



## Lexington-Fayette County Health Department

---

School Health  
650 Newtown Pike  
Lexington, KY 40508-1197  
(859) 288-2314  
(859) 288-2313 Fax

### EMERGENCY MEDICAL PLAN PARENT PACKET - DIABETES

Dear Parent/Guardian:

You have informed us that your student has a medical concern. Enclosed are forms, which need to be completed by both the Parent/Guardian and student's Physician. These forms are necessary in order for the School Nurse or appropriately trained school personnel to perform or administer specific medical treatment or procedures. This information will help us work with your student to minimize unnecessary restrictions, feelings of being treated differently, and possibly absenteeism.

Please send a current picture of your student in order for the student to be easily identified. This information will be distributed to appropriate school personnel on a need-to-know basis and may include bus drivers, substitute teachers, cafeteria staff, and others who work with your student daily.

To help your student, please let us know of any changes in your student's medical condition or emergency daytime phone numbers.

**The following need to be returned to the School Nurse:**

- **Health Care Plan for Diabetes**
- **Physician Order for Diabetes Care & Parent/Guardian Statement**
- **Physician Order for Glucagon (includes injectable and nasal routes), with completed parent/guardian statement and signature**

**Please note:** Effective July 15, 2014, KRS 158.838 was amended to require at least one school employee at each school who has met requirements of KRS 156.502 be on duty during the entire school day to **administer or assist with the self administration of insulin.**

We are looking forward to meeting the medical needs of your student!

Please call the School Health Services program at 288-2314 if you have any questions.

# HEALTH CARE PLAN FOR DIABETES

School Year: \_\_\_\_\_

*Note: This will be shared with the appropriate school personnel such as the Principal, student's teachers, cafeteria staff, and bus driver.*

Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

Allergies: \_\_\_\_\_

Bus # A.M. \_\_\_\_\_ Bus # P.M. \_\_\_\_\_ Walker  Car Rider

Please attach a current photo of your child here.

### Emergency Contact Information:

Parent/Guardian: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Home: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Home: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_ Hospital: \_\_\_\_\_

Location of Diabetic Snacks: \_\_\_\_\_

Location of Glucose Meter: \_\_\_\_\_

GLUCAGON ORDERED (Includes Nasal or injection)? \_\_\_\_ Yes \_\_\_\_ No LOCATION OF GLUCAGON \_\_\_\_\_

### HOW TO TREAT LOW BLOOD SUGAR

#### SIGNS AND SYMPTOMS OF LOW BLOOD SUGAR (HYPOGLYCEMIA):

- The student complains about feeling "low."
- The student exhibits some of all of the following symptoms:
  - ▶ Hungry
  - ▶ Weakness
  - ▶ Other \_\_\_\_\_
  - ▶ Shaky
  - ▶ Pale
  - ▶ Unable to Concentrate
  - ▶ Poor Coordination
  - ▶ Lethargic
  - ▶ Combative
  - ▶ Moist Skin, Sweating
  - ▶ Dizzy

#### IF BLOOD SUGAR IS \_\_\_\_\_ or less OR if signs of low blood sugar are present:

1. Give one of the following fast-acting carbohydrates:
  - 4 oz. (1/2 cup) Apple or Orange Juice
  - 4 oz. REGULAR soda – NOT diet!
  - Honey Packet
  - Half Tube of Cake Icing
  - Or: \_\_\_\_\_
2. Contact the School Nurse: **DO NOT LEAVE THE STUDENT ALONE OR SEND TO OFFICE ALONE**
3. Observe the student for 10 to 15 minutes and check for improvement:
  - Student feels/appears OK and
  - Blood Sugar is > \_\_\_\_\_ when re-checked.
4. If student continues to feel poorly or Blood Sugar is LESS THAN \_\_\_\_\_, repeat steps 1 through 3 until Blood Sugar is greater than \_\_\_\_\_.
5. If the student improves, have him/her eat one of the following:
  - Lunch or Snack – Whichever is due within the hour OR
  - Pre-packaged snack such as peanut butter crackers if lunch or snack is not scheduled within the hour.

Reviewed by: \_\_\_\_\_ RN Date: \_\_\_\_\_

# HEALTH CARE PLAN FOR DIABETES

School Year: \_\_\_\_\_

## IF STUDENT IS **UNABLE** TO PARTICIPATE IN CARE:

- If student is having symptoms such as:  
 Unable to Swallow     Uncooperative     Combative     Unconsciousness     Seizures  
Place student on his/her side and have someone else call Parent/Guardian and 911.  
Keep student safe if he/she has seizure activity by moving furniture, etc.
- GIVE **GLUCAGON** (Injection or Nasal Powder) per Physician order.
- Observe and monitor until EMS arrives.
- When improved, give REGULAR soda, apple juice or other fast acting carbohydrate as tolerated. Avoid giving orange juice if Glucagon was administered due to possible nausea and vomiting.

## HOW TO TREAT **HIGH** BLOOD SUGAR

### SIGNS AND SYMPTOMS OF HIGH BLOOD SUGAR (HYPERGLYCEMIA):

- The student with hyperglycemia will exhibit the following symptoms:
  - Excessive Thirst
  - Frequent Urination
  - Personality/Behavior Change
  - Nausea
  - Blurry Vision
  - Fatigue
  - Inability to Concentrate
  - Other \_\_\_\_\_
- If the student exhibits any of the symptoms listed above, check the student's Blood Glucose.

### IF BLOOD GLUCOSE IS HIGHER THAN \_\_\_\_\_, OR THE ABOVE SYMPTOMS ARE PRESENT:

- Encourage the student to drink water.
- Allow free access to the bathroom.
- Notify School Nurse**
- The School Nurse or trained diabetes personnel should check for urine ketones if ordered by Physician.  
✓ If ketones are elevated, contact Parent/Guardian for direction.
- If the student is **VOMITING** or **LETHARGIC**, call the Parent/Guardian OR call for medical assistance if Parent/Guardian or emergency contact cannot be reached.

EMERGENCY CONTACT LIST	TRAINED SCHOOL PERSONNEL
1. _____ Relation: _____ Phone: _____	1. _____ Rm: _____
2. _____ Relation: _____ Phone: _____	2. _____ Rm: _____
3. _____ Relation: _____ Phone: _____	3. _____ Rm: _____

Reviewed by: \_\_\_\_\_ RN      Date: \_\_\_\_\_

**PHYSICIAN ORDER FOR DIABETES CARE (or attach your agency's standard orders)**

To be completed by the student's Physician and returned to School Health: Confidential FAX (859) 288-2313 or by mail: Lexington-Fayette County Health Department, School Health Division, 650 Newtown Pike, Lexington, KY 40508

**STUDENT'S NAME:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

**BLOOD SUGAR MONITORING NEEDED DURING SCHOOL HOURS:**

Before Meal  2 Hours after Meal

Before Snack  Other (Explain): \_\_\_\_\_

\*Can Student perform his or her own Blood Sugar Checks?  Yes  No

**INSULIN:**

Type of Insulin to be administered at school: \_\_\_\_\_

Pen  Pump

Insulin Units to Carbohydrate Ratio: \_\_\_\_\_

Correction Factor: \_\_\_\_\_

CAN STUDENT GIVE OWN INJECTIONS?  Yes  No

CAN STUDENT CALCULATE CARBS & DETERMINE CORRECT AMOUNT OF INSULIN?  Yes  No

CAN STUDENT DIAL CORRECT DOSE OF INSULIN?  Yes  No

IF PUMP, CAN STUDENT EFFECTIVELY TROUBLESHOOT PROBLEMS?  Yes  No

**I ORDER THE TESTING OF URINE FOR KETONES IF BLOOD GLUCOSE IS > \_\_\_\_\_**

Additional Instructions: \_\_\_\_\_

I give permission to the school nurse and trained diabetes personnel to perform and carry out the diabetes care tasks as outlined in the above physician's orders.  Yes  No

I give permission for this student to check his/her own Blood Sugar, calculate his/her own carb intake, then determine and administer the appropriate amount of insulin INDEPENDENTLY. If student is deemed independent on the aforementioned procedures, the School Nurse or trained diabetes personnel WILL NOT oversee the student's actions.  Yes  No

X \_\_\_\_\_  
(Physician's Signature) \_\_\_\_\_ Date

\_\_\_\_\_  
(Physician's Name - Printed) \_\_\_\_\_ Telephone Number

**PARENT/GUARDIAN STATEMENT**

I, the undersigned Parent/Guardian of \_\_\_\_\_, **authorize a School Nurse or "trained staff member" to administer** the above medication to my student per Physician orders. I agree to furnish the necessary prescribed medication and agree to notify the School Nurse immediately of any changes. I agree to pick up any unused medication within two weeks of the last day of school, or it shall be destroyed.

I, the undersigned Parent/Guardian of \_\_\_\_\_ give consent for **\*\*my student to self-administer** the above medication(s). I understand the Fayette County Board of Education Medication Policies & Procedures (09.2241) are readily available for me to read. I hereby agree to release and hold the school staff free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from such treatment. I have read this Consent and understand all its terms. I sign it voluntarily and with full knowledge of its significance. **I agree to notify the School Nurse immediately if there is any change in my student's status or Physician's orders. The School Nurse reserves the right to monitor the student periodically throughout the year.**

X \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(Parent/Guardian Signature) \_\_\_\_\_ Date

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ RN Date: \_\_\_\_\_

# PHYSICIAN & PARENT/GUARDIAN AUTHORIZATION FOR GLUCAGON INJECTION MEDICATION ADMINISTRATION

The Board of Education of Fayette County has adopted a procedure wherein a member of the staff of the school the student is attending will administer either an injection or prescribed drug in the event of a crisis. The undersigned understands that the staff member administering the above care is not a trained health professional, but is trained by the School Nurse per state law and that this individual will undertake to do his or her best to comply with the recommended procedure as developed by the student's Physician in the case of a life-threatening emergency wherein immediate intervention is required by school personnel.

The undersigned Parent/Guardian does hereby consent to the intervention of school personnel in accordance with the instructions contained in the attached letter from the student's Physician. Additionally, the undersigned agrees to hold school personnel harmless for any injuries resulting from the emergency care unless the injury was caused by the volunteer's negligence.

## PHYSICIAN ORDER FOR GLUCAGON INJECTION

To be completed by the student's Physician and returned to School Health: Confidential FAX (859) 288-2313 or by mail: Lexington-Fayette County Health Department, School Health Division, 650 Newtown Pike, Lexington, KY 40508

**STUDENT'S NAME:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

**STUDENT'S TYPICAL REACTION:** \_\_\_\_\_

### ACTION TO BE TAKEN:

I order the administration of Glucagon for treatment of severe hypoglycemia. I understand that since the School Nurse is not present in the school at all times, the School Nurse will be teaching unlicensed staff from the school to administer the drug if needed.

Please administer Glucagon/Glucagen 1 mg by IM injection for Blood Sugar below \_\_\_\_\_ or unconsciousness. Must follow with a snack and contact Parent/Guardian.

**COMMENTS:** \_\_\_\_\_

*\* Fayette County Public Schools' Protocol requires notification of EMS and Parent/Guardian when Glucagon is administered.*

X \_\_\_\_\_  
(Physician's Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Physician's Name - Printed)

\_\_\_\_\_  
Telephone Number

**\* PLEASE NOTE: The School Nurse is NOT always in the school building and trains non-medical staff to administer medication.**

## PARENT/GUARDIAN STATEMENT

I, the undersigned parent/guardian of \_\_\_\_\_, request that a \*trained staff member administer the above medication to my student per Physician instructions. I agree to furnish the necessary prescribed medication and agree to notify the School Nurse immediately of any changes. I understand the Fayette County Board of Education Medication Policies & Procedures (09.2241) are readily available for me to read. I sign this voluntarily and with full knowledge of its significance. I agree to pick up any unused medication within two weeks of the last day of school, or it shall be destroyed. **I agree to notify the School Nurse immediately if there is any change in my student's status or Physician's orders.**

*\* Parent/Student are responsible to have medication available at school.*

X \_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

Home Phone: \_\_\_\_\_

Work: \_\_\_\_\_

Cell: \_\_\_\_\_

**Reviewed by:** \_\_\_\_\_ **RN** **Date:** \_\_\_\_\_

**PHYSICIAN & PARENT/GUARDIAN AUTHORIZATION  
FOR GLUCAGON (BAQSIMI NASAL POWDER) MEDICATION ADMINISTRATION**

The Board of Education of Fayette County has adopted a procedure wherein a member of the staff of the school the student is attending will administer either an injection or prescribed drug in the event of a crisis. The undersigned understands that the staff member administering the above care is not a trained health professional, but is trained by the School Nurse per state law and that this individual will undertake to do his or her best to comply with the recommended procedure as developed by the student's Physician in the case of a life-threatening emergency wherein immediate intervention is required by school personnel.

The undersigned Parent/Guardian does hereby consent to the intervention of school personnel in accordance with the instructions contained in the attached letter from the student's Physician. Additionally, the undersigned agrees to hold school personnel harmless for any injuries resulting from the emergency care unless the injury was caused by the volunteer's negligence.

**PHYSICIAN ORDER FOR BAQSIMI NASAL POWDER**

*To be completed by the student's Physician and returned to School Health: Confidential FAX (859) 288-2313 or by mail:  
Lexington-Fayette County Health Department, School Health Division, 650 Newtown Pike, Lexington, KY 40508*

**STUDENT'S NAME:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

**STUDENT'S TYPICAL REACTION:** \_\_\_\_\_

**ACTION TO BE TAKEN:**

- I order the administration of Baqsimi (glucagon) nasal powder 3mg for treatment of severe hypoglycemia. I understand that since the School Nurse is not present in the school at all times, the School Nurse will be teaching unlicensed staff from the school to administer the drug if needed.
- Please administer Baqsimi (glucagon) nasal power 3 mg for Blood Sugar below \_\_\_\_\_ or unconsciousness. Must follow with a snack and contact Parent/Guardian.

**COMMENTS:** \_\_\_\_\_

*\* Fayette County Public Schools' Protocol requires notification of EMS and Parent/Guardian when Glucagon is administered.*

X \_\_\_\_\_  
(Physician's Signature) \_\_\_\_\_ Date

\_\_\_\_\_  
(Physician's Name - Printed) \_\_\_\_\_ Telephone Number

**\* PLEASE NOTE: The School Nurse is NOT always in the school building and trains non-medical staff to administer medication.**

**PARENT/GUARDIAN STATEMENT**

- I, the undersigned parent/guardian of \_\_\_\_\_, request that a \*trained staff member administer the above medication to my student per Physician instructions. I agree to furnish the necessary prescribed medication and agree to notify the School Nurse immediately of any changes. I understand the Fayette County Board of Education Medication Policies & Procedures (09.2241) are readily available for me to read. I sign this voluntarily and with full knowledge of its significance. I agree to pick up any unused medication within two weeks of the last day of school, or it shall be destroyed. I agree to notify the School Nurse immediately if there is any change in my student's status or Physician's orders.

*\* Parent/Student are responsible to have medication available at school.*

X \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(Parent/Guardian Signature) \_\_\_\_\_ Date

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**Reviewed by:** \_\_\_\_\_ **RN** **Date:** \_\_\_\_\_

## **ROLES & RESPONSIBILITIES IN THE MANAGEMENT OF STUDENTS WITH DIABETES**

The School Nurse will work with the student, family, student's Physician, and school system personnel as a team to help the diabetic student achieve his or her optimal level of health. The following are responsibilities of each party:

### **PARENTS/GUARDIANS**

1. Provide all necessary equipment for the management of their child's diabetes such as glucose-testing equipment, urine ketone test strips, insulin administration equipment, a used sharps container, and glucagon. A record book may also be provided by the parent/guardian in which blood sugar, carbohydrate counts, and insulin can be recorded for home use, but the School Nurse will also record this information on Fayette County Health Department flow sheets which will be kept in the student's permanent chart.
2. Provide snacks to be kept at school.
3. If ordered by the physician, ensure prescribed Glucagon is taken to the front office at the beginning of the school year or when the child is newly diagnosed as diabetic. The prescribed Glucagon should be picked up by the parent/guardian at the end of the school year.
4. Effective treatment for hypoglycemic episodes should be available at school (e.g., glucose tablets, juice).
5. Complete Healthcare Plan for Diabetes packet and return as soon as possible to the School Nurse.
6. Inform the School Nurse immediately if any changes are made to the Healthcare Plan for Diabetes by the student's health care team.
7. Maintain current telephone numbers where they can be reached in an emergency.

### **SCHOOL NURSE**

1. Identify and maintain current list at school of diabetic students.
2. Send out Diabetic packet prior to the start of the school year for known diabetics and encourage prompt return from the parent/guardian.
3. Develop an Individual Health Plan for each diabetic in the school, which will be reviewed at least annually and as needed to keep current with the Physician's orders.
4. Maintain communication with health care team as needed to revise health care plan.
5. Maintain proper documentation.
6. Maintain skills so that they are up to date with the current trends in diabetic management.
7. Train the appropriate staff within the building about diabetes management and ensure they are fully aware of their role.
8. Perform and/or oversee blood glucose checks and/or insulin administration to students who cannot perform these tasks independently.
9. Work with the student and team to help the pupil achieve the greatest level of independence as appropriate.
10. Notify parent/guardian when supplies are low – (e.g., lancets, Insulin, blood glucose strips, alcohol pads).
11. Ensure Insulin and any prescribed Glucagon medications have not expired.

### **HEALTH-CARE TEAM (PHYSICIAN, DIABETES NURSE EDUCATOR, DIETICIAN, SOCIAL WORKER, ETC.)**

1. Complete Diabetic Health sheet, which will provide the orders needed for the School Nurse to develop the Diabetic Care Plan.
2. Maintain communication with School Nurse as needed to maintain and revise the Healthcare Plan for Diabetes.

### **STUDENT**

1. Adhere to meal plan.
2. Perform blood glucose tests and record in appropriate log if able.
3. Be available for School Nurse to administer treatment – blood glucose check and/or insulin injection.
4. Be an active participant in the health care plan.
5. IF ABLE - Notify a teacher or School Nurse immediately if symptoms of hyperglycemia or hypoglycemia are present.
6. Have a source of carbohydrate to correct hypoglycemia readily available.
7. Participate in school activities without unnecessary restrictions as deemed appropriate by the student and health care team.
8. "Participate in caring for his or her diabetes equipment in a responsible manner."

### **TEACHERS**

1. Participate in the development of the health care plan as appropriate.
2. Be aware of the symptoms of hypoglycemia and hyperglycemia and act appropriately.
3. Attend training offered by the School Nurse at the beginning of the school year or when a student is newly diagnosed with diabetes.
4. Allow student free access to bathroom and water when blood sugar is >200.
5. Provide information for any substitute teacher regarding the health care plan of a student with diabetes.
6. Notify School Nurse of upcoming field trips.
7. If the student is prescribed a Glucagon product (Injection or nasal), ensure that it accompanies him or her on ALL field trips.
8. Help the student comply with meal and snack requirements.
9. Accompany student to School Nurse's office or front office if feeling hyperglycemic or hypoglycemic.

#### **PRINCIPALS/ADMINISTRATORS**

1. Attend training for all emergency Glucagon products offered by the School Nurse at the beginning of the school year if school has known diabetics OR when a student is newly diagnosed as diabetic
2. Be aware of students who have diabetes in the school and where their healthcare plan is located

#### **FOOD SERVICE STAFF**

1. Be informed about the management of diabetes and the roles of foods and snacks.
2. Know the symptoms of hyperglycemia and hypoglycemia and appropriate treatment for hypoglycemia.
3. Be able to provide School Nurse with carbohydrate count of school menu offerings.
4. Be aware of a student's diabetes health care plan as it relates to food and snacks and accommodate the medical needs of the pupil.

#### **SPECIAL AREA TEACHERS AND COACHES**

1. Be aware of the student's health care plan and attend training offered by the School Nurse.
2. Know the symptoms of hyperglycemia and hypoglycemia and how to treat as outlined by the healthcare plan.
3. Be aware of the student's healthcare plan as it relates to sports and exercise and follow accordingly.
4. Encourage the student to participate in physical activities.

#### **BUS DRIVERS**

1. Be aware of students who have diabetes on the bus.
2. Know the symptoms of hyperglycemia and hypoglycemia and have a source of carbohydrates on the bus at all times such as hard candy or crackers.
3. Be aware of the student's health care plan as it relates to emergency situations and know how to react in the event of an emergency, especially hypoglycemia.
4. \*If a student complains of feeling hypoglycemic, ensure someone can meet him or her at the bus stop – DO NOT allow student to go home alone.