SPRINGBORO SCHOOLS
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Diabetes Management Plan

Student: _____ **School:** _____ **Effective Date:** _____

Date of Birth: _____ **Grade:** _____ **Homeroom Teacher:** _____

Contact Information and Diabetes Medical History

To be completed by Parent/Guardian:

Parent/Guardian #1: _____

Phone #: _____

Parent/Guardian #2: _____

Phone #: _____/_____

Other emergency contact: _____

Relationship: _____ Phone #: _____

Physician: _____

Nurse/Diabetes Educator: _____

Phone#: _____ **Fax#** _____

General Care Information:

- **Insulin Therapy:** _____**Daily Injections /Rapid Acting Insulin Type:** _____

  _____**Insulin Pump/ Pump Brand/Model:** _____

- **Continuous Glucose Monitor (CGM): YES NO**

  Brand/Model: _____ **Clinic iPad Data Sharing: YES NO**

- **Blood Glucose Monitoring**
  Target Range: _____ BG Level to Check Ketones at School: _____

- **Emergency Medication:** _____ **Pg. 1/3**

  Clinic _____ **Expiration Date:** _____ **Self-Carry** _____ **Expiration Date:** _____

Medical History	Parent/Guardian Response (check appropriate boxes and complete blanks)
Diagnosis information	Date/Age? Type of diabetes?
How often is child seen by diabetes physician?	Frequency: Date of last visit:
Nutritional needs	◆ Snacks □ _____AM _____PM _____Prior to Exercise/Activity ⑨ Only in case of low blood glucose ⑨ Student may determine if CHO counting ⑨ In the event of a class party may eat the treat (include insulin coverage if indicated in medical orders) ⑨ student able to determine whether to eat the treat ⑨ replace with parent supplied treat ⑨ may NOT eat the treat Other _____
Child's most common signs of low blood glucose	⑨ trembling ⑨ tingling ⑨ loss of coordination ⑨ dizziness ⑨ moist skin/sweating ⑨ slurred speech ⑨ heart pounding ⑨ hunger ⑨ confusion ⑨ weakness ⑨ fatigue ⑨ seizure ⑨ pale skin ⑨ headache ⑨ unconsciousness ⑨ change in mood or behavior ⑨ other _____
How often does child experience low blood glucose and how severe?	**Mild/Moderate:** ⑨ once a day ⑨ once a week ⑨ once a month What time of day is most common for hypoglycemia to occur? _____ **Severe:**(i.e. unconscious, unable to swallow, seizure, or needed Glucagon) Include date(s) of recent episode(s) _____
Hospitalized for Ketoacidosis	____ YES ____NO If yes, Date: _____
Field trips	Is Parent/guardian will accompany child during field trips? ____ YES ____ NO
Serious illness, injuries or hospitalizations this past year	Date(s) and describe
List any other medications currently being taken	

I have read and understand Springboro Community City Schools Medication Policy. **An updated copy of my child's care plan will be provided the clinic staff. I understand that I will provide all the supplies necessary for the treatment of my child's diabetes. I also consent the release of information contained in this Diabetes Management Plan to other staff members that care for my child and may need to know this information to maintain my child's health and safety. I give permission to contact the above named physician and members of the diabetes management team regarding my child's diabetes should the need arise and *for information to be sent to the school district via facsimile.***

Parent /Guardian Name: _____ **Date:** _____

Parent/Guardian Signature: _____

Nurse Signature: _____ **Date:** _____ **Pg. 2/3**

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Permission to Self-Carry and Self Administer Diabetes Care

To be completed by physician/provider, parent/guardian, and student. This form is not required by law, but serves to inform everyone of expectations and responsibilities.

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

Student's physician or licensed provider confirms that the student has a diagnosis of diabetes, is independent and can perform diabetes care, and has approval to self-administer his/her diabetes care including:

_____Glucose Monitoring

_____Insulin calculation and administration (including pump operation & pump equipment)

The student understands that he/she is to promptly report to school nurse or staff as soon as symptoms of high or low blood glucose appear or when not feeling well.

I agree to prepare a written/electronic Diabetes Medical Management Plan/Orders in consultation with the student's parents and appropriate school personnel.

Specific duration of order: _____ **SCHOOL YEAR**	**Physician/Provider Signature:**	**Date:**	**Office Phone #:**

To be Completed by the Parent:

My child has been instructed in and understands his/her diabetic self-management. My child understands that he/she is responsible and accountable for carrying and using his/her medication and equipment.

I will provide the school nurse/staff with a copy of my child's Diabetic Medical Management Plan signed by his/her physician.

I hereby give permission for the school to administer the medication prescribed in the care plan, if indicated (Example: Student requests assistance or becomes unable to perform self-care).

I also given permission for the school nurse to contact the above physician/provider regarding my child's diabetes care (authorization is required if contact is other than the school nurse).

I will not hold the school board or any of its employees liable for any negative outcomes resulting from the self-administration of diabetes medication by my child.

I understand that the school nurse, after consultation with the parent/guardian and school administrator, may impose reasonable limitations or restrictions upon my child's possession and self-administration of diabetes medications relative to his/her age and maturity or other relevant considerations.

I understand that the school administration may revoke permission to possess and self-administer diabetes medication at any point during the school year if it is determined that my child has abused the privilege of possession and self-administration or he/she is not safely and effectively self-administering the medication.

_____ _____

Parent/Guardian Signature Date

_____ _____

Student Signature Date

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