HOLDINGFORD PUBLIC SCHOOLS – ISD #738
P.O. Box 250, Holdingford, MN. 56340

Dr. Chris Swenson	Angela Safran	Jim Stang	Garrity Gerber
Superintendent	Secondary Principal	Elementary Principal	Business Manager
320-746-2196	320-746-4309	320-746-4461	320-746-4306

Diabetes Management Plan

Dear Parent/Guardian,

We are planning for the new school year and are aware that your child has a history of diabetes. To ensure that we have the most accurate information to care for your child, information needs to be **updated annually**. We welcome an opportunity to meet with you and to further discuss your child's diagnosis and how we can best implement a personalized school diabetes management plan.

This is regarding my child, _____.

You will need to provide the following:

1. Diabetes Management Plan from your child's doctor or our attached school district Diabetes Management Plan
2. Blood glucose monitor to keep at school
3. Medication (insulin or back up insulin, glucagon) in a current labeled container provided by your pharmacy
4. Test strips
5. Lancets
6. Ketostix
7. Snacks/juice/glucose tabs
8. Any other necessary supplies to support your child (i.e. batteries for pump, etc.)

Please contact Kristen Bruns, School Nurse, or Kaitlyn Thell, Assistant School Nurse, with questions or concerns, or to set up a meeting to further discuss your child's health care/emergency plan. Thank you!

Kristen Bruns, RN, LSN
School Nurse, Holdingford Public Schools
kristen.bruns@isd738.org
Elementary Health Office: (320) 746-4369

Kaitlyn Thell, LPN
Assistant School Nurse, Holdingford Public Schools
kaitlyn.thell@isd738.org
High School Health Office: (320) 746-4368

Diabetes Management Plan

A physician should complete the information on this page.
A parent should complete page 2.

Student Information

Last Name:	First Name:	Date of Birth:	Grade:	School:

Parent/Guardian Information

Parent/Guardian #1		Parent/Guardian #2	
Last Name:	First Name:	Last Name:	First Name:
Phone #1:	Phone #2:	Phone #1:	Phone #2:

Blood Glucose Monitoring and Insulin

Blood Glucose Target Number/Range:	
Blood Glucose Testing Times:	▢ Pre-snack (Time: _____ am/pm) ▢ Pre-lunch (Time: _____ am/pm) ▢ Pre-dismissal (Time: _____ am/pm) ▢ Pre-phy. ed. (Time: _____ am/pm) ▢ Other (Time: _____ am/pm) ▢ Other (Time: _____ am/pm)
Snack/Lunch Bolus:	_____ unit(s) per _____ grams of carbohydrates **OR** ▢ Per Pump
Correction Scale:	_____ unit per _____ blood glucose points over _____ (See "Correction Scale" below) ▢ Per Pump
Student can self-administer insulin/manipulate pump:	▢ Yes ▢ No
Parent may adjust insulin doses as needed:	▢ Yes ▢ No
Student wears a continuous glucose sensor:	▢ Yes ▢ No

Medications (please list all medications student is taking)

Medication Name:	Dose:	Time:	Route:	Possible Side Effects:

Correction Scale - for Hyperglycemia (a "correction" bolus, ONLY given 3 hours after last correction bolus)	**Hypoglycemia**
High Blood Glucose > _____ mg/dl	**Low Blood Glucose < _____ mg/dl**

▢ **Per Pump**
▢ **Correction Insulin** (in addition to scheduled meal dose)
 	
BG Value / **Units of Insulin**
Less than _____ _____
_____ - _____ _____
_____ - _____ _____
_____ - _____ _____
_____ - _____ _____
_____ - _____ _____
More than _____ _____
• Administer insulin per "Correction Scale" if more than 3 hours since last correction injection/bolus.
• Re-check BG in 1 hour if it is > _____.
• Check ketones if BG is >300 twice. Notify parents if ketones are present.
	Immediately treat with 15 grams of fast-acting carbohydrates. (examples: 4oz juice, 3-4 glucose tabs, 1 packet of fruit snacks, etc.)
	
	• Re-check BG in 15 minutes and repeat treatment if blood glucose remains low.
	• If student will participate in additional exercise before the next meal, student should have another 15 grams of carbohydrates to prevent hypoglycemia.
	• Notify parents of BG < _____ mg/dl.
	• Immediately administer glucagon (_____ mg) if the student is unconscious or having seizures.
	  ○ Place student on their side as vomiting is a common side effect.
	  ○ **Call 911.**
	  ○ Notify parents/guardians.
	• Additional instructions: _____

• Notify parents of BG > _____ mg/dl. • Additional instructions: _____	_____

Last Name:	First Name:	Date of Birth:	Grade:	School:

Field Trips:

- All testing supplies, snacks for hypoglycemia, and if needed, a copy of your doctor's orders or our district's Diabetes Care Plan will be sent.
- Specific testing times and insulin administration instructions will be determined for field trip.
- If supplied by parent, glucagon will be sent along on the field trip to be used by 911 personnel, or by a school staff person who has been trained by the Licensed School Nurse/RN, and has been delegated the task of giving glucagon.

Parent/Guardian Request for Administration of Medication

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
2. I release school personnel from liability in the event of adverse reactions resulting from taking the medication(s).
3. I will notify the health office of any change in the medication(s), i.e. dosage change, medication is discontinued, etc.
4. I give permission for the medication(s) to be given by school personnel as delegated by the school nurse.
5. If my child has any remaining medication(s) during or at the end of the school year, I will pick up the medication(s) from the health office.

NOTE: Medication must be supplied in the original prescription bottle.

Parent/guardian signature _____ Date _____

Parent/Guardian Authorization for Release of Medication Information

1. I give permission for Health Services personnel to communicate, as needed, with school staff about my child's medical condition(s).
2. I give permission for Health Services personnel to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical condition(s) being treated by the medication(s).
3. I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to Health Services personnel.

Parent/guardian signature _____ Date _____

Parent/Guardian Authorization for Management Plan: I understand that this care plan may be revoked at any time in writing, and that it expires in one calendar year. I authorize the above plan to be followed in school.

Printed Name:	Signature:	Date: