Central Community Unit School District 301
Dr. Todd Stirn, Superintendent

Student Services Department, Health Services Division

Dear Parent/Guardian,

The Nursing Department of Central CUSD 301 is committed to promoting your student's ability to learn through optimal health and well-being. Our mission is to assist students in establishing successful management of health conditions and facilitating growth in independent care while maintaining safety in school.

Effective diabetes management in school is necessary for the safety and long-term health of your student. Additionally, maintaining target blood glucose levels maximizes readiness for learning and can provide for improved alertness and physical stamina. To help us achieve this, the nursing staff works closely with you, your student, the healthcare provider, and school personnel. Facilitation of care for your student requires the following documents to be completed yearly:

- **Written Diabetes Orders and Management Plan:** To be provided by and signed by the healthcare provider and dated within 12 months prior to the first day of attendance.
- **Authorization for Self-Monitor and/or Self-Management**: This document is enclosed and should be completed by the parents/guardians who wish to have their student independently monitor and/or manage their condition while at school. *Please note: if your student is to self-monitor and/or self-manage any aspect of their care, authorization from the healthcare provider must be documented in the Diabetes Orders/Management Plan.
- **Individual Healthcare Plan (IHP)**: Upon receipt of the Diabetes Orders/Management Plan, the IHP document will be completed by school health services staff and reviewed with parents.

Parents/guardians are encouraged to contact the school nurse to arrange a mutually convenient time to review all aspects of your student's care. Paperwork should be submitted to the school health office prior to the start of the school year. The health services staff will review and finalize for implementation. Please feel free to contact us with any questions or concerns.

Respectfully,

Central CUSD 301 Health Services Staff

	CHS	CMS	PKMS	HBT	CT	PV	LL
Ph	847-464-6030	847-464-6000	847-717-8100	847-464-6008	847-717-8000	847-464-6014	847-464-6011
Fax	847-464-6039	847-464-0233	847-717-8105	847-464-6022	847-717-8006	847-464-6024	630-365-2283

Central Community Unit School District 301
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Student Services Department, Health Services Division

Individualized Healthcare Plan for Student with Diabetes

Name: ______________________________ D.O.B: ______________

School: ____________ Grade: ______ Homeroom: ____________ Year: ______________

Date Diagnosed: _________ Healthcare Provider: __________________ Phone Number: ___________

Target Blood Sugar Range: ______________

Date of physician's orders for the current school year:___________

Treatment Plan for School (Check all that apply)

- ☐ Type of Insulin:___________________
- ☐ Type of Primary Insulin Delivery Device: (circle one) Pump / Pen / Vial and Syringe
- ☐ Type of Secondary Insulin Delivery Device: (circle one) Pen / Vial and Syringe
- ☐ Continuous Glucose Monitoring (CGM) device prescribed
- ☐ Insulin to Carb Ratio (I:CR): ____unit(s)/_____grams
- ☐ Fixed Insulin Lunch Dose ______units
- ☐ Glucose Test Times:
  - ☐ Arrival to School:_______
  - ☐ Before AM Snack:_______
  - ☐ Before Lunch:_______
  - ☐ Before Exercise:_______
  - ☐ After Exercise:_______
  - ☐ Before PM Snack:_______
  - ☐ Before School Departure:_______
    - ☐ Bus Rider ☐ Walker ☐ Parent Pick-Up ☐ Self-Drive
  - ☐ Other:_______

Location:
- ☐ Independent
- ☐ Health Office
- ☐ Other:___________

By Whom:
- ☐ Independent
- ☐ School Nurse or TDCA

- ☐ Scheduled Snack Times: __________________ ☐ Snack Insulin Dose _____units or per pump
- ☐ PE/Activity Restrictions: Cannot exercise if blood sugar is below________ or above _______
  - ☐ Additional PE Instructions:____
- ☐ Not permitted to get on the bus/walk home/drive if sugar is less than ______ or greater than ______
- ☐ Other:____

Supplies to be provided by Parents: Insulin and administration supplies, insulin pump supplies, blood glucose monitor and all monitoring supplies if prescribed, snack foods, fast-acting glucose source, Ketone testing supplies, Glucagon emergency kit, and a disaster preparedness kit.

Hyperglycemia Protocol: (See Physician Orders)

1. Provide water
2. Test Ketones when blood sugar greater than: ___________
3. Notify parent/guardian if Ketones: ____________________
4. Additional Ketone Testing Instructions: ____

____

Hypoglycemia Protocol: (See Physician Orders)

If symptomatic or blood sugar is less than ______

1. Eat/drink 15 grams of carbohydrate
2. Check BG again in 15 minutes; if not above ______, repeat treatment
3. Check BG again in 15 minutes; is not above ______, repeat treatment and contact parent
4. Additional Instructions:____

____

Glucagon Administration: If child becomes unconscious, unable to cooperate, or has a seizure, give Glucagon 0.5 / 1.0mg subcutaneously (circle one). Call 911 and parents. Do not force eating or drinking. Turn on side.

Additional Instructions/Accommodations:

____

____

____

Emergency Contact Information:

Name	Relationship	Cell Phone	Home Phone	Work Phone
1.				
2.				
3.				

I give permission for this care plan to be in place at school and for the medications ordered herein to be administered by school staff. I further consent to sharing this plan and the action plan(s) with administrators, classroom teachers, bus drivers and other appropriate school personnel who may need to know and for school staff to communicate with the student's healthcare provider and staff. I will update the school when changes are made in the medical management plan. I approve this Individualized Healthcare Plan for my child. I recognize that the records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights & Privacy Act

Parent/Guardian Signature ____________________________________ Date ________

Signature of Nurse ____________________________________ Date________

Central Community Unit School District 301
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Student Services Department, Health Services Division

Authorization for Self-Monitor and/or Self-Management of Diabetes Medical Management Plan

Name of Student ______________________________ Date of Birth: ______________ School ______________________________ Grade/ Homeroom ________ Year __________ Diagnosis ______________________________ Medication ______________

I hereby authorize Central Community Unit School District 301 to allow my child to (*circle one or both*): **self-monitor / self-manage** their Diabetes Medical Management Plan as prescribed by his/her physician during the following: (1) while in school; (2) while at a school sponsored activity; (3) while under the supervision of school personnel; and/or (4) before or after normal school activities. I attest that the student has been instructed on and is capable of self-monitoring and self-managing and that he/she understands the need for the medicine and to report any side effects to school staff. I further acknowledge and agree that the School District and its employees and agents are to incur no liability, except for willful and wanton conduct by any of the said parties, as a result of any injury arising from self-monitoring, self-management. I further acknowledge and agree that, in the absence of willful and wanton conduct on the part of the School District and its employees and agents, I waive any claims that I might have against said parties arising out of self-monitoring, self-management. In addition, I agree to indemnify and hold harmless the School District and its employees and agents, either jointly or severally, except claims based on willful and wanton conduct on behalf of said parties from and against any and all claims, damages, causes of action or injury incurred or resulting from self-monitoring, self-management of their Diabetes Medical Management Plan.

- ☐ I certify that my child can independently perform blood glucose monitoring without supervision from school staff
- ☐ I certify that my child can independently perform insulin administration via injection and/or pen without supervision from school staff
- ☐ I certify that my child can independently manage his/her insulin pump without supervision from school staff
- ☐ I certify that my child can independently monitor his/her Continuous Glucose Monitor (CGM) without supervision from school staff
- ☐ I certify that my child can independently monitor and manage his/her care without supervision from school staff except in emergencies.

Print Name of Parent / Guardian ______________________________ Date __________

Signature of Parent / Guardian ______________________________ Date __________

Print Name of Emancipated Student ______________________________ D.O.B. ________

Signature of Emancipated Student ______________________________ Date __________

Central Community Unit School District 301
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Student Services Department, Health Services Division

Action Plan for Student with Diabetes

Name: ______________________ D.O.B: ____________

School: __________ Grade: ______ Homeroom: __________ Year: ____________

Date Diagnosed: ________ Healthcare Provider: ______________ Phone Number: __________

Emergency Contact: ______________________ Phone Number: __________

Target Blood Sugar Range: ________________

Low Blood Sugar (Hypoglycemia)

An ADULT must accompany any student with a suspected low blood sugar level.

Symptoms and/or **blood sugar less than:** ______

Mild:
Hunger
Irritable
Weak
Pale
Dizziness
Shakiness
Headache
Other:

Moderate:
Sleepiness
Change in Behavior
Confusion
Slurred Speech
Poor Coordination
Other:

Severe:
Unconscious
Seizures
Unable to Swallow
Other:

Action

- Treat for low blood sugar immediately
- Check blood sugar level, if possible
- **Notify School Nurse/TDCA**
- **Notify Parent/Guardian**

Mild:
1. Provide 15 gm fast-acting sugar (glucose tabs, juice, soda, frosting)
2. Wait 15 minutes
3. Recheck Blood Sugar
4. If blood sugar <70, repeat sugar source and contact parent
5. If blood sugar within target range, student may return to class if feeling better

Moderate:
1. Provide 15 gm fast-acting sugar (glucose tabs, juice, soda, frosting)
2. Wait 15 minutes
3. Recheck Blood Sugar
4. If blood sugar <70, repeat sugar source and contact parent
5. Provide snack if no meal within 1 hour
6. If blood sugar within target range, student may return to class if feeling better

Severe:
1. Call 911
2. Don't give **ANYTHING** by mouth
3. Give Glucagon: ________
4. Position on side
5. Stay with student

*This Action Plan may be distributed to administrators, classroom teachers, bus drivers and other appropriate school personnel

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Action Plan for Student with Diabetes

Name: ______________________ D.O.B: __________

School: __________ Grade: _____ Homeroom: __________ Year: __________

Date Diagnosed: ________ Healthcare Provider: ______________ Phone Number: __________

Emergency Contact: ______________________ Phone Number: __________

Target Blood Sugar Range: ______________

High Blood Sugar (Hyperglycemia)

Symptoms:

Increased Thirst
Frequent Urination
Increased Hunger
Lack of Concentration
Stomach Pains
Blurry Vision
Sweet Breath
Nausea
Vomiting*

Action

If student is feeling well:

1. Provide water
2. Check Ketones, if possible
3. Allow liberal bathroom privileges
4. Communicate with School Nurse and Parent/Guardian

If student is NOT feeling well:

1. Call parent/guardian to pick up student
2. Provide water
3. Check Ketones, if possible
4. Notify School Nurse/TDCA

***For Vomiting with Confusion, Labored Breathing, and/or Coma**

1. Call 911
2. Notify School Nurse/TDCA
3. Notify Parent/Guardian

*This Action Plan may be distributed to administrators, classroom teachers, bus drivers and other appropriate school personnel