TWINSBURG CITY SCHOOL DISTRICT

11136 Ravenna Road • Twinsburg OH 44087-1022
Phone 330.486.2000 • Fax 330.425.7216

LETTER TO PARENTS
DIABETES

TO: Parents

FROM: School Health Clinic

DATE: _____

Subject: Diabetes

You have told us that your child has diabetes.

The American Diabetes Association recommends that all students with diabetes have a Diabetic Health Care Plan at school. This plan needs to be completed by your health care provider each school year. The Diabetic Health Care Plan must be signed by the health care provider and the student's parent/guardian. Some health care providers may have their own forms. These are acceptable as long as the requested information is provided and it is signed by the health care provider and the parent/guardian.

In order to provide the best care, please update us with any changes in the management of your child's diabetes. This plan will be shared with the appropriate school personnel such as the classroom teacher(s) and principal.

It is the responsibility of the parent/guardian to provide the school with all the information, materials and supplies necessary for school personnel to care for their student's diabetes at school.

Please return the Diabetic Health Care Plan to your child's school. Thank you.

Revised 8/2022

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Please use the numbers below to fax forms to the appropriate school.

SCHOOL BUILDING	*GRADES*	*FAX NUMBER*
Twinsburg High School	9-12	330-405-7406
R.B. Chamberlin Middle School	7-8	330-963-8313
George G. Dodge Intermediate School	4-6	330-963-8323
Samuel Bissell Elementary School	2-3	330-963-8333
Wilcox Primary School	PreK, K-1	330-963-8332

Revised 8/2022

Twinsburg City School District

Student

Photo

Diabetes Health Care Plan for Continuous Glucose Monitoring

School:_____

Start Date: _____ End Date: _____

Name:_____ Grade/ Homeroom: ____ Teacher:_____

1. Sensor Glucose (SG) is the value displayed on the sensor and Blood Glucose (BG) is the value obtained from a fingerstick.
2. School personnel and/or student should always check that the sensor is fully attached to the body.
3. School personnel are not expected to follow on Dexcom Share or Medtronic Connect.
4. Do not disconnect CGM for sports or activities.
5. If adhesive is peeling off, reinforce with medical tape.
6. If CGM falls off, do not throw pieces away, place in a bag, and contact and return to parents.
7. Insulin injections should be at least 3 inches away from CGM device.
8. Do not give Tylenol while using the Dexcom G5 CGM. Tylenol is OK with Dexcom G6, Libre or Medtronic.
9. **Do not use SG to determine if student has been adequately treated for a low. This should be determined with BG.**

Student Information

TYPE OF CGM: □ Dexcom G5/G6 □ Freestyle Libre

□ Medtronic Guardian with Threshold Suspend □ On □ Off

□ Medtronic 670G (see attached)

□ Tandem Basal IQ with Dexcom G6 – if basal suspended at mealtime, ok to resume insulin prior to bolus

CGM Instructions (In addition to school orders):

□ If SG is < 80mg/dL, follow orders for hypoglycemia.

□ SG may be used for insulin dosing and to indicate need to treat low if preferred by parent

Authorization for the Release of Information:

I hereby give permission for _____ (school) to exchange specific, confidential medical information with _____ (Diabetes healthcare provider) on my child_____, to develop more effective ways of providing for the healthcare needs of my child at school

Prescriber Signature_____Date_____

Parent Signature_____Date_____

Rev.10/2019

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University Hospitals Rainbow Babies & Children's

Reviewed by Drs. Carly Wilbur & Jamie Wood

Twinsburg City School District

Student

Photo

Diabetes Health Care Plan for Insulin Administration via Syringe or Pen

School:_____

Start Date: _____ End Date: _____

Name:_____ Grade/ Homeroom: ____ Teacher:_____

Transportation: ☐ Bus ☐ Car ☐Van ☐ Type 1 ☐ Type 2

Parent/ Guardian Contact: Call in order of preference

Name *Telephone Number* *Relationship*

1._____

2._____

3. _____

Prescriber Name _____Phone_____Fax_____

Blood Glucose Monitoring: Meter Location _____ Student permitted to carry meter and check in classroom ☐ Yes ☐ No

BG= Blood Glucose **SG**= Sensor Glucose

Testing Time ☐ Before Breakfast/Lunch ☐1-2 hours after lunch ☐ Before/after snack ☐ Before/after exercise ☐ Before recess ☐ Before bus ride/walking home ☐ **Always** check when student is feeling high, low and during illness ☐ Other_____

Snacks: ☐ Please allow a _____gram snack at_____ ☐ before/after exercise, if needed.

Snacks are provided by parent /guardian and are located in _____

Signs of Low Blood Sugar personality change, feels funny, irritability, inattentiveness, tingling sensations headache, hunger, clammy skin, dizziness, drowsiness, slurred speech, seeing double, pale face, shallow fast breathing, fainting

Treatment for Hypoglycemia/Low Blood Sugar

If student is showing signs of hypoglycemia or if BG/SG is below _____mg/dl

☐ **Treat with _____ grams of quick-acting glucose:**

☐ __oz juice or ☐ ____ glucose tablets or ☐ Glucose Gel or ☐ Other _____

☐ Retest blood sugar every 15 minutes, repeat treatment until blood sugar level is above target ____mg/dl

☐ If no meal or snack within the hour give a 15-gram snack

☐ If student unconscious or having a seizure (severe hypoglycemia): Call 911 and then parents

☐ Give Glucagon: Amount of Glucagon to be administered: _____ (0.5 or 1 mg) IM, SC **OR** ☐ Baqsimi 3 mg intranasally

☐ **Notify parent/guardian for blood sugar below _____mg/dl**

Treatment for Hyperglycemia /High Blood Sugar

If student showing signs of high blood sugar or if blood sugar is above _____mg/dl

☐ Allow free access to water and bathroom

☐ Check ketones for blood sugar over 250 mg/dl, Notify parent/guardian if ketones are **moderate to large**

☐ **Notify parent/guardian for blood sugar over** _____mg/dl

☐ Student does not have to be sent home for trace/small urine ketones

☐ See insulin correction scale (next page)

☐ **Call 911 and parent/guardian for *hyperglycemia emergency*. Symptoms may include nausea &vomiting, heavy breathing, severe abdominal pain, chest pain, increased sleepiness or lethargy, or loss of consciousness.**

Document all blood sugars and treatment

Name: _____

Orders for Insulin Administration

Insulin is administered via: ☐**Vial/Syringe** ☐**Insulin Pen** ☐ **Not taking insulin at school**

Can student draw up correct dose, determine correct amount and give own injections?

☐**Yes** ☐**No** ☐**Needs supervision (describe)**_____

Insulin Type: _____ Student permitted to carry insulin & supplies: ☐ **Yes** ☐**No**

Calculation of Insulin Dose: A+B=C

A. Insulin to Carbohydrate Ratio: 1 unit of Insulin per _____ grams of carbohydrate

Give ___ units for ____ grams
Give ___ units for ____ grams
Give ___ units for ____ grams
Give ___ units for ____ grams

OR

_____ ÷ _____ = _____ **Units of Insulin (A)**
Carbohydrates To Eat | **Carbohydrate Ratio** | **Carbohydrate Bolus**

B. Correction Factor: _____ unit/s of insulin for every ____ over _____ mg/dl
Target BG

If BG/SG is _____ to _____mg/dl Give____ units
If BG/SG is _____ to _____mg/dl Give____ units
If BG/SG is _____ to _____mg/dl Give____ units
If BG/SG is _____ to _____mg/dl Give____ units
If BG/SG is _____ to _____mg/dl Give____ units
If BG/SG is _____ to _____mg/dl Give____ units
If BG/SG is _____ to _____mg/dl Give____ units
If BG/SG is _____ to _____mg/dl Give____ units

OR

_____ - _____ = _____ ÷ _____ = _____ **Units of Insulin (B)**
Current BG/SG | **Target BG** | **Amount to Correct** | **Correction Factor**

C. Mealtime Insulin dose = A + B

☐Other:_____

Give mealtime dose: ☐ before meals ☐ immediately after meals ☐ If blood glucose is less than 100mg/dl give after eating

☐ Parental authorization should be obtained before administering a correction dose for high blood glucose level (excluding meal time)

☐Parents are authorized to adjust the insulin dosage +/- by _____ units for the following reasons:

☐Increase/Decrease Carbohydrate ☐Increase/Decrease Activity ☐Parties ☐Other_____

Student self-care task	**Independent**	**School Assistance**
Blood Glucose Monitoring		
Carbohydrate Counting		
Selection of snacks and meals		
Insulin Dose calculation		
Insulin injection Administration		
Treatment for mild hypoglycemia		
Test Urine/Blood for Ketones		

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Prescriber Signature_____Date_____

Parent Signature_____Date_____

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University Hospitals Rainbow Babies & Children's

Rev. 10/2019 Reviewed by Drs Carly Wilbur & Jamie Wood

Diabetes Health Care Plan for Insulin Administration via Insulin Pump

Twinsburg City School District

School:_____

Start Date: _____ End Date: _____

Name:_____ Grade/ Homeroom: _____ Teacher:_____

Transportation: ☐ Bus ☐ Car ☐ Van ☐ Type 1 ☐ Type 2

Parent/ Guardian Contact: Call in order of preference

	Name	*Telephone Number*	*Relationship*
1.			
2.			
3.			

Student Photo

Prescriber Name _____Phone_____Fax_____

Blood Glucose Monitoring: Meter Location _____ Student permitted to carry meter and check in classroom ☐ Yes ☐ No

BG= Blood Glucose **SG**= Sensor Glucose

Testing Time ☐ Before Breakfast/Lunch ☐ 1-2 hours after lunch ☐ Before/after snack ☐ Before/after exercise ☐ Before recess ☐ Before riding bus/walking home ☐ **Always** check when student is feeling high, low and during illness ☐ Other_____

Snacks: ☐ Please allow a ____gram snack at_____ ☐ before/after exercise, if needed

Snacks are provided by parent /guardian and located in _____

Signs of Low Blood Sugar
personality change, feels funny, irritability, inattentiveness, tingling sensations headache, hunger, clammy skin, dizziness, drowsiness, slurred speech, seeing double,
pale face, shallow fast breathing, fainting

Treatment for Hypoglycemia/Low Blood Sugar

If student is showing signs of hypoglycemia or if BG/SG is below _____mg/dl

☐ **Treat with _____ grams of quick-acting glucose:**

☐ ____oz juice or ☐ ____ glucose tablets or ☐ Glucose Gel or ☐ Other_____

☐ Retest blood sugar every 15 minutes, repeat treatment until blood sugar level is above target _____mg/dl

☐ If no meal or snack within the hour give a 15 gram snack

☐ If student unconscious or having a seizure (severe hypoglycemia): Call 911 and then parents

☐ Give Glucagon: Amount of Glucagon to be administered:_____(0.5 or 1mg) IM,SC **OR** ☐ Baqsimi 3 mg intranasally

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Treatment for Hyperglycemia /High Blood Sugar

If student showing signs of high blood sugar or if blood sugar is above _____mg/dl

☐ Allow free access to water and bathroom

☐ Check ketones for blood sugar over 250 mg/dl, Notify parent/guardian if ketones are **moderate to large**

☐ **Notify parent/guardian for blood sugar over** _____mg/dl

☐ Student does not have to be sent home for trace/small urine ketones

☐ See insulin correction scale (next page)

☐ **Call 911 and parent/guardian for *hyperglycemia emergency*. Symptoms may include nausea &vomiting, heavy breathing, severe abdominal pain, chest pain, increased sleepiness or lethargy, or loss of consciousness.**

Document all blood sugars and treatment

Name: _____

Orders for Insulin Administered via Pump

Brand/Model of pump _____ Type of insulin in pump_____

Can student manage Insulin Pump Independently: ☐Yes ☐ No ☐Needs supervision (describe)_____

_____

Insulin to Carb Ratio: ___ units per _____grams Correction Scale: ____units per ____over _____mg/dl

Give lunch dose: ☐ before meals ☐ immediately after meals ☐ if BG/SG is less than 100mg/dl give after meals

☐Parents are authorized to adjust insulin dosage +/- by _____ units for the following reasons:

☐Increase/Decrease Carbohydrate ☐Increase/Decrease Activity ☐Parties ☐Other_____

Student may: ☐Use temporary rate ☐ Use extended bolus ☐Suspend pump for activity/lows

If student is not able to perform above features on own, staff will only be able to suspend pump for severe lows.

☐For BG/SG greater than 250 mg/dl that has not decreased in 2 hours after correction, consider pump failure or infusion site failure and contact parents. Check ketones.

☐For infusion set failure, contact parent/guardian: Can student change own infusion set ☐Yes ☐ No

☐ Student/parent insert new infusion set

☐ Administer insulin by pen or syringe using pump recommendation

☐For suspected pump failure suspend pump and contact parent/guardian

☐ Administer insulin by syringe or pen using pump recommendation

Activities/Skills	**Independent**	
Blood Glucose Monitoring	Yes	No
Carbohydrate Counting	Yes	No
Selection of snacks and meals	Yes	No
Treatment for mild hypoglycemia	Yes	No
Test urine/blood for ketones	Yes	No
Management of Insulin Pump	Yes	No
Management of CGM	Yes	No

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Prescriber Signature_____Date_____

Parent Signature_____Date_____

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