- or hyperglycemia, seek help from the school nurse or Level III trained staff. Discuss blood glucose results in comparison with symptoms and treat blood glucose level if necessary.
- Eat all foods as planned after determining amount of lunch insulin dose.
- Notify my parent/guardian of the need for additional diabetic supplies at school.

Student Name & Signature: _____ **Date:** _____

HEALTH SERVICES
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Authorization for Administration of Diabetes Management and Care Services By Unlicensed Diabetes Care Assistant

Information to Parents: The health and safety of each student is always of paramount importance to every RISD employee. The District is committed to providing a high level of care to meet any special medical needs students exhibit. To help carry out that commitment, RISD ensures that a Registered Nurse is assigned to each campus. The 79th Texas Legislature, through Houses Bill 984, amended the Health and Safety Code to provide more specific requirements for the provision of diabetes management and care services to students in public schools who seek care for the student's diabetes while at school. The school, in conjunction with the parent, will develop for each student who seeks care for diabetes at school an Individualized Health Plan that will specify the diabetes management and care services the student requires at school. Traditionally, the school nurse has provided any medical care students might require at school. Under HB 984, each school also must train other employees to serve as Unlicensed Diabetes Care Assistants who can provide diabetes management and care services if a nurse is not available when a student needs such services. Such services include the administration of insulin or, in an emergency, glucagon. RISD has trained staff at each school to provide such services. HB 984 further specifies that an Unlicensed Diabetes Care Assistant exercises his or her judgment and discretion in providing diabetes care services and that nothing in the statute limits the immunity from liability afforded to employees under section 22.0511 of the Texas Education Code.

Under HB 984, an Unlicensed Diabetes Care Assistant may only administer diabetes care and management services if the student's parent/guardian authorizes an Unlicensed Diabetes Care Assistant to assist the student and confirms his or her understanding that an Unlicensed Diabetes Care Assistant is immune from liability for civil damages under section 22.0511 of the Texas Education Code.

Please check the appropriate box below to indicate your election whether to allow an Unlicensed Diabetes Care Assistant to provide services to your child:

☐ **YES** Agreement for Services: I authorize an Unlicensed Diabetes Care Assistant to provide diabetes management and care services to my child at school. I understand that an Unlicensed Diabetes Care Assistant is immune from liability for civil damages under section 22.0511 of the Texas Education Code.

☐ **NO** I **DO NOT** authorize an Unlicensed Diabetes Care Assistant to provide diabetes management and care services to my child at school.

☐ My child can manage his/her diabetes completely independently and will not seek assistance for his/her diabetes while at school. I understand the school nurse will provide emergency care as needed. This information will be shared with school district personnel as needed.

_____ _____

STUDENT NAME *(Please Print)* **SCHOOL**

_____ _____

Signature of Parent/Legal Guardian **Date Signed**

2020-2021

HEALTH SERVICES
Richardson Independent School District

Parent/Provider Request for Administration of Medication by School Personnel

Date of Request:_____ **School:**_____ **Teacher/Grade:** _____

Student's Name:_____ **Birth date:**____/____/____

Medication:_____ **Exp. Date**____ **Dosage:** _____

Route of administration: ☐ by mouth ☐ inhaled ☐ topical ☐ eye(s) ☐ ear(s) ☐ nasal ☐ injection (circle: IM SQ IV) ☐ rectal ☐ GT/JT

Time to be Administered:_____ **Dates to be Administered:** _____

Condition for which medication is required: _____

Has your child ever taken this medication before? YES NO

Medication Allergies: ☐ No Known Medication Allergies ☐ Allergic to: _____

Special Instructions or known Side Effects of medication on your child: _____

_____

Please indicate how you would like the medication to be returned home when the medication order expires:

☐ Send home in my child's backpack* ☐ Parent/Guardian will pick up med from clinic ☐ Do not return med, please discard any remaining doses

**Controlled substances (such as Ritalin, amphetamine salts, etc.) must be transported by a parent/guardian and will not be released to students.*

The district will take reasonable measures to store medication at ambient room temperatures unless refrigeration is required. Parents must take home medications during school breaks to avoid exposing medications to extreme heat or cold.

My signature below indicates that I request that RISD staff administer the medication specified above to my child, and I am giving permission for RISD staff to contact the physician for additional information, if needed. I understand that for prescription medications, only a 30-day supply will be accepted at a time.

Parent/Guardian Signature:_____ **Email:** _____

Parent's Primary Phone: (____)_____-_____ **Alternate Phone:** (____)_____-_____

Provider's Name:_____ **Phone:** (____)_____-_____

**A provider's signature is required to administer over-the-counter medications for more than 10 consecutive school days from the date of the original request. Medications with a printed pharmacy label for the student do NOT require the provider's signature below.*

***Provider's Signature:** _____

FOR OFFICE USE ONLY! ☐ Entered in Focus ☐ Teacher Notified___/___ ☐ IHP in Focus & eStar (if applicable)

Prescription Medication Count:

Date	# Pills	Counter's Signature	Witness Initials	Date	# Pills	Counter's Signature	Witness Initials

Comments (Indicated by * on back of form):

Date	Comments	Date	Comments

Date	RN Review

Medication returned to: Parent / Student _____ Date _____
Parent/Student Signature

STUDENT NAME: _____ **MEDICATION:** _____

DOSAGE: _____ **TIME:** _____

DAY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	DAY
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DAY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	DAY

CHARTING CODES

A	DC	FT	H	OOM	R	*
Absent	Discontinued	Field Trip	Hold	Out of Medication	REACH	Comments

* Indicates Comments on front of form