KISD Nursing Staff

Kaufman Independent School District

Diabetes Individualized Health Care Plan

Parent/Guardian:

Please complete and return the attached forms for your child as soon as possible. As well as your child's Physicians Diabetic Management Plan. This information will be shared with those whom come in contact with your child during the school year.

Please check the front and back of each form carefully. Please complete each section and sign where indicated. Please verify whether you would like to discuss your child's IHP.

If you have any questions or concerns please contact your Campus Nurse.

Thank You for your cooperation in this matter.

KISD Nursing Staff

KAUFMAN ISD
Diabetes Medical Management Plan

Effective Dates: _____

This plan should be completed by the student's personal health care team and parents/guardian. It should be reviewed with relevant school staff and copies should be kept in a place that is easily accessed by the school nurse, trained diabetes personnel, and other authorized personnel.

Student's Name: _____
Date of Birth:_____Date of Diabetes Diagnosis: _____
Grade:_____Homeroom Teacher: _____
Physical Condition:____Diabetes Type 1 ___Diabetes Type 2

Contact Information

Mother/Guardian: _____
Address: _____
_____
Telephone: Home_____Work_____Cell_____
Father/Guardian: _____
Address: _____
Telephone: Home_____Work_____Cell_____

Student's Doctor/Health Care Provider

Name: _____
Address: _____
Telephone: _____

Other Emergency Contacts

Name:_____
Relationship:_____
Telephone: Home_____Work_____Cell_____

Notify parents/guardian or emergency contact in the following situations:

_____
_____
_____
_____

MY CHILD RIDES A BUS: YES [ ] #_____ NO [ ]

Hypoglycemia (Low Blood Sugar)
Usual symptoms of hypoglycemia:

_____

_____

Treatment of hypoglycemia:

_____

_____

Glucagon should be given if the student is unconscious, having a seizure(convulsion), or unable to swallow. Route_____, Dosage_____, site for glucagon injection: _____arm,
___thigh,____other.
If glucagon is required, administer it promptly. Then, call 911(or other emergency assistance) and the parents/guardian.

Hyperglycemia (High Blood Sugar)
Usual symptoms of hyperglycemia:

_____

_____

Treatment of hyperglycemia:

_____

_____

Urine should be checked for ketones when blood glucose levels are above _____mg/d.
Treatment for ketones: _____

Supplies to be kept at School

	Blood glucose meter, blood glucose test strips, batteries for meter		Insulin pump and supplies
	Lancet device, lancets, gloves, etc.		Insulin pen, pen needles, insulin cartridges
	Urine ketone strips		Fast-acting source of glucose
	Insulin vitals and syringes		Carbohydrate containing snack
	Glucagon emergency kit		

Signatures

This Diabetes Medical Management Plan has been approved by:

_____ _____
Student's Physician/Health Care Provider Date

I give permission to the school nurse, trained diabetes personnel, and other designated staff members of _____School to perform and carry out the diabetes care tasks as outlined by_____'s Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

Acknowledged and received by:

_____ _____
Parent/Guardian Date

_____ _____
KISD Campus Nurse Date

Kaufman Independent School District

Diabetic Individualized Health Care Plan

Children with Diabetes need a strong network for the many hours they spend in school and school related activities. Your campus Nurse will work with you, your child and their physician in providing and coordinating diabetes care at school.

In addition to the school Nurse, under HB 984, each school also must train other employees to serve as (UDCA) Unlicensed Diabetic Care Assistant who can provide diabetes management and care services if a nurse is not available when a student needs such services. Each school in which a student with diabetes is enrolled has a trained staff member to provide such services.

Please check the appropriate boxes below to indicate your election whether to allow:

An (UDCAJ Unlicensed Diabetic Care Assistant to provide Services to your child:

[ ] YES **Agreement for Services:** I authorize an Unlicensed Diabetic Care Assistant to provide diabetes management and care services to my child at school. I understand that 'an Unlicensed Diabetic Care Assistant is immune from liability for civil damages under section 22.0511of the Texas Education Code.

[ ] NO **I DO NOT** authorize an Unlicensed Diabetic Care Assistant to provide diabetes management and care services to my child at school. I understand that in the event the school Nurse is not available, **I the Parent/Guardian will be responsible for administration of the diabetic care for my child.**

Self-care: If **YES**, paperwork **MUST** be completed and returned to the school Nurse as soon as possible:

[ ] YES My child **CAN** manage his/her diabetes independently and will **NOT** seek assistance for his/her diabetes care while at school. I understand the school Nurse will provide emergency care as needed. This information will be shared with school district personnel as needed.

Acknowledged and received by:

_____ _____

Student's Parent/Guardian Date

_____ _____

KISD Campus Nurse Date