FORMS

Helping the Student with Diabetes Succeed

A Guide for School Personnel

Minnesota Supplement

June 2008
Forms in this packet accompany the resource - **Helping the Student with Diabetes Succeed, A Guide for School Personnel - Minnesota Supplement.** The forms are in Word format so they can be adapted by the licensed school nurse according to the policies of his/her district and are

The Diabetes Task Force in Minnesota prepared the Guidelines with the aim of providing Minnesota schools with the tools to:

- Guide school personnel in understanding the needs of students with diabetes including the nature of the disease and its management so that care is specific to each student’s health needs and care is consistent and coordinated across all school settings.

- Assure that the safety of a student with diabetes is maintained in school through development and implementation of an Individualized Healthcare Plan and through training of school staff.

- Support a student with diabetes in becoming independent in his/her self-care management, consistent with his/her age, capabilities and interest.

- Enhance opportunities of students with diabetes to fully participate in all school activities.

Licensed School Nurses are welcome to print, replicate and distribute these tools to educators, assistant staff, parents and others who are part of the team providing comprehensive, coordinated care and support in schools.

> **If the forms are used as is, they may be source labeled as Helping Students with Diabetes Succeed, A Guide for School Personnel - Minnesota Supplement. If the forms are adapted in any way, please so state by adding “Adapted by ___person or agency___, ___date__.”**

The tools should be used after reviewing the Minnesota guidelines and the National Diabetes Education Program (NDEP) school guidelines.

**Minnesota Diabetes Task Force.**

**National Diabetes Education Program (NDEP).**
**Helping the Student with Diabetes Succeed** – to be updated 2008.
**Tools for Delegation:**

Here find forms for the Licensed School Nurse (LSN) to use in implementing the health care directives specified in the Diabetes Medical Management Plan (DMMP) and Individualized Healthcare Plan (IHP). The DMMP or IHP remains the record the LSN uses for assessment and planning and to make and document decisions for each student with diabetes. These forms supplement, but do NOT supplant, the student’s Diabetes Medical Management Plan (DMMP) or Individualized Healthcare Plan (IHP).

The LSN may use these procedures when delegating diabetes care tasks to Unlicensed Assistive Personnel (UAP) in school settings. These become the record of training provided to the UAP and his/her successful demonstration managing the tasks.

The LSN should offer training for all school staff regarding diabetes and emergency care, either at the beginning of the school year or when a student that has diabetes enrolls (NDEP Level I Training).

**Tasks & Skills Sheets:**

- Ketone Testing: Blood
- Ketone Testing: Urine
- Carbohydrate Counting
- Blood Glucose Testing  Insulin Administration: Syringe
- Insulin Administration: Pen Devise
- Insulin Administration: Pump Therapy
- Continuous Glucose Sensor
- Glucagon Administration
- Self Administration of Diabetes Medication and Blood Glucose Monitoring

Also see the NDEP Level I Training which covers these tasks using the equipment specified.
Ketone Testing

Successful delegation of blood or urine ketone testing is dependent on the use of a student’s Individual Healthcare Plan (IHP) or Emergency Care Plan (ECP) which clearly outlines the actions to be taken based on results of blood or urine ketone testing.

<table>
<thead>
<tr>
<th>Blood glucose meter brand: __________________________</th>
<th>School Staff Being Trained:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood glucose meter instructions and toll free number attached: ___</td>
<td></td>
</tr>
<tr>
<td>Blood ketone testing capability: ______ Yes ______ No</td>
<td>Licensed School Nurse:</td>
</tr>
</tbody>
</table>

Blood Ketone Testing Task

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Demo Date</th>
<th>Date/Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Gather supplies (meter, test strip, lancing device, IHP/ECP for follow-up instructions).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Wash hands.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Insert blood ketone strip into meter which turns meter on.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Verify that code on meter matches code for blood ketone strips.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Poke finger or alternative site with lancing device.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Cover lanced site with cotton ball/tissue if needed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Document meter result.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Based on the measure of ketones in the blood, follow IHP or ECP for action plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Inspect area for blood spills and follow district protocol.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Document procedure, findings and actions taken.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Licensed School Nurse Signature/Initials: Date:  

School Staff Signature/Initials:
Urine Ketone Testing

Successful delegation of blood or urine ketone testing is dependent on the use of a student’s Individual Healthcare Plan (IHP) or Emergency Care Plan (ECP) which clearly outlines the actions to be taken based on results of blood or urine ketone testing.

<table>
<thead>
<tr>
<th>Urine ketostix expiration date:</th>
<th>School Staff Being Trained:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Licensed School Nurse:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Put &quot;√&quot; if skill achieved:</th>
<th>Demo Date</th>
<th>Date/initial &quot;√&quot;</th>
<th>Date/initial &quot;√&quot;</th>
<th>Date/initial &quot;√&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Gather supplies (Ketostix, watch, cup, IHP/ECP for follow-up instructions).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Wash hands.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Have the student begin to void and pass ketostix through urine stream (if able); time for 15 seconds.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OR 3. If student is unable, have student urinate into a cup and dip ketostix into urine; time for 15 seconds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. After 15 seconds compare color on strip to color key on the ketostix bottle.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Based on the measure of ketones in the urine, follow IHP or ECP for action plan.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Inspect area for urine spills and follow district protocol for clean up.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Document procedure, findings and actions taken.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

School Nurse Signature/Initials: Date:

School Staff Signature/Initials:
Carbohydrate Counting

Proper amounts and timing of carbohydrate containing foods is an essential part of diabetes management. Delayed meals or snacks, or improper food choices can result in low blood sugars. Consuming too many foods with high carbohydrate content without also taking adequate insulin can result in high blood sugars.

Students may require assistance in determining carbohydrate content of various foods or may need help in determining appropriate choices when exchanging foods. Printed manuals, food labels, and district food services are all resources that can be used to determine the carbohydrate content of specific foods.

Successful delegation of carbohydrate counting is dependent on access to written materials and on the use of an Individual Healthcare Plan which clearly outlines the designated meal plan. The meal plan should include the recommended number of carbohydrate choices for each meal or snack.

School Staff Being Trained:

Licensed School Nurse:

GENERAL GUIDE:
All fruits, breads, pasta, milk and milk products, and some vegetables contain carbohydrate.

<table>
<thead>
<tr>
<th>Carbohydrate Counting - Task</th>
<th>Put &quot;√&quot; if skill achieved:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. School staff aware of meal plan.</td>
<td>Date/initial</td>
</tr>
<tr>
<td>2. School staff instructed on how to determine the amount of carbohydrates in food choices (written lists of foods and carbohydrate amounts available at school).</td>
<td>Date/initial</td>
</tr>
<tr>
<td>3. School staff able to verify with student or assist student with counting exact number of carbohydrates in food choices.</td>
<td>Date/initial</td>
</tr>
<tr>
<td>5. Document procedure, findings and actions taken.</td>
<td></td>
</tr>
</tbody>
</table>

School Nurse Signature/Initials: Date:

School Staff Signature/Initials:
## Blood Glucose Testing

Successful delegation of blood glucose testing is dependent on the use of student’s Individual Healthcare Plan (IHP) or Emergency Care Plan (ECP) which clearly outlines the actions to be taken.

<table>
<thead>
<tr>
<th>Blood glucose meter brand: __________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood ketone testing capability: Yes: ________ No: _______</td>
</tr>
<tr>
<td>Meter strip expiration date: __________________________</td>
</tr>
</tbody>
</table>

Blood glucose meter instructions and toll free number attached

### School Staff Being Trained:

<table>
<thead>
<tr>
<th>Licensed School Nurse:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Put &quot;&quot; if skill achieved:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demo Date</td>
</tr>
<tr>
<td>1. Gather supplies (meter, test strip, lancing device, IHP/ECP for follow-up instructions).</td>
</tr>
<tr>
<td>2. Wash hands.</td>
</tr>
<tr>
<td>3. Insert blood glucose strip in meter, which turns meter on.</td>
</tr>
<tr>
<td>4. Verify that code on meter matches code for blood glucose strips.</td>
</tr>
<tr>
<td>5. Poke finger or alternative site with lancing device.</td>
</tr>
<tr>
<td>6. Apply blood to test strip.</td>
</tr>
<tr>
<td>7. Cover lanced site with cotton ball/tissue, if needed.</td>
</tr>
<tr>
<td>8. Document meter result.</td>
</tr>
<tr>
<td>8. Follow IHP or ECP for action plan.</td>
</tr>
<tr>
<td>9. Inspect area for blood spills and follow district protocol for cleanup.</td>
</tr>
<tr>
<td>10. Document procedure, findings and actions taken.</td>
</tr>
</tbody>
</table>

### School Nurse Signature/Initials: __________________________ |

### School Staff Signature/Initials: __________________________ |

### Know it. Show it. ✓
Insulin Administration: Syringe

Successful delegation of insulin administration is dependent on the use of the student’s Individual Healthcare Plan (IHP) or Emergency Care Plan (ECP) which clearly outlines the actions to be taken.

Put "✓" if skill achieved:

<table>
<thead>
<tr>
<th></th>
<th>Demo Date</th>
<th>Date/initial</th>
<th>Date/initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Gather supplies (Insulin bottle, syringe, alcohol wipe, IHP/ECP for follow-up instructions).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Wash hands and put on disposable gloves.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Wipe top of bottle with alcohol wipe (optional).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Pull the plunger down to let __ units of air into the syringe.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Push the needle through the center of the rubber top of the insulin bottle.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Push the air into the bottle and leave the needle in the bottle.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Turn the insulin bottle and syringe upside down.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Pull the plunger down slowly to get insulin into the syringe. Make sure you have the correct number of units.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Check for air bubbles and, if present, the air bubbles back in the bottle and repeat Step 9.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Check to make sure you have __ units of insulin in the syringe and take the insulin syringe out of the bottle.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Assist the child…….</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td>Gently pinch skin and insert insulin syringe and needle.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>Insert the needle at a 90 degree angle.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>Push plunger in to deliver insulin and count to five with skin pinched and needle in place.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td>Release the skin and keep needle in place in the skin for a count of five seconds.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td>Remove insulin syringe and needle from skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f.</td>
<td>Dispose of gloves and wash hands.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Do not recap needle. Dispose of syringe in sharps container.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

School Nurse Signature/Initials: Date:

School Staff Signature/Initials:
Insulin Administration: Pen Device

Successful delegation of insulin administration is dependent on the use of the student’s Individual Healthcare Plan (IHP) or Emergency Care Plan (ECP) which clearly outlines the actions to be taken.

School Staff Being Trained:
Licensed School Nurse:

Put "√" if skill achieved:

<table>
<thead>
<tr>
<th></th>
<th>Demo Date</th>
<th>Date/Initial</th>
<th>Date/Initial</th>
<th>Date/Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Gather supplies (Insulin pen or cartridge, pen needles, alcohol wipe {optional}).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Wash hands and put on disposable gloves.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Load insulin cartridge, if needed and wipe insulin pen top with alcohol wipe {optional}.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Screw on the needle to the end of the insulin pen.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Prime the needle by dialing the pen to 2 units.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Push the plunger until you see a small drop or stream of insulin.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Turn the dose knob to the desired dose for this child.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Assist the student in choosing the injection site.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a:</td>
<td>Gently pinch skin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b:</td>
<td>Insert the needle at a 90 degree angle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c:</td>
<td>Push injection button (top of pen) down completely to deliver insulin and count to five with skin pinched and needle in place</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d:</td>
<td>Release pinched skin and keep needle in place for a count of five seconds.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e:</td>
<td>Remove insulin pen and needle from skin.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Replace the outer shield of the needle before unscrewing the needle and dispose of properly in a sharps container.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Dispose of gloves and wash hands.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Document procedure, findings and actions taken.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

School Nurse Signature/Initials:  Date:

School Staff Signature/Initials:  Date:
Insulin Administration: Pump Therapy

Successful delegation of insulin administration is dependent on the use of the student’s Individual Healthcare Plan (IHP) or Emergency Care Plan (ECP) which clearly outlines the actions to be taken.

<table>
<thead>
<tr>
<th>Put &quot;✓&quot; if skill achieved:</th>
<th>Demo Date</th>
<th>Date/initial</th>
<th>Date/initial</th>
<th>Date/initial</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Insulin Pump:</strong> ____________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Toll free number:</strong> ____________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>School Staff Trained:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Licensed School Nurse:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Students using an insulin pump need to have the following supplies available at school. Check supplies:
   - a. Extra insulin for emergencies if the student’s pump malfunctions.
   - b. Syringes or an insulin pen device to administer insulin if needed.
   - c. Extra pump supplies: Infusion set and inserter, reservoir, insulin and batteries.

2. School staff are instructed on type of pump and basic operating functions of the pump:
   - a. How to give a bolus
   - b. How to use the dose calculator function in the pump
   - c. How to suspend the pump
   - d. How to check the status of the pump
   - e. How to verify the last bolus given
   - f. How to verify the pump is not in “no delivery” mode
   - g. How to change the batteries in the pump

3. For students using an insulin dose calculator (Bolus Wizard®), staff will be able to demonstrate how to look at pump dose calculations for dose of insulin to verify dose is within parameters and can activate to administer dose.

4. Written protocol for bolus and testing of blood sugar are available and reviewed.

5. If the pump infusion set is no longer functional, and the student is unable to re-insert their own infusion set, a parent/guardian is contacted to come to school to re-insert the infusion set.

6. Document procedure, findings and actions taken.

<table>
<thead>
<tr>
<th>School Nurse Signature/Initials:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>School Staff Signature/Initials:</td>
<td></td>
</tr>
</tbody>
</table>
Continuous Glucose Sensor

Successful delegation of continuous glucose sensing is dependent on the use of the student’s Individual Healthcare Plan (IHP) or Emergency Care Plan (ECP) which clearly outlines the actions to be taken.

<table>
<thead>
<tr>
<th>Type of Continuous Glucose Sensor: _____________________</th>
<th>School Staff Being Trained: _____________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toll free number: _________________________________</td>
<td>Licensed School Nurse: _________________________</td>
</tr>
</tbody>
</table>

1. Students who wear continuous glucose sensor systems should not use the sensor glucose when calculating food or correction insulin bolus.
   - Students should always have a glucose meter for confirming sensor readings.

Glucose Meter Name: ____________________________

2. School staff are instructed on type of continuous glucose sensor and basic operating functions of the sensor device:
   a. How to read the glucose result and look at trend arrows:

   b. How and when to calibrate sensor (as per product specification/parents directions):

   c. What to do when an alarm goes off.
      - Know how to clear alarms and document the settings of low and high glucose alerts.
      - Know recommendations to follow when alarms go off.
      - Able to confirm with meter blood glucose.

   d. How to change the batteries in the sensor system

3. For students using an insulin dose calculator (Bolus Wizard®) with their insulin pump, manually enter the finger stick glucose result into the insulin pump.

4. Written protocol for:
   - Confirmatory meter BG’s and correction/food boluses are available and reviewed with school staff

5. Document procedure, findings and actions taken.

School Nurse Signature/Initials: _____________________ Date:

School Staff Signature/Initials: _____________________
Glucagon Administration

Glucagon is a hormone that causes a rise in blood sugar. Glucagon can be administered to a student that exhibits loss of consciousness, seizure or is unable to swallow and needs to treat a low blood sugar. Glucagon administration is ordered by the health care provider and directed by the parent.

The parent needs to supply the Glucagon Emergency Kit to the school along with the physician orders. The school needs to keep the kit in an accessible designated place at room temperature along with list of designated trained individuals who can administer the glucagon. The school should have more one person trained in the administration of glucagon.

Successful delegation of carbohydrate counting is dependent on access to written materials and on the use of an Individual Healthcare Plan which clearly outlines the designated meal plan. The meal plan should include the recommended number of carbohydrate choices for each meal or snack.

School Staff Being Trained:

Licensed School Nurse:

Glucagon Administration Task

<table>
<thead>
<tr>
<th>Glucagon Administration Task</th>
<th>Date checked:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check the expiration date of the supplied glucagon kit annually, replace if out of date.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Use ONLY when child with diabetes is unconscious or having a seizure.</th>
<th>Demo Date</th>
<th>Date/initial &quot;√&quot;</th>
<th>Date/initial &quot;√&quot;</th>
<th>Date/initial &quot;√&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Remove any objects that may injure child from immediate space.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2a. If two people present, one immediately calls for emergency assistance (911); notifies school nurse, principal and parents; the second prepares the glucagon.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2b. If only one person is present, immediately call 911, then prepare and administer the glucagon, then call school nurse, principal and parent.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Wash hands, then glove (if appropriate).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Using the Glucagon Emergency Kit, remove the vial (bottle) cap and clean vial rubber top with alcohol swab if time allows.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Remove the needle protector from the syringe, and inject entire contents of syringe into the vial of Glucagon.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Shake vial gently until glucagon mixes and solution is clear. Do not use if solution is not clear.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Using the syringe, withdraw ________ amount of solution into the syringe. Note: If child is &lt; 6 yrs old, a prescribed dose of less than ½ mg may need to be drawn up using an insulin syringe.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
8. Insert the needle of syringe at 90 degree angle into one of the following sites: thigh, upper/outer part of arm or buttock. Push the plunger of syringe to deliver the medication solution into the site.

9. Withdraw the needle and apply light pressure with alcohol swab or cotton ball at the injection.

10. Dispose of used syringe and vial in sharps container.

11. Turn child onto one side in case he/she vomits.

12. Remove gloves, dispose, and wash hands.

**Following the Glucagon Injection:**

1. Wait 10 minutes, check blood sugar. Student usually responds within 5 minutes of glucagon injection.

2a. Give 4 oz of juice, regular (non-diet) soda, or sugar in water if able to swallow.

2b. If unable to drink, glucose gel, honey, or frosting may be given to help raise the blood sugar.

3. Encourage solid food (crackers, peanut butter, or cheese sandwich) 10 minutes after taking and tolerating liquid.

COMPLETE RECOVERY may take 1 to 2 hours. The effects of glucagon lasts 12 to 25 minutes.

4. The EMS system, school nurse, and parents should have responded to your calls by now and decision for EMS transport, going home with parent, or resuming activities needs to be made. Students often go home from school with the parent/guardian to be more closely monitored as they are at higher risk of a low blood sugar reaction within the next 24 hours.

5. Advise family to notify their health care provider of the episode of severe hypoglycemia for possible need for insulin adjustment.

6. Document procedure, findings and actions taken.

---

**School Nurse Signature/Initials:**

**Date:**

---

**School Staff Signature/Initials:**
# Self Administration of diabetes medication and blood glucose monitoring

**Licensed School Nurse:**

**Student:**

**Date:**

<table>
<thead>
<tr>
<th><strong>Put &quot;√&quot; if skill achieved:</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Self Administration Task:</strong></th>
<th><strong>Student Demo Date</strong></th>
<th><strong>Date/Initial &quot;√&quot;</strong></th>
<th><strong>Date/Initial &quot;√&quot;</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Meet with student and review the following:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Parent in agreement with self-management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. HealthCare provider agrees with self management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Student identifies diabetes supplies needed at school and identifies where supplies will be kept.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Student able to demonstrate correct technique in insulin administration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Student able to demonstrate correct technique in blood glucose monitoring.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Student able to verbalize when to seek assistance with diabetes management.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Student able to verbalize specific school staff to notify when needing assistance with diabetes management.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. School staff identified that will assist student with diabetes management when needed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Student signs the self administration plan.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Inform the Licensed School Nurse of changes/concerns in the student self management plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Document procedure, findings and actions taken.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**School Nurse Signature/Initials:**

**Date:**

**School Staff Signature/Initials:**
Sample Plans for Students with Diabetes

DIABETES: INDIVIDUAL HEALTHCARE PLAN

DIABETES: EMERGENCY CARE PLAN

Type 2 DIABETES PREVENTION: REQUEST FOR DIAGNOSIS & PLAN
Student Name: ___________________________ Date:____________________
Birth date: ___________________ Student ID No. ___________________
Grade/Room: _____________________

ASSESSMENT DATA: (check or circle if applicable)
Reviewed:
Diabetes Questionnaire _______ Diabetes Plan _______

Family Resources:
1. Primary Contact: ______________________ Phone ___ Written___ In person___ Email ___
2. Type of Contact: ______________________ Phone ___ Written___ In person___ Email ___
3. MD follow-up: 1mo__ 3mo__ 6mo__ 9mo__ 12mo__
4. Has phone: Y / N / Sometimes
5. Has transportation Y / N / Sometime
6. Uses community resources: Y / N / Sometimes

Student’s Strengths:
developed age-appropriate self management skills ___
good problem solving ability ___
effective coping skills ___ good social skills ___
communicates needs ___ accepts diagnosis ___

Self Management:
1. Meal Plan: Carb Counting: Y / N Scheduled snacks: Y / N Time: __________ Other: __________________
2. Blood Glucose Monitoring: Meter Type: _____________ Testing Independently: Y / N
3. Exercise Plan: Extra Carbs for PE days: Y / N Amount: __________________

Current medications:
Insulin type: ______________________ Dose: ___________ Time: __________ Delivery Method: ___________ 
Correction dose: __________ units insulin per __________ above __________ mg/dl.
Student able to self-adjust insulin: Y / N Comment: __________________

Oral diabetes agents: Name:

NURSING DIAGNOSIS:
1. Potential for less than optimal school achievement due to diabetes management (D.M).
2. Potential for lack of knowledge about D.M.
3. Potential for future acute and chronic complications related to D.M.
4. Other (list) ___________________

GOALS:
1. Increase knowledge &/or skills related to diabetes to maintain optimal blood glucose control.
2. Participate in regular school/class activities with modifications made as necessary.
3. Other (describe) ____________

INTERVENTIONS:
☐ Provides standard of care and education as listed on diabetes health record: Met: ☐ Not Met: ☐
☐ Provide individual education with staff regarding students unique needs: Met: ☐ Not Met: ☐
☐ Extensive coordination among school, Health Care Provider, & family regarding diabetes management: Met: ☐ Not Met: ☐
☐ Coordinate with school staff for classroom or school modification. Met: ☐ Not Met: ☐
☐ Develop Emergency Care Plan for student (attached). Met: ☐ Not Met: ☐
☐ Develop Emergency Care Plan for student (attached). Met: ☐ Not Met: ☐

Comments: __________________

Annual Review: date:

STUDENT OUTCOMES:
1. Student will participate in classroom/school activities with modifications as needed.
2. Student will improve or maintain understanding of checked items under Diabetes Education/Self Management Skills.
3. Other (list) ___________________

Licensed School Nurse Signature: ___________________________ Date plan developed: __________
DIABETES
EMERGENCY HEALTHCARE PLAN (ECP)

Student Name: ___________________________ Date: ________________
Birth date: ___________________ Student ID No. ____________________ Grade/Room: __________________

Parent/Guardian Name: _________________________ Phone: (____)_____________________
Emergency Contact: ___________________________ Phone: (____)_____________________
Emergency Contact: ___________________________ Phone: (____)_____________________
Health Care Provider: ___________________________ Phone: (____)_____________________
Hospital in case of emergency: ___________________________ Emergency supplies located: _____________

SYMPTOMS*
Low Blood Sugar
Less than: _________

MILD
Hunger Dizziness
Irritable Shakiness
Weak Anxious
Pallor Drowsy
Crying Headache
Sweating
Unable to concentrate
Other: ______________

MODERATE
Sleepiness Erratic behavior Confusion
Slurred speech Poor coordination

SEVERE
Unable to swallow
Combative Unconscious
Seizures

ACTION
• Treat symptoms as listed below
• Check Blood Sugar
• Notify School Nurse:
  Name: __________________
  Pager: ________________

MILD
☐ Provide sugar source:
  • 2-3 glucose tabs
  • 4 oz juice
  • 4 oz regular soda or glucose gel
☐ Wait 10 to 15 minutes
☐ Retest blood glucose. If less than _____mg/dl, retreat with sugar source.
☐ If blood sugar within target range: _____mg/dl, student may return to class.

MODERATE
☐ Provide sugar source:
  • 2-3 glucose tabs
  • 4 oz juice
  • 4 oz regular soda or glucose gel
☐ Wait 10 to 15 minutes
☐ Retest blood glucose. If less than _____mg/dl, retreat with sugar source.
☐ Notify Parent or guardian.
☐ Provide snack if no meal for more than 1 hour.
☐ If blood sugar within target range: _____mg/dl, student may return to class if feeling better.

SEVERE
☐ Call 911
☐ Give Glucagon, if ordered.
☐ Position on side
☐ Contact Parent/Guardian & School Nurse

* Never send a child with suspected low blood sugar anywhere alone.

Licensed School Nurse Signature: ___________________________ Date plan developed: ___________
Copy(ies) given to: ___________________________ Date ________
Adapted from P.E.D.S, 2003 12-05
**TYPE 2 DIABETES PREVENTION:**
REQUEST FOR DIAGNOSIS & PLAN

Student Name: ________________________ Date: ______________ 
Gender: ____ Birth date: ____________ Student ID No.: ____________ Grade/Room: ____________
School: _____________________________ Parent/Guardian: ______________ Phone: ______________

**Dear Health Care Provider:**
This student was seen in the school health office. Here is a brief summary of Licensed School Nurse/RN observations:

<table>
<thead>
<tr>
<th>Presenting symptoms:</th>
<th>Date___________</th>
<th>Diabetes risk factors:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ht ______ Wt ______</td>
<td>BMI ≥ 95th %ile for age/gender _______</td>
<td>□ Parent or sibling diagnosed with diabetes</td>
</tr>
<tr>
<td>BP ______ BP %ile ___</td>
<td>Family hx of HTN</td>
<td>□ Grandparent or aunt/uncle diagnosed with diabetes</td>
</tr>
<tr>
<td>□ Increased thirst</td>
<td></td>
<td>□ Mother diagnosed with gestational diabetes</td>
</tr>
<tr>
<td>□ Exercise intolerance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Acanthosis nigricans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Fatigue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Weight gain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Other: Specify ______</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Education provided by the LSN/RN:**

- □ Participate in 60 minutes of physical activity/day
- □ Reduce TV/computer/video game use to < 2 hrs/day
- □ Eat 1½ cups of fruit and 2½ cups of vegetables/day
- □ Diabetes prevention handout ______Language________
- □ Community resources given ______________________
- □ Other: Please specify ____________________________

**Other data/comments:** __________________________________

**To support this student’s health, please address the following:** The American Diabetes Association (2007) Clinical Practice Recommendations and the American Heart Association (2005) Scientific Report recommend:

- ▪ 8 or more hours fasting venous blood glucose and lipoprotein profile
- ▪ If the FBG is > or = 126 mg/dl, confirm by repeat testing on a different day.
- ▪ The use of hemoglobin A1C for diagnosis of diabetes is not recommended at this time.
- ▪ Medical evaluation of child and child/family diabetes education.
- ▪ Referral to a nutritionist/dietician and exercise program.

**Health Care Provider Response:** The following diagnosis has been made *(ICD 9 codes in parentheses):*

- □ Overweight (278.02)  □ Obese (278)  □ Acanthosis nigricans (701.2)  □ Hypertension (401.9)
- □ Hypercholesterolemia (272.0)  □ Metabolic syndrome (277.7)  □ Pre-diabetes (790.29)
- □ Impaired fasting glucose (790.29) (FBG = 100-125 mg/dl)  □ Unspecified sleep apnea (780.57)
- □ Impaired glucose tolerance (790.22) (2-hr post Oral Glucose Tolerance Test [OGTT]=140-199 mg/dl)
- □ Diabetes mellitus (250.0) (FBG > or = 126 mg/dl or 2-hr post OGTT > or = 200mg/dl)
- □ Other: Please specify: ___________________________________

**Treatment plan:** ____________________________________

**Health Care Provider name/signature**
Clinic Name _______________ Phone ___________________ Date ____________

Please return or fax this form to the Licensed School Nurse. Thank you.
Licensed School Nurse ___________________________ Date ____________
Phone/pager # ___________________ Fax # ___________________
Responsibilities of Delegation:

Delegating Registered Nurse,  
the Person Receiving Delegation  
and the Agency or Employer, MNA

Checklist for Delegation
Responsibilities of the Delegating Registered Nurse, the Person Receiving Delegation and the Agency or Employer

Minnesota Nurses Association Position Paper: Delegation and Supervision of Nursing Activities, 1997

In any delegation situation, the delegating Registered Nurse, the person receiving the delegation, and the agency or employer have specific responsibilities.

The Registered Nurse who is delegating is responsible to:
• Use a thoughtful decision-making process.
• Provide clear and specific directions.
• Individualize the plan of care to meet the student needs.
• Communicate the method of performance, expected results and parameters.
• Supervise performance and documentation of the task.
• Evaluate the patient (student) outcome.

The person receiving delegation is responsible to:
• Demonstrate competence to perform a specific task.
• Ask questions if directions are not understood.
• Follow directions from the registered nurse.
• Follow established protocols and guidelines.
• Communicate concerns promptly to the registered nurse.
• Report observations and activities to the delegating Registered Nurse.
• Document the provision of care.

The agency, employer, manager, supervisor or administrator is responsible to:
• Provide adequate staffing and other resources needed for safe and effective patient (student) care.
• Follow up on every report of concern for safe staffing or concern for nursing practice, and take steps to correct situations which bar safe or effective health care.
• Provide education and orientation to all employees, including information on delegation.

When there are inadequate resources to give safe, effective care, the Registered Nurse will immediately report the situation and will provide the best care possible in the circumstances. Once the Registered Nurse has notified the appropriate parties, he/she is accountable only to give the best care possible with the available resources.

If systems or individuals delegate nursing tasks bypassing Registered Nurse authority over nursing care, that Registered Nurse should not be held accountable for the outcome of the delegated task. These guidelines apply regardless of employer policy. The Registered Nurse is accountable to advocate for patients (students).

In working with non-healthcare professionals the Registered Nurse retains accountability for the health plan and outcome. This includes working with teachers, caseworkers, job coaches, corrections officers, and other professionals involved in care. Delegation of nursing care tasks may be cost effective or cost prohibitive. The cost of inappropriate delegation to clients, nurses, employers, payers and society exceed the cost of adequate professional nursing care.
## Checklist for Delegation


<table>
<thead>
<tr>
<th>CHECK when completed</th>
<th>For each student with diabetes:</th>
</tr>
</thead>
</table>
| **1.**               | The Licensed School Nurse (LSN) validates the necessary prescriber’s orders, parent/guardian authorization, and any other legal documentation necessary for implementing the nursing care.  
   - Health care provider has provided specific written orders related to insulin, glucagons, and/or oral diabetic medications.  
   - Health care provider has provided directions for blood glucose monitoring, meals and snacks, and exercise goals/restrictions.  
   - Health care provider has provided specific directions for managing hyperglycemia and hypoglycemia.  
   - Parent has provided signed authorizations for medications and treatments.  
   - Parent has provided emergency contact information.  
   - Parent has provided all necessary equipment and supplies. |
| **2.**               | The LSN conducts an initial nursing assessment.  
   - LSN has reviewed records, student’s health history, current health status and management of diabetes care at home.  
   - Student is medically stable.  
   - Student has completed initial diabetes education.  
   - Student has demonstrated skill competence of tasks he/she performs.  
   - Student is cooperative with diabetes medical management plan. |
| **3.**               | Consistent with the state’s nursing practice act and the LSN’s assessment of the student, the LSN determines what level of care is required: LSN, RN, LPN, or UAP.*  
   - Considerations for delegating nursing tasks include:  
     - Low potential for harm  
     - Minimal complexity of the nursing activity  
     - Minimal required problem solving and innovation.  
     - High predictability of outcome.  
   - For example, with Glucagon administration to a student with diabetes in severe hypoglycemia:  
     - Glucagon is a hormone that has low potential for harm.  
     - The mixing of the glucagon solution can be taught and practiced (this is the most complex part of the activity). It is administered by injection.  
     - The decision to administer is spelled out in the plan, is obvious and critical:  
       - Known that student has diabetes.  
       - Student is unresponsive.  
       - Plan states to give glucagon (No judgment needs to be made.)  
     - Outcomes highly predicted: a rise in blood sugar and vomiting.  
   - Consistent with the nurse practice act, the LSN determines the amount of training required for the Unlicensed Assistive Personnel (UAP). If the individual has not completed standardized diabetes training, the LSN must ensure that the UAP obtains such training in addition to receiving student-specific training. |

* LSN - Licensed School Nurse, a 4 year degreed or greater RN who is licensed by the Minnesota Board of Teaching.  
  RN - Registered Nurse (may be a 2 year or 4 year professional nurse; 4 year RN is likely eligible for licensure as an LSN)  
  LPN – Licensed Practical Nurse – 1 year preparation. Can provide diabetes management care only as delegated by the LSN.  
  UAP - Unlicensed Assistive Personnel – all other persons, no matter if they have several degrees, are who not licensed to provide nursing care. Can provide diabetes management care only as delegated by the LSN.
## Checklist for Delegation – CONTINUED

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
</table>
| 5.   | Prior to delegation, the LSN must have evaluated the competence of the individual to safely perform the task.  
   - The UAP has completed all necessary training.  
   - The UAP has demonstrated skill competence. |
| 6.   | The LSN provides a written plan of care (Individualized Health Plan, Emergency Care Plan, Specific procedural guidelines) to be followed by the unlicensed staff member (UAP).  
   - The plans identify communication links between the LSN and parents, health care provider, and UAP.  
   - The plans provide specific direction for when LSN notification, reassessment, and intervention are warranted related to a change in the student’s condition, the performance of the procedure, or other circumstances.  
   - The plans are communicated with the UAP. |
| 7.   | The LSN determines the amount and type of LSN supervision necessary.  
   - On-site supervision of delegated tasks allows for direct monitoring of delegated tasks for a minimum of 20% of the UAP’s work time.  
   - Off-site supervision during the UAP’s work-time allows for the nurse to be available to provide directions through various means of verbal or written communications. |
| 8.   | The LSN determines the frequency and type of student health reassessment necessary for ongoing safety and efficacy.  
   - The LSN plans time to interact and care for the student to assess and monitor the student's responses and the outcomes for the plan of care. |
| 9.   | The LSN trains the UAP to document the delegated care according to the standards and requirements of the Board of Nursing and school district procedures.  
   - The UAP documents the delegated tasks completed daily. |
| 10.  | The LSN documents activities appropriate to each of the nursing actions listed above. |

If one or more of these steps are unable to be accomplished, it is recommended that more in-depth preparation is needed before delegation to unlicensed personnel will be safe.

Delegation of nursing tasks to be performed by a LPN or UAP are specific to that student. Delegated tasks do not transfer to another student. The LSN needs to assess a new student with diabetes, knowledge, acceptance, his/her stability, the medical order (insulin-food-activity balance), etc. Teaching the UAP about diabetes, procedures and documentation will need to be reviewed for the second student with unique aspects if the second student's care highlighted.
Sample Mutual Agreements:

General Health Services Agreement

Insulin Pump Management

Student Independent Performance of Blood Glucose Testing & Insulin Administration

Student Independent Performance of Blood Glucose Testing

Student Independent Performance of Medication Administration

Student Success in Diabetes Management at School
General HEALTH SERVICES MUTUAL AGREEMENT

Student Name: ______________________________________ Date: ________________
Gender: _____ Birth date: ___________ Student ID No.: ________________ Grade/Room: ___________
School: ___________________________ Primary teacher/Advisor: ___________________________

Each party indicates agreement with the responsibilities listed by initialing his/her role.

_____ the student will: ________________________________

_____________________________________________________________________

_____________________________________________________________________

_____ the parent will: ________________________________

_____________________________________________________________________

_____________________________________________________________________

_____ the licensed school nurse will: ________________________________

_____________________________________________________________________

_____________________________________________________________________

_____ the health assistant or trained staff will: ________________________________

_____________________________________________________________________

_____________________________________________________________________

This agreement remains in place for one school year and will be reviewed for renewal prior to the start of the next school year. If non-compliance is a problem or there is a change in status of the parties, any party may call for an immediate review of the agreement.

The undersigned are in agreement with the responsibilities as stated.

___________________________________ Student
___________________________________ School Administrator
___________________________________ Parent/guardian
___________________________________ Designated Staff
___________________________________ Licensed School Nurse / Registered Nurse

A copy of this agreement will be attached to the Diabetes Medical Management Plan and the school Individualized Healthcare Plan or 504 plan.
HEALTH SERVICES MUTUAL AGREEMENT:
Insulin Pump Management

Student Name: __________________________________________ Date: ______________
Gender: _____ Birth date: ___________ Student ID No.: _______________________ Grade/Room: __________
School: ___________________________ Primary teacher/Advisor: ____________________________

Each party indicates agreement with the responsibilities listed by initialing his/her role.

____ The student will:
  • Be responsible for needle/catheter site preparation and insertion.
  • Be responsible for programming the pump functions.
  • Immediately report to appropriate school personnel any pump malfunctions (dead batteries, high pressure alarm/no delivery, etc.).
  • Deliver the appropriate bolus based on blood glucose values and planned food consumption.
  • Use Standard Precautions when discarding pump tubing, needles, and cannulas.
  • Notify parents of any pump incidents.
  • Ensure pump/tubing safety during physical activities. If the student chooses to use a quick-release set during activities he/she will ensure that euglycemia is maintained as much as possible (checking blood glucose before and after activities, taking extra carbohydrates as needed, re-connecting the pump after completion of activities, etc.).
  • Take care of any skin site problems (bleeding, tenderness, itching, oozing, etc.). If the pump tubing becomes dislodged at school the student will report immediately to the health office and insert a new set.

____ The parent will:
  • Be responsible for keeping an extra set of pump batteries, tubing, tape (Tegaderm, Op-Site, etc.), insulin, syringe, and solution(s) needed to prep skin sites (alcohol swabs, betadine, etc.) on the school site in case it is needed.

____ The licensed school nurse will:
  • Inform, by phone, the physician and/or parent/guardian of any unusual circumstances.

____ The health assistant/designated staff will:
  • Notify the licensed school nurse of any unusual circumstances.

This agreement remains in place for one school year and will be reviewed for renewal prior to the start of the next school year. If non-compliance is a problem or there is a change in status of the parties, any party may call for an immediate review of the agreement.

The undersigned are in agreement with the responsibilities as stated.

__________________________________________
Student

__________________________________________
Parent/guardian

__________________________________________
Licensed School Nurse

__________________________________________
School Administrator

__________________________________________
Designated Staff

A copy of this agreement will be attached to the Diabetes Medical Management Plan and the school Individualized Healthcare Plan or 504 plan.
HEALTH SERVICES MUTUAL AGREEMENT:
Student Independent Performance of Blood Glucose Testing & Insulin Administration

Student Name: ____________________________ Date: ________________
Gender: ____ Birth date: _______ Student ID No.: ___________________ Grade/Room: _______
School: ___________________________ Primary teacher/Advisor: __________________________

Each party indicates agreement with the responsibilities listed by initialing his/her role.

_____ The student will:
• Independently perform blood glucose testing in accordance with written procedures.
• Daily record the result of blood glucose test and insulin dose (as agreed upon by parent and licensed school nurse).
• Seek help from designated school staff if any problems with their diabetes should occur.
• Keep parent informed of diabetes issues.
• Treat hypoglycemia per written procedure.
• Determine insulin dose based on the physician's order.
• Self-administer insulin per written procedures.
• Follow Universal Precautions (change lancet device at home, dispose of needle and syringe in a designated sharps container, place cotton ball over lanced skin until bleeding stops or use a spot bandage to cover area).

_____ The parent will:
• Provide necessary equipment such as: blood glucose testing kit, juice, snacks, glucose product, syringes and insulin.
• Within 24 hours, inform the school nurse, in writing, of any changes in the student's health status, medication, or treatment regimen.
• Provide signed consents.

_____ The licensed school nurse will:
• Ensure that the student has the necessary skills, maturity and competence for blood glucose testing and independent administration of insulin.
• Evaluate Blood Glucose Testing records, consult student and parent with any concerns regarding interventions or contract compliance.
• Inform, by phone, the physician and/or parent/guardian of any unusual circumstances.
• Arrange to have the parent contacted, by phone, when supplies or insulin are running low.

_____ The health clerk/designated staff will:
• Intervene as instructed for low blood glucose in accordance with written procedure.
• Record the date and time of insulin administration on the Medication Log.
• Provide a copy of this log to the physician's office as directed.
• Notify the school nurse of any unusual circumstances.

This agreement remains in place for one school year and will be reviewed for renewal prior to the start of the next school year. If non-compliance is a problem or there is a change in status of the parties, any party may call for an immediate review of the agreement.

The undersigned are in agreement with the responsibilities as stated.

Student ____________________________________________ School Administrator

Parent/guardian ____________________________________________ Designated Staff

Licensed School Nurse

A copy of this agreement will be attached to the Diabetes Medical Management Plan and the school Individualized Healthcare Plan or 504 plan.
HEALTH SERVICES MUTUAL AGREEMENT:
Student Independent Performance of Blood Glucose Testing

Student Name: ________________________________________________ Date: ________________
Gender: ____ Birth date: _________ Student ID No.: __________________ Grade/Room: __________
School: ___________________ Primary teacher/Advisor: ______________________

Each party indicates agreement with the responsibilities listed by initialing his/her role.

____ The student will:
• Independently perform blood glucose testing in accordance with written procedures.
• Keep daily records of blood glucose test and insulin dose (as agreed upon by parent and school nurse).
• Seek help from designated school staff if any problems with their diabetes should occur.
• Keep parent informed of diabetes issues.
• Treat hypoglycemia per written procedure.
• Follow Standard Precautions (change lancet device at home, place cotton ball over lanced skin until bleeding stops or use a spot bandage to cover area).

____ The parent/guardian will:
• Ensure that necessary skills, maturity and competence are present for independent blood glucose testing.
• Provide necessary equipment such as blood glucose testing meter, testing strips, cotton alls, spot bandages, etc.
• Within 24 hours, inform the school nurse, in writing, of any changes in the student's health status, medication, or treatment regimen.
• Provide necessary signed consents.

____ The school nurse will:
• Ensure that necessary skills, maturity and competence are present for independent blood glucose testing.
• Evaluate blood glucose testing records, consult student and parent regarding any concerns regarding interventions or contract compliance.
• Inform, by phone, the physician and/or the parent/care provider of any unusual circumstances.
• Arrange to have the parent/care provider contacted, by phone, when supplies are low.

____ The health assistant/designated staff will:
• Provide necessary assistance upon request of the student, parent or school nurse.
• Notify the school nurse of any unusual circumstances.
• Ensure that copies of the blood glucose testing log are kept in office.
• Provide a copy of this log to the physician's office as directed.

This agreement remains in place for one school year and will be reviewed for renewal prior to the start of the next school year. If non-compliance is a problem or there is a change in status of the parties, any party may call for an immediate review of the agreement.

The undersigned are in agreement with the responsibilities as stated.

___________________________________ Student
______________________________ __________

_____________________________________ Parent/guardian

_____________________________________ Licensed School Nurse

_____________________________________ School Administrator

_____________________________________ Designated Staff

A copy of this agreement will be attached to the Diabetes Medical Management Plan and the school Individualized Healthcare Plan or 504 plan.
HEALTH SERVICES MUTUAL AGREEMENT:
Student Independent Performance of Medication Administration

Student Name: ___________________________ Date: _______________
Gender: ____ Birth date: _______ Student ID No.: __________________ Grade/Room: ____________
School: ___________________ Primary teacher/Advisor: __________________

This Medication Agreement is designed to ensure student safety and well-being. Each party indicates agreement with the responsibilities listed by initialing his/her role.

Self administer _________________________________ at __________________________________________
(Name of Medication) (Specify time or conditions as-needed.)

___ The student will:
• Demonstrate and explain to the licensed school nurse the correct use of the medication including frequency.
• Store medication safely along with a copy of this agreement in _________________________.
• Take medication independently and discreetly - and - Keep parent informed.
• Notify Health Services immediately if medication is lost or stolen.
• Agree to NOT share medication with other students (this is subject to disciplinary action).
• Other: ______________________________________________________________________

___ The parent/guardian will:
• Provide written parent and physician authorization - and - Monitor/Verify that student takes medication as prescribed knowing that school personnel cannot monitor self-administration.
• Provide back-up medication in Health Office for emergency use.
• Inform School Nurse within 24 hours of any change in medication treatment regime.
• Contact School Nurse in May/June to discuss plan for the next school year.
• Authorize telephone communication between School Nurse and physician as needed.

___ The licensed school nurse will:
• Develop the authorized Medication Agreement and any related Individualized Healthcare Plan (IHP).
• Inform appropriate school personnel (ex., Health Clerk, Office Staff, Teachers, Noon Supervisors, Bus Drivers).
• Monitor agreement implementation on a regular basis.

___ The health assistant/designated staff will:
• Be aware of the student’s Medication Agreement.
• Notify both licensed school nurse and parent in event of unusual circumstances or emergency.

___ Other "Need To Know Personnel" will:
• Be aware of the student’s Medication Agreement. Classroom teachers: Leave information for substitute teacher.
• Report unusual circumstances to Health Services immediately.

VERIFY MEDICATION AGREEMENT
Review of this Medication Agreement will occur: _____ Prior to Next School Year _____ As specified: ______________
"Need to Know" Personnel will be informed of Medication Agreement by Licensed School Nurse as of (date)________
Licensed School Nurse ___________________________ Date ____________

VERIFY MEDICATION AGREEMENT
If non-compliance or a change in status occurs, the student, parent or licensed school nurse may call for an immediate review. We have read and agree to the contents of this Medication Agreement:
Student ___________________________ Parent ___________________________ Date __________

A copy of this agreement will be attached to the Diabetes Medical Management Plan and the Individualized Healthcare Plan or 504 plan.
HEALTH SERVICES MUTUAL AGREEMENT:
Student Success in Diabetes Management at School

Student Name: ___________________________ Date: ________________
Gender: _____ Birth date: __________ Student ID No.: ___________ Grade/Room: ____________
School: ___________________________ Primary teacher/Advisor: ____________________________

This Medication Agreement is designed to ensure student safety and well-being. Each party indicates agreement with the responsibilities listed by initialing his/her role.

<table>
<thead>
<tr>
<th>Choose THREE habits or behaviors you think you can change over the next 1 to 3 months.</th>
<th>How well did you do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>TO HELP ME CONTROL MY BLOOD GLUCOSE LEVELS, I WILL:</td>
<td>Never</td>
</tr>
<tr>
<td>1. Check my blood glucose _____ times each day.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>____ Breakfast ____ Lunch ____ Supper ____ Bedtime ____Other: __________________________</td>
<td></td>
</tr>
<tr>
<td>2. Record and average my blood glucose each week.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>3. Attend a class on Insulin Dose Adjustment. Date: ______________________________________</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4. Adjust insulin doses according to guidelines.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>5. Evaluate the effect of a meal or snack amount or time by checking a blood glucose</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>before and after. Time to check: ______________________________________________________</td>
<td></td>
</tr>
<tr>
<td>What to do: ________________________________</td>
<td></td>
</tr>
<tr>
<td>6. I will avoid this site _________, and use these sites _________________ for all injections.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>7. I will start an exercise program. Type: ______________________________________________</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>How long: ___________________________ When: _____________________________</td>
<td></td>
</tr>
<tr>
<td>8. Carry ___________________________ for low blood glucose treatment at all times.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>9. Follow my meal plan: Not skip ___________________________ (meal/snack).</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>10. Follow my meal plan: Avoid extra carbs between ___________________________ (time).</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>11. Limit ___________________________ in my meal plan by eating less ______________________</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>12. Add more ___________________________ to my meal plan by eating more __________________</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

TO FEEL BETTER ABOUT HAVING DIABETES, I WILL:

| How long: ___________________________ When: _____________________________ | 1 2 3 4 5 |
| TO FEEL BETTER ABOUT HAVING DIABETES, I WILL:                                    |         |
| 1. Wear a medical ID at all times.                                                  | 1 2 3 4 5 |
| 2. Submit a camp application.                                                       | 1 2 3 4 5 |
| 3. Tell a friend about my diabetes by ______________________________________________ | 1 2 3 4 5 |
| 4. Review my glucose record book with my parents _______ times per week.             | 1 2 3 4 5 |
| 5. Make an appointment with _________________________________.                      | 1 2 3 4 5 |