Carroll ISD Health Services
Parental Authorization for Diabetes Action Plan

Parent please answer:	
Special Ed services?	yes / no
Active 504 plan?	yes / no
I would like 504 information	yes / no

Name:_____ **D.O.B.:**_____ **Grade/Teacher:**_____
Parent/Guardian: _____ **Phone:** _____
Parent/Guardian: _____ **Phone**: _____
Transportation: ☐ Car rider ☐ Walker ☐ Drives self ☐ Rides bus # _____
After School Activities: ☐ Athletics ☐ Band ☐ Club ☐ Other _____

Date or age of diabetes diagnosis: _____ ☐ **Type 1** ☐ **Type 2**

In the last year has student been treated in the emergency room for high or low blood sugar? ☐ **No** ☐ **Yes**

Lunch will primarily be: ☐ **Brought from home** ☐ **Purchased from cafeteria**

Checking Blood Glucose

Brand/model of blood glucose meter: _____

Target range of blood glucose before meals: ☐ **90-130 mg/dl** ☐ **Other:** _____

Blood glucose level is checked (*select all that apply*):

- ☐ **Before breakfast** ☐ **After breakfast** ☐ **___ hours after breakfast** ☐ **2 hours after a correction dose**
- ☐ **Before lunch** ☐ **After lunch** ☐ **___ hours after lunch** ☐ **Before dismissal**
- ☐ **Mid-morning** ☐ **Before PE** ☐ **After PE** ☐ **As needed for signs of illness**
- ☐ **As needed for signs/symptoms of low or high blood glucose**

Student's self-care blood glucose checking skills:
Please indicate whether student can perform the following skills independently.

- ☐ **No** ☐ **Yes** **Independently checks own blood glucose.**
- ☐ **No** ☐ **Yes** **May check blood glucose with supervision.**
- ☐ **No** ☐ **Yes** **Requires a school nurse or trained diabetes personnel (UDCA) to check blood glucose.**
- ☐ **No** ☐ **Yes** **Uses a smartphone or other monitoring technology to track blood glucose values.**

Does student have a continuous glucose monitor (CGM)? ☐ **No** ☐ **Yes, Brand/model:** _____

Student's self-care CGM skills:
Please indicate whether student can perform the following skills independently.

- ☐ **No** ☐ **Yes** **My student can troubleshoot alarms and malfunctions independently.**
- ☐ **No** ☐ **Yes** **My student knows what to do and is able to deal with a HIGH alarm.**
- ☐ **No** ☐ **Yes** **My student knows what to do and is able to deal with a LOW alarm.**
- ☐ **No** ☐ **Yes** **My student can calibrate the CGM.**
- ☐ **No** ☐ **Yes** **My student knows what to do when CGM indicates a rapid trending rise or fall in the blood glucose level.**

Insulin Therapy

Insulin delivery device: ☐ **Syringe** ☐ **Insulin pen** ☐ **Insulin pump** ☐ **None, takes oral medication** _____
Insulin therapy at school: ☐ **Adjustable (basal-bolus) insulin** ☐ **Fixed insulin therapy** ☐ **No insulin**
Name/brand of insulin: _____

Student's self-care insulin administration skills:
Please check all that apply:

- ☐ **Independently calculates and gives own injections.**
- ☐ **May calculate/give own injections with supervision.**
- ☐ **Requires a school nurse or trained diabetes personnel to calculate dose & student can give own injection with supervision.**
- ☐ **Requires a school nurse or trained personnel to calculate dose and give the injection.**

Hypoglycemia

Common signs of hypoglycemia (low blood sugar) are hunger, irritability, lethargy, sleepiness, light-headedness, headache, shakiness, pale skin, profuse sweating, cold and/or clammy skin, disorientation, inability to follow directions, rapid breathing, faintness, rapid heartbeat, unconsciousness and convulsions.

Please describe your student's usual behavior/symptoms of hypoglycemia: _____

_____

What blood sugar level is typically considered low for your student? _____

Does your student recognize his/her low blood sugar symptoms? ☐ **No** ☐ **Yes** ☐ **Sometimes**

Can your student independently treat his/her low blood sugar? ☐ **No** ☐ **Yes**

Is there a typical time of day your student experiences low blood sugar? ☐ **No** ☐ **Yes, specify: _____**

Emergency Treatment:

If your student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions, the school nurse or Unlicensed Diabetic Care Assistnat (UCDA) will follow the Diabetes Management Plan provided by the doctor and do the following:

- **Position student on his/her side to prevent choking**
- **Administer glucagon (must be provided by parent and medication orders received from physician)**
- **Call 911 to initiate Emergency Medical Services**
- **Call student's parents**

Hyperglycemia

Common signs of hyperglycemia (high blood sugar) are thirst, changes in behavior, frequent urination, headache, warm dry skin, blurred vision, rapid heartbeat, rapid breathing, nausea and/or vomiting.

Please describe your student's usual behavior/symptoms of hypoglycemia: _____

_____

What blood sugar level is typically considered high for your student? _____

Does your student recognize his/her high blood sugar symptoms? ☐ **No** ☐ **Yes** ☐ **Sometimes**

Can your student independently treat his/her low blood sugar? ☐ **No** ☐ **Yes**

Is there a typical time of day your student experiences low blood sugar? ☐ **No** ☐ **Yes, specify: _____**

Emergency Treatment:

If your student shows signs of a hyperglycemic emergency (dry mouth, extreme thirst, vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increased sleepiness or lethargy, or a depressed level of consciousness) the school nurse or Unlicensed Diabetic Care Assistant (UCDA) will follow the Diabetes Management Plan provided by the doctor, notify the parents and call 911 to initiate Emergency Medical Services.

Care and Treatment at School

Please check all appropriate boxes below:

☐ **Yes, I authorize an unlicensed diabetes care assistant (UDCA) to provide diabetes management and care services as defined in the physician's orders and the student's Diabetes Care Plan. I understand that the UDCA is immune from liability for civil damages under section 22.0511 of the Texas Education code.**

☐ **No, I do not authorize an UDCA to provide diabetes management and care services to my student at school. I understand the school nurse, if available, or EMS, will provide emergency care as needed.**

☐ **Yes, my student can manage his/her diabetes independently and will not seek assistance for his/her diabetes while at school. I understand the school nurse, if available, or EMS, will provide emergency care as needed. I understand the school nurse may temporarily supervise this responsibility if my student cannot demonstrate safe diabetes care while at school.**

☐ **Yes, I request that my student's classmates be informed that my student has diabetes and be given age-appropriate instruction regarding diabetes care.**

☐ **Yes, I authorize reciprocal release of information related to diabetes care and management between the school nurse and my student's health care provider.**

Parent/guardian signature: _____ Date: _____