Wylie ISD
.....building our future

Request for Diabetic Information

Dear Parent,

Our records indicate that your child has diabetes that may require treatment at school or a school related event. Attached to this letter are the following forms that will give Wylie ISD the necessary information and authorization to treat your child.

1. **Diabetes Management Plan** - Must be updated and signed by the doctor and parent **every** school year. It includes Authorization for Self administration of Medication, and Authorization of Emergency Care.
2. **Unlicensed Diabetic Care Assistant** (UDCA) Permission Form
3. **Administration of Medication Request Forms** (2) – One should be used for each medication sent to school. Includes permission to share information with Staff for the best possible care of your child.
4. **Bus**(if applicable), Teacher and Staff reference cards

Your child's supplies should include: (if required in students Management Plan)

- Glucometer
- Juice and Snacks
- Glucagon
- Syringes, alcohol pads, and lancets

Should you have any questions, please do not hesitate to contact the school nurse.

Sincerely,

Wylie ISD School Nurse
Phone:

<u>Please bring all supplies, wallet size photo of your child and this completed paperwork to the school nurse.</u>

Wylie Independent School District
School Health

DIABETES MANAGEMENT PLAN

1. Student: _____ DOB: _____
   School: _____

2. Diagnosis: **Insulin Dependent Diabetes Mellitus**

3. Procedures: (parent to provide diabetic supplies for all procedures)
   a. Test blood before lunch and as needed.
   b. Test urine ketones when blood glucose is over 250 and/or when child is ill.
   c. Please mark one: ☐Regular ☐Humalog ☐Novolog ☐Apidra

   The above insulin given based on the following guidelines:

   ☐Child may/may not prepare insulin injection

   ☐Child may/may not administer insulin injection

   Blood glucose below _____ no additional insulin
   Blood glucose from _____ to _____ = _____ units insulin SQ
   Blood glucose from _____ to _____ = _____ units insulin SQ
   Blood glucose from _____ to _____ = _____ units insulin SQ
   Notify parent if blood glucose is over _____

Father's Name: _____ Phone: _____

Mother's Name: _____ Phone: _____

   d. Child to eat lunch following pre-lunch testing.

4. Precautions:
   a. **HYPOGLYCEMIA: Signs of hypoglycemia include trembling, sweating, shaking, pale, weak, dizzy, sleepy, lethargic, confusion, coma or seizures. See treatment chart on the following page.**
   b. **HYPERGLYCEMIA: Signs include frequency of urination and excessive thirst. See the treatment chart on the following page. (Note: Deep rapid respirations combined with a fruity odor to the breath and positive urinary ketones are signs of ketoacidosis. This is an emergency. Notify parent.)**

5. Meal Plan:
   Breakfast: _____ grams
   Mid AM Snack: _____ grams
   Lunch: _____ grams
   Mid PM Snack: _____ grams

Physician: _____ Phone: _____ Date: _____

Physician Signature: _____

I consent for the District's designee, including District medical professionals, to share/obtain my student's health related information with the medical health professional or health care provider identified above, in order to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, medical treatments as outlined in a student's Diabetes Medical Management or other WISD form requesting school health care services. I understand that school related health services will not be provided to my student without my required consent, as outlined herein.

Signature: _____ Relationship: _____ Date _____

Home Phone: _____ Work Phone: _____

GUIDELINES FOR RESPONDING TO BLOOD GLUCOSE TEST RESULTS

If blood glucose is ***BELOW 70***: (hypoglycemia, insulin reaction, low blood sugar):

A. Give child 15 grams carbohydrate: (such as)
   6 lifesavers
   4 ounces of juice
   6 ounces of regular soda
   2-3 glucose tabs
   If it is lunch or snack time, allow the child to eat the meal or snack.

B. Allow child to rest 10 minutes, recheck blood glucose, if over 80 (or IHP number) return to class.

C. If symptoms persist (or blood glucose remains below 80), repeat steps A and B.

If blood glucose is ***BELOW 70*** and the child is **unconscious or seizing**:

A. Enact School Emergency Response Plan: 1. Call 911
   2. Notify parent.

B. If **available:** inject Glucagon _____ mg. SQ (per IHP).
   If **not available**: rub a small amount of glucose gel (or cake frosting) on child's gums and oral mucosa.

C. If seizing utilize the seizure protocol.

If blood glucose is ***FROM 70 to 250***: Follow usual meal plan, ordered lunch time insulin, and daily activities unless otherwise directed by IHP.

If blood glucose is ***OVER 250***:

A. Test for urinary ketones.

B. If urinary ketones are NEGATIVE:
   a. Follow usual meal plan.
   b. Encourage calorie-free fluids.
   c. Give regular insulin based on sliding scale (per IHP).

B. If urinary ketones are POSITIVE (small, moderate or large):
   a. Encourage calorie-free liquids.
   b. Give regular insulin per sliding scale.
   c. Re-test blood glucose and urinary ketones every 2 hours, or until ketones are negative.
   d. Notify parent for: (these signs can indicate Diabetic Ketoacidosis, a diabetic emergency)
      1. Large ketones
      2. Nausea with vomiting
      3. Deep rapid respirations
      4. Fruity odor to the breath

_____ INDEPENDENT SCHOOL DISTRICT

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 _____ISD 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, _____ISD 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. _____ISD 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 boxes below to indicate your election whether to allow 1. an Unlicensed Diabetes Care Assistant to provide services to your child; 2. self-care; 3. disclosure of your child's condition:

- ☐ **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.
- ☐ **YES** My child can manage his/her diabetes 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.
- ☐ **YES** I request that my child's classmates be informed that my child has diabetes, and given age-appropriate instruction regarding diabetes care, so that they understand the importance of symptoms and the types of intervention that may occur in the classroom.

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

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

WYLIE

PARENT REQUEST FOR ADMINISTRATION OF
MEDICATION BY SCHOOL PERSONNEL

- All prescribed and over the counter medication must be in a container labeled by the pharmacist or prescriber for the named student.
- Non prescription or over the counter medications must be age/wt appropriate, in the original container (NO BAGGIES) with the label intact and the student's name clearly written.
- The medication may be administered by a designate of the principal.
- A separate permission form is required for each medication.
- No expired medications will be accepted or administered.
- Sample medication will be accepted only with written directions from the physician.
- All medication not picked up by the parent on or before the last day of school will be discarded.

Student Name: _____ DOB/Age: _____ Grade:_____ Teacher:_____

Medication: _____ Strength(mg): _____ Exp date: _____

Physician: _____ Prescription #: _____

Condition for which medication is to be administered: _____

Specific Instructions: _____

Route of Medication: ORAL TOPICAL INHALANT INJECTABLE OTHER _____

When to Administer: Dosage may not exceed recommended dose without written instructions.

_____ DAILY _____ ONE TIME DOSE _____ AS NEEDED (PRN)

Time to be given: _____ Dosage: _____ tab cap tsp tbsp puffs vial ml (circle one)

Administer this medication until: _____ end of school year OR _____ specific date ___/___/_____

I authorize, as needed, the sharing of information regarding my child's health between the school nurse, Wylie ISD faculty/staff and the prescribing health care provider to ensure his/her health and safety during school hours.

I give my consent for the above medication to be administered to the above named student by Wylie ISD school personnel. I release Wylie ISD and their employees from any liability in dispensing the above medications.

Parent Signature: _____ Phone: _____ Date: _____

Physician Signature: _____ Phone: _____ Date: _____

This information is confidential and can only be shared on a "need to know" basis.

Quick Reference Emergency Plan – Transportation/Bus Driver

for a Student with Diabetes

Hypoglycemia

(Low Blood Sugar) **Bus # _____**

Student's Name: _____

Grade/Teacher: _____ Date of Plan: _____

Emergency Contact Information:

Mother/Guardian _____

Home phone: _____ Work phone: _____ Cell phone: _____

Father/Guardian _____

Home phone: _____ Work phone: _____ Cell phone: _____

School Phone: _____ School nurse phone: Clinic _____ Cell: _____

Trained Diabetes personnel: _____

Is student self care? _____ Yes _____ No

Never send/leave a student with suspected low blood sugar anywhere alone

Causes of Hypoglycemia
- Too much insulin
- Missed food
- Delayed food
- Too much or too intense exercise
- Unscheduled exercise

Onset
- Sudden

Symptoms

Mild
- Hunger
- Shakiness
- Weakness
- Paleness
- Anxiety
- Dizziness
- Sweating
- Drowsiness
- Personality change
- Unable to concentrate
- Irritability
- Other: _____

circle student's usual symptoms

Moderate
- Headache
- Behavior change
- Poor coordination
- Able to swallow
- Other: _____
- Blurry vision
- Weakness
- Slurred speech
- Confusion

circle student's usual symptoms

Severe
- Loss of consciousness
- Seizure

circle student's usual symptoms

Actions Needed
WHEN IN DOUBT, ALWAYS TREAT FOR HYPOGLYCEMIA

Mild / Moderate
- Ask student if quick sugar source is in backpack
- Provide quick sugar source:
  4-6 Life savers
  or 3 teaspoons of glucose gel
  or 3-4 glucose tablets
  or 4 oz juice
  or 6 oz regular (not diet) soda
- Call Dispatch to contact parent/guardian, school nurse/school
- Repeat quick-sugar source if symptoms persist
- If student is self care, allow student to check blood sugar and eat a quick sugar source if necessary, according to plan of care

Severe
- Don't attempt to give anything by mouth
- If unconscious, position on side, if possible
- Call Dispatch to contact 911, parent/guardian, school nurse/school
- Stay with student

This information is confidential and can only be shared on a "need to know" basis.

Quick Reference Emergency Plan – Level II

for a Student with Diabetes

Hypoglycemia

(Low Blood Sugar)

Student's Name: _____

Grade/Teacher: _____ Date of Plan: _____

Emergency Contact Information:

Mother/Guardian _____

Home phone: _____ Work phone: _____ Cell phone: _____

Father/Guardian _____

Home phone: _____ Work phone: _____ Cell phone: _____

Trained Diabetes personnel: _____

Scheduled classroom snack: _____

Is student self care? _____ Yes _____ No

Never send/leave a student with suspected low blood sugar anywhere alone

Causes of Hypoglycemia

- Too much insulin
- Missed food
- Delayed food
- Too much or too intense exercise
- Unscheduled exercise

Onset

- Sudden

Symptoms

Mild

- Hunger
- Shakiness
- Weakness
- Paleness
- Anxiety
- Dizziness
- Sweating
- Drowsiness
- Personality change
- Unable to concentrate
- Irritability
- Other: _____

circle student's usual symptoms

Moderate

- Headache
- Behavior change
- Poor coordination
- Able to swallow
- Other: _____
- Blurry vision
- Weakness
- Slurred speech
- Confusion

circle student's usual symptoms

Severe

- Loss of consciousness
- Seizure

circle student's usual symptoms

Actions Needed

WHEN IN DOUBT, ALWAYS TREAT FOR HYPOGLYCEMIA

Mild / Moderate

- Allow student to eat a quick sugar source. The student may have this sugar source in a backpack or teacher may have been provided an appropriate sugar source (4-6 life savers, glucose gel, glucose tablets)
- If the student is self-care, allow student to check blood sugar and eat quick sugar source if necessary, according to plan of care
- Please allow immediate access to the clinic if needed. Student will need to be escorted or may send another student for the nurse or trained diabetes personnel.

Severe

- Don't attempt to give anything by mouth
- If unconscious, position on side, if possible
- Send a runner for the school nurse or trained diabetes personnel
- Keep calm and reassure other people nearby
- Stay with student

This information is confidential and can only be shared on a "need to know" basis.

Quick Reference Emergency Plan – Level II

for a Student with Diabetes

Hyperglycemia

(High Blood Sugar)

Student's Name: _____

Grade/Teacher: _____ Date of Plan: _____

Emergency Contact Information:

Mother/Guardian _____

Home phone: _____ Work phone: _____ Cell phone: _____

Father/Guardian _____

Home phone: _____ Work phone: _____ Cell phone: _____

Trained Diabetes Personnel: _____

Scheduled classroom snack: _____

Is student self care? _____ Yes _____ No