URBANA SCHOOL DISTRICT 116

Jean F. Burkholder Administrative Service Center
1101 E. University Ave., Suite B
Urbana, IL 61802
www.usd116.org

URBANA
SCHOOL DISTRICT #116

Dr. Jennifer Ivory-Tatum
Superintendent

Dear Parent/Guardian,

The Care of Students with Diabetes Act makes provisions for a student with diabetes while at school. Students with diabetes are more likely to succeed in school when school staff, parents, and students work together. We ask your assistance in helping us make your child's school year a healthy learning experience. To implement a Diabetes Medical Management Plan for your child, please complete the attached forms with assistance from your students Healthcare Provider, and *return to the Main Office or Building Nurse at your students school*:

- ☐ **Diabetes Medical Management Plan**
- ☐ **Authorization for Administration of Diabetes Management and Care by a Delegated Care Aide**
- ☐ **Authorization for Use and Disclosure of Protected Health Info. & Education Records**

Your child may self-manage their diabetes while at school: for this to occur your child must be *authorized* according to his or her **Diabetes Medical Management Plan (on pg. 3 under Student's Self Care)**. Some of the provisions of self-management include the ability to:

- Check blood glucose as needed
- Self-Administer insulin
- Treat hypoglycemia and hyperglycemia and manage their diabetes in the classroom, in any area of the school or school grounds and at any school related activity or event in accordance with their Diabetes Medical Management Plan
- Possess on his/her person, at all times the supplies and equipment necessary to monitor and treat their diabetes again in accordance with their Diabetes Medical Management Plan. This includes the carrying of; lancets, test strips, needle tips, insulin syringes, insulin pens, insulin pump, infusion sets, glucometers, glucose tablets, glucagon injection kit, food and drink.

Delegated Care Aides: will be provided by the school District **(written parent authorization required)** to assist your child with their diabetes when/if the Building Nurse is not available. The Delegated Care Aide will be trained to assist a student with diabetes in accordance with his/her diabetes medical management plan, including training to do the following:

- Check blood glucose and record results
- Recognize and respond to the symptoms of hypoglycemia and hyperglycemia according to the diabetes care plan
- Estimate the number of carbohydrates in a snack or lunch
- Administer insulin according to the student's diabetes care plan and keep a record of the amount administered
- Respond in an emergency, including how to administer glucagon and call 911

If your child: *rides the bus*, is in the *Before or After School Program (BSCCP/ASCCP)*, or is in *SPLASH* please notify each program respectively of any special accommodations your child may require.

A lunch menu providing the carbohydrate counts of listed menu items will be available at your child's school. Please contact your Building Nurse or the District Nurse at (217)-384-3549 if you have any questions or concerns.

Sincerely, Amy Marx RN | District Nurse

Diabetes Medical Management Plan (DMMP)

Student:_____ DOB: _____ Date: _____
School:_____ School year: _____ to _____
School Fax #: _____ School Phone #: _____

Diabetes Health Care Provider

□ Valeria Benavides, MD □ Sarah Dominique, APRN,CDE □ Mark Miller, MD □ Samantha Robbins APRN
□ Sue Ellyn Sauder, MD □ Michael Torchinsky, MD □ Anu Vishwanath, MD □ _____

Address: **Pediatric Diabetes Resource Center (PDRC)**, 530 NE Glen Oak, Peoria, IL 61637
Office Phone: 309-624-2480 OR 1-888-436-2278
Fax: 309-624-2481
Email: diabetescenter@osfhealthcare.org
For additional resources, visit www.childrenshospitalofil.org → Programs and Services → Diabetes

Monitor Blood Glucose:

□ Before breakfast □ Before lunch
□ As needed for symptoms of low or high blood glucose or illness
□ _____

Target range for blood glucose: _____ to _____ mg/dL

Methods of Monitoring:

Finger Stick:
- Use fingertip with lancing device and blood glucose meter.
- For students not wearing a sensor

Sensor (sometimes called CGM): Sensor: _____
- Finger stick monitoring is necessary if student's symptoms do not match sensor reading and/or sensor reading is missing an arrow and/or number.

Hypoglycemia

Blood glucose reading less than 70 mg/dL; also known as Low Blood Sugar
Student should not be left alone if blood glucose is less than 70 mg/dL and/or has low blood glucose symptoms.

Mild symptoms: Student is alert and shows signs of shakiness, dizziness, sweating, extreme hunger, headache, pale skin color, behavioral changes, other: _____

Treatment:
- Give 15 grams rapid-acting carbohydrate (e.g. Glucose tabs, fruit juice, Smarties®, granulated sugar) with NO insulin.
- Recheck blood glucose in 15 minutes after treating. Repeat treatment if blood glucose is less than 70 mg/dL and/or symptoms persist

Moderate *symptoms*: Student shows signs of severe confusion, disorientation, not able to or unwilling to swallow, may be combative

Treatment:
- Keeping head elevated, give 15 grams carbohydrate using glucose/icing gel applied between cheek and gum.
- Recheck blood glucose in 15 minutes after treating. Repeat treatment if blood glucose is less than 70 mg/dL and/or symptoms of hypoglycemia persists.

Severe symptoms: seizures, unconsciousness, unable or unwilling to swallow

Treatment: □ Inject Glucagon or GlucaGen®: 0.5 mg 1.0 mg intramuscularly (IM) in outer thighs or buttock and place student on his/her side as vomiting may occur.

Hypoglycemia (severe) continued:

- ☐ Administer Baqsimi™: Place tip of device into nostril; press device plunger until green line no longer shows; place student on his/her side as vomiting may occur.
  - ***Do not remove the Shrink Wrap or open the tube until time of use.***
- ☐ Inject Gvoke™PFS: 0.5 mg 1.0 mg subcutaneously in lower abdomen, outer thighs or outer upper arm; place student on his/her side as vomiting may occur.
  - ***Do not open foil pouch until time of use.***
- Contact parent/guardian.
- Call 9-1-1 if specified in 504 Health Plan and/or student does not respond within 15 minutes.
- Do not refrigerate or freeze severe low blood glucose medications.

Hyperglycemia *Any blood glucose reading above target blood glucose. Also called high blood sugar.* ***Allow student bathroom privileges and water access as needed.***

Treatment:
- Give student water to drink.
- Give correction insulin dose before meals and/or at times specified in 504 Health Plan.
- Check for urine ketones if student has one or more of the following:
  nausea vomiting headache "feels sick" stomach pain fever
  unexpected blood glucose above ***300*** mg/dL for ***two*** routine checks in a row

When ***trace or small*** urine ketones are present:
- Contact parent/guardian if specified in 504 Health Plan.
- Push fluids: 8 ounces of water every 30 – 60 minutes.
- Check blood glucose and urine ketones every two hours
- Give correction insulin dose using rapid-acting insulin every two hours if blood glucose is above target.

When ***moderate to large*** ketones are present:
- Follow the instructions for trace or small urine ketones **AND** do the following:
- If blood glucose is less than 150 mg/dL, treat with 15 grams of carbohydrates every 15 minutes until the blood glucose is equal to or greater than 150 mg/dL.
- Once/when blood glucose is 150 mg/dL or more, calculate correction insulin dose for current blood glucose. Next, calculate the ketone treatment insulin dose using the following:
  For ***moderate*** *urine ketones:* Multiply correction insulin dose by **1.5**
  For ***large*** *urine ketones:* Multiply correction insulin dose by **2.0**
- Calculate food insulin dose for any carbohydrates eaten after blood sugar is greater than 150 mg/dL, and add to the above ketone treatment insulin dose.
- Administer insulin by syringe or insulin pen ***even if on insulin pump***.
- If on insulin pump therapy, consider/do an infusion site change.
- Avoid physical activity.
- Recheck blood glucose and urine ketones ***every two hours***. Repeat treatment until ketones are small, trace, or none.
- ***Call 9-1-1 if student has any of the following symptoms: chest pain, shortness of breath, heavy breathing, and/or decreased level of consciousness.***

Diet □ Count carbohydrates in foods/beverages. Total grams of carbohydrate student eats at meal times can vary.
□ Gluten-free.

Medication
- PDRC recommends administering insulin ***before*** the student eats. Timing of insulin should be clarified with parent/guardian at 504 Health Plan meeting.
- A blood glucose taken less than ***two hours*** after insulin administration ***should NOT be corrected.***

Rapid-acting insulin: _____ Given by: □ syringe or insulin pen
□ insulin pump: _____

Dose information for rapid-acting insulin:

Blood Glucose Correction:

Blood glucose target: _____ mg/dL Correction/sensitivity factor: 1 unit/_____

Carbohydrate counting: Give 1 unit rapid-acting insulin per specified grams of carbohydrate

Insulin-to-carbohydrate ratio:

Breakfast: 1 unit: _____ grams Lunch: 1 unit: _____ grams

How to calculate rapid-acting insulin doses at meal times:

Correction insulin dose:

High blood glucose reading – Blood glucose target = _____ ÷ Correction factor/Sensitivity factor
= Units insulin for correction

Food insulin dose:

Total grams carbohydrate in meal ÷ Insulin-to-carbohydrate ratio = Units insulin for food

Total insulin dose:

Correction insulin dose + Food insulin dose = Total units of insulin

An insulin pump will calculate the insulin dose when blood glucose and/or total grams of carbohydrates are entered into pump. See pump settings for current insulin dose information.

Snacks

Routine snacks are not required; however, student is allowed to have snacks the same as his/her classmates. Blood glucose monitoring is not required with snacks. Insulin is to be given for carbohydrates unless specified differently in 504 Health Plan. (For students using injection therapy a low carb snack may not need insulin.) **Clarify plan with parent/guardian for blood glucose monitoring and insulin dosing.**

Student's Self Care

Per Illinois law, student should have access to supervision, support and assistance by properly trained school personnel. Details of support should be discussed with student and parent/guardian at 504 Health Plan meeting. PDRC recommendations for this student are:

□ Student requires adult assistance with diabetes tasks.
□ Student can perform diabetes tasks but requires adult verification that tasks are completed correctly.
□ Student independently self-manages diabetes, requiring assistance only for emergency care.

Dose Adjustments Parent/guardian is authorized to change doses as needed.

□ Yes □ No □ Only after talking to PDRC health care provider/professional staff

Diabetes Supplies

PDRC teaches that diabetes supplies should be in the same room as the student at all times, in accordance with school law, and with awareness of unexpected situations including lockdown, tornado, and fire.

The following diabetes supplies and equipment are used to monitor and treat diabetes:

glucometers	lancets/lancing device	blood glucose test strips	insulin
batteries/charger	ketone test strips	food/drink/snacks	
syringes/insulin pens and pen needles		rapid-acting carbohydrate food/glucose tablets	
sensor with receiver/reader/phone		severe hypoglycemia medication(s)	

For student on insulin pump therapy, additional supplies include alcohol wipes, insulin pump/PDM/DASH™, infusion sets/pods, and/or cartridges, reservoirs, tubing, and insertion device.

Handling of <u>used</u> sharps should be in accordance to FDA guidelines.

Other _____

_____

_____

_____

_____

Signatures

My signature below provides authorization for the above written orders and exchange of health information to assist the trained diabetes care aid/school nurse/school administrator in developing an individualized 504 Health Plan.

Physician/Health Care Provider: _____ Date: _____

I give permission for my child's healthcare provider to share information with the school for completion of this plan. I understand that 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 whenever there is any change in the student's health status or care. School may contact parent/guardian if questions regarding diabetes care arise. I also give the school permission to contact my child's health care provider.

Parent/Guardian: _____ Date: _____

As parent/guardian of the above named student, I give my permission to the diabetes care aide/school nurse/school administrator or other trained designated staff to perform and carry out the diabetes tasks as outlined in this Diabetes Medical Management Plan and/or 504 Medical Plan.

Parent/Guardian: _____ Date: _____

School Representative: _____ Date: _____

Urbana School District # 116
Diabetes

Authorization for Administration of Diabetes Management and Care by a Delegated Care Aide

Information about Delegated Care Aides:
Urbana School District provides for the management and care of students with diabetes based on Public Act 096-1485, the Care of Students with Diabetes Act passed by the Illinois General Assembly. The district is committed to providing a high level of care to accommodate any special medical needs a student may require while at school. For each student that seeks care for diabetes at school, the school following the physician's diabetes medical treatment and management plan, in conjunction with the parents will develop a plan to provide for management and care of the student's diabetes while at school. To help carry out those needs the district employs registered nurses to assist with the administration of medication over the student's lunch hour. The district support nurse and district nurse are available on a very limited basis to provide assistance at the schools. Because of the limited nursing services available, Delegated Care Aides will be provided as per section 20 of Public Act 096-1485. Delegated Care Aides will be trained to provide care based on the student's diabetes medical management plan. **The Delegated Care Aid will be trained to do the following: check blood glucose and record results, according to the child's diabetes care plan recognize and respond to symptoms of hyperglycemia and hypoglycemia, estimate the number of carbohydrates in a snack or lunch and administer insulin according to the student's diabetes medical management plan and keep a record of the amount administered, respond in an emergency, including administration of glucagon and calling 911.**

In accordance with Public Act 096-1485 the Delegated Care Aide may administer diabetes care and management only if authorized by the student's parent/guardian.

Please check the appropriate box below to indicate your election whether to allow a Delegated Care Aide to provide services to your child under the child's diabetes medical management plan

□ **YES** Agreement for services: I authorize a Delegated Care Aide to provide diabetes management and care to my child at school. I understand that the School District, Delegated Care Aides/School Employees are not liable for civil damages as a result of conduct, other than willful or wanton, related to the care of my child with diabetes. Civil Immunity is based on section 45 of Public Act 096-1485 of the Care of Students with Diabetes Act.

□ **NO** **I DO NOT** authorize a Delegated Care Aide to provide diabetes management and care to my child at school. I understand that in the event the medication nurse, support nurse and/or district nurse are not available, I the parent/guardian will be responsible for the administration of diabetes care to my child and 911 will be called in the case of medical emergency.

_____ _____
STUDENT NAME SCHOOL

_____ _____
PARENT SIGNATURE DATE SIGNED

08/11

Urbana School District #116
1101 E. University Avenue, Suite B, Urbana IL 61802
217-384-3600

Authorization for Use and Disclosure of Protected Health Information and Education Records

Patient/Student Name: _____ **Date of Birth:** _____

I hereby authorize: _____
_____
_____

to disclose protected health information and/or educational records to:

_____
_____
_____

_____ Check here if authorization is given for the parties listed above to mutually exchange the information described below.

Description:

The health information to be disclosed consists of (check all that apply):

_____ Any and all records in the possession of _____ including mental health, HIV and/or substance abuse records. (Cross out any item that you do not authorize to be released)
_____ Records regarding treatment for the following condition or injury _____
_____ Records covering the period of time between _____ and _____
_____ Other (be specific, including dates) _____

The education information to be disclosed consists of (check all that apply):

_____ Any and all educational records, including special education records
_____ Records covering the period of time between _____ and _____
_____ Other _____

Purpose: This information is to be disclosed at the individual's request and will be used for the following purpose(s) (check all that apply)

_____ Educational evaluation and program planning
_____ Health assessment and planning for health care services and treatment in school
_____ Medical evaluation and treatment
_____ Other _____

This authorization is valid for one calendar year and will expire on _____. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I understand that my revocation of this authorization will not be effective for actions taken by the school district or health care provider in reliance upon my authorization and prior to notice of my revocation. I understand that failing to authorize disclosure of records may adversely impact the educational programming and/or medical treatment for my child. I recognize that health 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 and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care. I also understand that I have the right to inspect and copy educational records and to challenge their contents.

Parent Signature _____ Date _____

Student Signature* _____ Date _____

*student signature required if the minor student is over age 12 and if this authorization is for the release of mental health records