Madison School District 321

Diabetes **HYPERGLYCEMIA**
↑ (high blood sugar) ↑
Emergency Health Care Plan

School Year:	Student Picture
School:	
Grade:	

STUDENT INFORMATION			
Student:		DOB:	
Parent:	Phone:	Email:	
Parent:	Phone:	Email:	
Healthcare Provider:	Phone:	Fax:	
District Nurse: Rachel Moore, RN	Phone: 208-206-0908	Fax: 208-359-3370	

SPECIAL CONSIDERATIONS

Special considerations and precautions (regarding school activities, field trips, sports, etc.):

Location of testing supplies, snacks, insulin, emergency meds:_____

Causes of Hyperglycemia

Too little insulin or other blood glucose-lowering medications	Illness	Decreased physical activity
Insulin pump or infusion set malfunction	Infection	Severe physical or emotional stress
Food intake that has not been covered adequately by insulin	Injury	Onset - over several hours or days

Hyperglycemia Symptoms

Mild to Moderate		Severe
Increased thirst and/or dry mouth		Chest pain
Frequent or increased urination		Confusion
Change in appetite/nausea/stomach pain		Labored breathing
Blurry vision	Inability to concentrate	Severe abdominal pain
Sweet/fruity breath	Flushing of skin	Very weak
Fatigue/sleepiness		Unconscious
Other _____		Blood sugar >_____
		Other

Actions for Treating Hyperglycemia

Treatment for Mild to Moderate Hyperglycemia

Check the blood glucose level

For blood glucose greater than _____mg/dL AND at least _____ hours since last insulin dose, give:

◯ Correction dose calculation

target blood glucose (_____)
correction factor (_____)

****insert numbers in equation below**

↙

(current blood glucose level) - (target blood glucose) = _____ units of insulin
(correction factor) ***give this amount***

***** *OR* *****

◯ Correction dose scale

blood glucose _____ to _____ mg/dL, give _____ units
blood glucose _____ to _____ mg/dL, give _____ units
blood glucose _____ to _____ mg/dL, give _____ units

treatment continued on next page……

Treatment for Mild to Moderate Hyperglycemia - continued

Notify parent/guardians if blood glucose is over _____ mg/dL.
Give extra water or non-sugar-containing drinks (not fruit juices): _____ ounces per hour.
Allow free and unrestricted access to the restroom.
Recheck blood glucose every 2 hours to determine if decreasing to target range of _____mg/dL.
Restrict participation in physical activity if blood glucose is greater than _____mg/dL.

Treatment for Severe Hyperglycemia

Have someone else <u>Call 911!</u>	Call Parent/Guardians/Emergency Contacts
DO NOT LEAVE STUDENT ALONE!	Call District Nurse
Administer insulin correction dose - see 1st page	Document on Incident Report Form

PARENT TO COMPLETE

As Parent/Guardian of the named student:

* I give permission for my child's Health Care Provider to release/share information with the District Nurse for the completion of this plan of care and to exchange health information and records.
* I understand the information contained in this plan will be shared with Madison School District staff on a need-to-know basis.
* I give permission to the District Nurse and other Madison School District staff to follow this Emergency Care Plan and administer medication as directed.
* I agree to release, indemnify, and hold harmless the District Nurse and other Madison School District staff from lawsuits, claim expense, demand or action, etc., against them for helping my child with diabetes treatment, provided the personnel are following physician instruction as written in the emergency action plan above.
* I understand I am responsible for maintaining necessary supplies, medication, and equipment.
* My child and I understand there are serious consequences for sharing any medication with others.
* I understand I am responsible to notify the District Nurse of any change in my child's health status, care, or medication order. If the prescription on the medication order is changed, I understand a new Medication Request Form, Emergency Care Plan Form, and an amendment to the DMMP must be completed before the school staff can administer the medication.
* I understand that if any emergency medication is administered at school, Emergency Medical Services (EMS) will be notified for evaluation, monitoring, and possible further treatment.
* I understand that if my child is given emergency medication, he/she may not remain at school unless I can be present to monitor him/her for adverse reactions. I understand that trained school employee volunteers can only monitor him/her until I arrive or EMS arrive.

Parent Name:	**Phone:**
Parent Signature:	**Date:**

HEALTHCARE PROVIDER TO COMPLETE - Please read, check one of the options, and sign below

This student is under my care. This Diabetes Hyperglycemia Action Plan reflects my plan of care.

◯ It is **medically appropriate** for the student to **self-carry and self-administer** diabetes medication *when able and appropriate*, and be in possession of diabetes medication, testing supplies, and snacks at all times.

***** This student has been trained and has demonstrated proper medication administration procedure.***

◯ It is **medically appropriate** for the student to **self-carry** diabetes medication, testing supplies, and snacks, but **NOT to self-administer** medication. Please have the designated school personnel administer this student's medication.

◯ It is **NOT medically appropriate** for the student to **self-carry or self-administer** medication. Please have the designated school personnel maintain the medication, testing supplies, and snacks and administer the medication.

Healthcare Provider Name (print):	**Phone:**
Healthcare Provider Signature:	**Date:**
District Nurse has reviewed this plan:	**Date:**