

**Chesterfield County Public Schools
Office of Student Health Services**

Request for Individualized Healthcare Plan

Dear Parent/Guardian:

Providing a safe, supportive and nurturing environment is a goal of Chesterfield County Public Schools (CCPS). The health information provided for your child indicates that he/she has a health concern. To adequately meet your child's health needs while in school, please do the following as soon as possible:

1. Have your licensed healthcare provider (physician, physician's assistant or nurse practitioner) complete and sign the attached Individualized Healthcare Plan (IHP). IHPs are also available online at <http://mychesterfieldschools.com/parents/student-health-and-safety/>.
2. Provide your signature on the IHP. Signing the IHP certifies that:
 - You understand school staff and/or the school health nurse may communicate with the Licensed Healthcare Provider/medical office staff about the IHP.
 - You understand you are responsible for providing the school with all medication for your child in the original container per Chesterfield County School Board policy 4130/4130R *Administration of Medication to Students*.
 - You understand you are responsible for completing the Chesterfield County Public Schools School Medication Record for medication ordered in this health plan.
 - You understand emergency medication you provide will be administered as ordered by the Licensed Healthcare Provider.
 - **You agree to this health plan for your student.**
3. Return the completed plan to the attention of the school nurse at the school your child will be or is attending.

It may be necessary for some students to carry and self-administer emergency medication. This requires proper documentation by a licensed healthcare provider on the appropriate health plan. Permission for a student to possess and self-administer medication (for example auto-injectable epinephrine or medication to manage asthma or diabetes) is effective for one school year and must be renewed annually. Please consult with your school nurse for details.

If medication is needed for your child, complete the CCPS School Medication Record form required for all medications that students take during the school day. This form is available in the school clinic and at <http://mychesterfieldschools.com/parents/student-health-and-safety/>. Medication must be provided by the parent/guardian and brought to school by the parent/guardian in the original appropriately labeled container. See the CCPS website for details regarding the medication policy and regulation (4130 and 4130R).

For students with a life-threatening food allergy, the Food Allergy Medical Statement must be completed by a physician, physician's assistant or nurse practitioner if the child needs any of the following: to be identified by cafeteria staff as having a life-threatening allergy; if child is lactose intolerant; if substitutions or food modifications need to be made in the school breakfast or lunch programs. The Cafeteria Manager at school must also be notified. For assistance you may contact the Nutritionist, CCPS Food & Nutrition Department, at (804) 743-3717.

A health condition may be considered a disability. If you suspect your child may have a disability, ask your child's teacher, Counselor, school nurse or administrator for a referral to consider eligibility for 504 or special education services.

If you have any questions, call the registered nurse at your child's school. We appreciate your prompt attention to this matter. Thank you for partnering with us to support your child's well-being in school.

Sincerely,

Chesterfield County Public Schools
Office of Student Health Services

Patient: _____ Date of Birth: _____ Effective Date: 2020 – 2021 School Year

**Chesterfield County Public Schools
Office of Student Health Services**

**Virginia School Diabetes Medical Management Plan (DMMP)
Part 1 - Contact Information and Medical History**

Virginia Diabetes Council - School Diabetes Care Practice and Protocol - Provides guidelines, recommended accommodations and references applicable to all students with diabetes. This document is electronically available: <http://www.virginiadiabetes.org>

Instructions: Parent / Guardian to complete form. Thank you.

School: _____ Grade: _____

Homeroom Teacher: _____ Effective Date : _____

Parent/Guardian #1:

Address: _____ Telephone: _____

Email: _____

Parent/Guardian #2:

Address: _____ Telephone: _____

Email: _____

Other emergency contact:

Address: _____ Telephone: _____

Email: _____

Physician/ Health Care Provider:

Address: _____ Telephone: _____ Fax: _____

Certified Diabetic Educator:

Telephone: _____ Fax: _____

Required by Virginia Law:

I give permission to the school nurse and designated school personnel* who have been trained to perform and carry out the diabetes care tasks for my child as outlined in my child's *Diabetes Medical Management Plan* as ordered by the prescribing health care provider. (Code of Virginia § 22.1-274)

Parent authorization for trained school designees to administer:

INSULIN Yes No **BAQSIMI** Yes No **GLUCAGON** Yes No

I consent to the release of information contained in the Diabetes Medical Management Plan to 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. I also give permission to contact my endocrinologist and members of the diabetes management team regarding my child's diabetes should the need arise.

*Note: If at any time you would like to have the names of the designated school personnel that have been trained, please contact the school nurse. Names and training records are kept by the school nurse.

- I understand I am responsible for providing the school with all medication for my child in the original container per Chesterfield County School Board policy 4130/4130R *Administration of Medication to Students*.
- I understand I am responsible for completing the Chesterfield County Public Schools School Medication Record for medication ordered in this health plan.

Parent / Guardian Name / Signature :	Date:
School Nurse Name / Signature:	Date:

**Chesterfield County Public Schools
Office of Student Health Services**

Medical History	Parent/Guardian Response (check appropriate boxes and complete blanks)				
Diagnosis information	At what age? _____ Type of diabetes? <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Other _____				
Allergies (include foods, medications, etc.)					
How often is child seen by diabetes healthcare provider?	Frequency: _____		Date of last visit: _____		
Nutritional needs	<input type="checkbox"/> Gluten Free <input type="checkbox"/> Other _____				
Snacks	<input type="checkbox"/> _____ AM _____ PM <input type="checkbox"/> Per parent / guardian (i.e. - Before exercise/activity to prevent hypoglycemia, insulin is NOT administered with these snacks.) <input type="checkbox"/> In the event of a class party / special activity – per parent/guardian’s discretion				
Child’s most common signs of low blood glucose	<input type="checkbox"/> trembling <input type="checkbox"/> tingling <input type="checkbox"/> loss of coordination <input type="checkbox"/> dizziness <input type="checkbox"/> moist skin/sweating <input type="checkbox"/> slurred speech <input type="checkbox"/> heart pounding <input type="checkbox"/> hunger <input type="checkbox"/> confusion <input type="checkbox"/> weakness <input type="checkbox"/> fatigue <input type="checkbox"/> seizure <input type="checkbox"/> pale skin <input type="checkbox"/> headache <input type="checkbox"/> unconsciousness <input type="checkbox"/> change in mood or behavior <input type="checkbox"/> other _____				
Has your child ever experienced an episode of hypoglycemia that required an emergency response?	<input type="checkbox"/> Yes Date _____ Please explain: _____ <input type="checkbox"/> No _____				
Frequency of hypoglycemia	<input type="checkbox"/> once a day <input type="checkbox"/> once a week <input type="checkbox"/> once a month Indicate date(s) of last episode(s) _____ What time of day is most common for hypoglycemia to occur? _____				
Illness/hospitalizations in the last year	Date(s) and describe: _____				
List any other medications currently being taken	Name of Medication	Dose	When to give	Oral / Injection	Duration
Other concerns and comments					

Supplies to bring to school:	
<ul style="list-style-type: none"> • Glucose meter, testing strips, lancets, and batteries for the meter • Urine and/or blood ketone test strips and meter • Insulin(s), syringes, and/or insulin pen(s) and supplies • Insulin pump and supplies, including syringes, pen(s), and insulin(s) in case of pump failure 	<ul style="list-style-type: none"> • Carbohydrate-containing snacks, such as whole grain crackers, dried fruit or yogurt • Hypoglycemia treatment supplies; quick-acting glucose and carbohydrate snacks • Water • Glucagon emergency kit • Antiseptic wipes or wet wipes • Other medications

Virginia School Diabetes Medical Management Plan (DMMP) Part 2

Notice to Parent(s) / Guardian(s):

Medication(s) must be brought to school appropriately labeled by the pharmacy or physician/healthcare provider. In order for schools to safely administer medication in the school setting, the following should be observed:

- A new copy of the DMMP must be completed at the beginning of each school year.
- This form or healthcare provider prescription must be received in order to change diabetes care at school, except for those changes indicated for parent's / guardian's adjustment.
- Trained school personnel may assist child in increasing independence with self-management skills as developmentally appropriate with parental / guardian consent.

Student's Diagnosis:

- Type 1 Diabetes Type 2 Diabetes ICD-10:

MONITORING	
<p>Blood Glucose Monitoring With meter, lancets, lancing device, and test strips</p>	<p><input type="checkbox"/> Yes:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Requires assistance to monitor blood glucose <input type="checkbox"/> May monitor own blood glucose with supervision <input type="checkbox"/> Independently monitors own blood glucose - Refer to page 8 for permission form
<p>When to check blood glucose</p>	<p><input type="checkbox"/> Before meals</p> <p><input type="checkbox"/> For symptoms of hypoglycemia and/or hyperglycemia</p> <p><input type="checkbox"/> Anytime the student does not feel well</p> <p><input type="checkbox"/> Before Physical Education Class</p> <p><input type="checkbox"/> After Physical Education Class</p> <p><input type="checkbox"/> Additional Blood Glucose monitoring may be performed at parent / guardian's request: _____</p>
<p>Continuous Glucose Monitor</p> <p><input type="checkbox"/> Yes - Dex Com / Medtronic</p> <p><input type="checkbox"/> Low limit alarm: _____</p> <p><input type="checkbox"/> High limit alarm: _____</p> <p><input type="checkbox"/> Parent/Guardian may adjust alarms</p>	<ul style="list-style-type: none"> • Always confirm Continuous Glucose Monitor results with finger stick check before taking action on sensor blood glucose level. • If student has symptoms or signs of hypoglycemia, check blood glucose level by finger stick, regardless of Continuous Glucose Monitor reading. • If sensor is dislodged, do NOT discard, student will bring home.
<p>Ketone Checking Urine or Blood</p>	<p><input type="checkbox"/> Yes: Anytime the BG > _____ mg/dL two times in a row, at least one hour apart, or when student complains of nausea, vomiting, abdominal pain (See page 7 for hyperglycemia management)</p>

EXERCISE AND SPORTS

A source of fast-acting glucose & glucagon **must** be available in case of hypoglycemia.

Student should **not** exercise for the following reasons:

- His/her blood glucose is < _____ mg/dL (refer to page 7 for hypoglycemia management)
- His/her urine ketones are moderate to large (blood ketones >1.0 mmol/L) immediately prior to exercise (See page 8 for hyperglycemia management)

Student can return to exercise when:

- Blood glucose is > _____ mg/dL OR
- Urine ketones are trace to small (blood ketones < 0.6 mmol/L - 1.0 mmol/L)

MEDICATION – (Other than insulin)

Name	Dose / Route	When to give	Directions
<input type="checkbox"/> Glucagon	<input type="checkbox"/> 0.5 mg intramuscular or subcutaneous <input type="checkbox"/> 1.0 mg intramuscular or subcutaneous	<ul style="list-style-type: none"> • Unconscious • Semi-conscious • Unable to control his/her airway • Unable to swallow <p style="text-align: center;">AND/OR</p> <ul style="list-style-type: none"> • Seizing 	<ul style="list-style-type: none"> • Reconstitute per medication instructions • INJECT IMMEDIATELY • Roll student to side-lying position, medication increases vomiting risk • Call 911 • Call parent / guardian
<input type="checkbox"/> Glucophage (Metformin)	<input type="checkbox"/> 500 mg by mouth with food <input type="checkbox"/> 1000 mg by mouth with food		<input type="checkbox"/> To be given at school _____ AM <input type="checkbox"/> To be given at school _____ PM
<input type="checkbox"/> Other			

INSULIN
To be administered subcutaneously by insulin pen; insulin vial and a syringe; or insulin pump
ALWAYS treat hypoglycemia before administration of insulin.

Insulin to be given during school hours:	<input type="checkbox"/> Yes: <input type="checkbox"/> Requires assistance to calculate/give injections <input type="checkbox"/> May calculate/give own injections with supervision <input type="checkbox"/> Independently calculates/gives own injection - Refer to page 8 for permission form
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INTENSIVE
COLUMN A + COLUMN B = TOTAL INSULIN DOSE

COLUMN A (CARBOHYDRATE COVERAGE) = # carbohydrates consumed ÷ carbohydrate ratio
COLUMN B (CORRECTION DOSE) = actual blood glucose – target pre-meal blood glucose ÷ correction factor

- When rounding, only round the total insulin dose
- If uneven, then round to the nearest half or whole unit. (for example, total dose = 1.4 units- then give 1.5 units)
- If physical activity follows meal, then may round down. (for example, total dose = 1.4 units – then give 1.0 units)

INSULIN TYPE	COLUMN A Carbohydrate Coverage	PLUS	COLUMN B Correction Dose												
<input type="checkbox"/> <u>Rapid Acting Insulin</u> Humalog, Novolog or Apidra <input type="checkbox"/> <u>Short Acting Insulin</u> Humulin Regular or Novolin Regular <ul style="list-style-type: none"> • If carbohydrate intake can be predetermined, insulin should always be given prior to meal/snack • If carbohydrate intake <u>cannot</u> be predetermined, insulin should be given as soon as possible after completion of meal/snack 	<input type="checkbox"/> BREAKFAST Carbohydrate Ratio: ___ unit(s) for every ___ grams of carbohydrates <input type="checkbox"/> LUNCH Carbohydrate Ratio: ___ unit(s) for every ___ grams of carbohydrates <input type="checkbox"/> SNACK Carbohydrate Ratio: ___ unit(s) for every ___ grams of carbohydrate <input type="checkbox"/> PARENT/GUARDIAN may adjust Carbohydrate Ratio from: ___ unit(s) for every ___ grams of carbohydrate to ___ unit(s) for every ___ grams of carbohydrate <input type="checkbox"/> EXERCISE Carbohydrate Ratio: Per parent/guardian. Follow the carbohydrate ratio range as indicated in “ Parent/Guardian carbohydrate ratio ”	PLUS	<input type="checkbox"/> Correction Formula: Actual blood glucose - _____ (target) ÷ _____ (correction factor) = _____ units of insulin (Add this to carbohydrate coverage, column A) OR <input type="checkbox"/> Follow the correction dose scale below: <table style="width: 100%; border-collapse: collapse; font-size: x-small;"> <tr> <td style="width: 50%; border: 1px solid black; padding: 2px;">For blood glucose above TARGET _____</td> <td style="width: 50%; border: 1px solid black; padding: 2px;">Then add this many units of insulin to carbohydrate coverage, column A</td> </tr> <tr><td style="border: 1px solid black; height: 15px;"> </td><td style="border: 1px solid black; height: 15px;"> </td></tr> <tr><td style="border: 1px solid black; height: 15px;"> </td><td style="border: 1px solid black; height: 15px;"> </td></tr> <tr><td style="border: 1px solid black; height: 15px;"> </td><td style="border: 1px solid black; height: 15px;"> </td></tr> <tr><td style="border: 1px solid black; height: 15px;"> </td><td style="border: 1px solid black; height: 15px;"> </td></tr> <tr><td style="border: 1px solid black; height: 15px;"> </td><td style="border: 1px solid black; height: 15px;"> </td></tr> </table> <input type="checkbox"/> This correction may be used to administer insulin for elevated blood glucose if 3 hours or more since last insulin dose.	For blood glucose above TARGET _____	Then add this many units of insulin to carbohydrate coverage, column A										
For blood glucose above TARGET _____	Then add this many units of insulin to carbohydrate coverage, column A														

CONVENTIONAL

INSULIN TYPE	WHEN	DOSING	
<input type="checkbox"/> <u>Rapid Acting Insulin</u> Humalog, Novolog or Apidra <input type="checkbox"/> <u>Short Acting Insulin</u> Humulin or Novolin Regular	<input type="checkbox"/> PRE meals for _____ grams of carbohydrate	Blood Glucose	Units of Insulin
		Less than	

STUDENT ON INSULIN PUMP - Pump Brand/Model: _____
 If unable to reach parent/ guardian for pump operation, insulin by injection may be given per DMMP orders.

Student Skills		
1. Count carbohydrates	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
2. Bolus for carbohydrates consumed	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
3. Calculate and administer correction bolus	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
4. Give injection with syringe or pen, if needed	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
5. Disconnect pump	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
6. Reconnect pump at infusion set	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
7. Access bolus history on pump	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
8. Prepare reservoir and tubing	<input type="checkbox"/> Independent	<input type="checkbox"/> Parent/Guardian
9. Insert infusion set	<input type="checkbox"/> Independent	<input type="checkbox"/> Parent/Guardian
10. Use & programming of square/extended/dual/combo bolus features	<input type="checkbox"/> Independent	<input type="checkbox"/> Parent/Guardian
11. Use and programming of temporary basal for exercise and illness	<input type="checkbox"/> Independent	<input type="checkbox"/> Parent/Guardian
12. Re-program pump settings if needed	<input type="checkbox"/> Independent	<input type="checkbox"/> Parent/Guardian
13. Trouble shoot alarms and malfunctions, i.e. change insulin pump batteries	<input type="checkbox"/> Independent	<input type="checkbox"/> Parent/Guardian

Additional Times to contact the parent / guardian

<ul style="list-style-type: none"> • Dislodged infusion set • Pump malfunction • Repeated alarms 	<ul style="list-style-type: none"> • Insulin injection given for high blood glucose and / or ketones • Leakage of insulin at connection to pump or infusion site. • Soreness, redness or bleeding at infusion site
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LONG ACTING INSULIN
 To be given during school hours
 AND / OR
 For extended day, overnight field trips, unplanned disaster / emergency (72 hours)

Insulin Type	WHEN TO GIVE	CURRENT DOSE - To be confirmed prior to extended day or overnight field trip event	
		<input type="checkbox"/> Humulin NPH OR Novolin NPH <input type="checkbox"/> Lantus <input type="checkbox"/> Levemir <input type="checkbox"/> Other _____	<input type="checkbox"/> To be given during school hours <input type="checkbox"/> To be given for extended day, overnight field trip, unplanned disaster or emergency

Hypoglycemia Management (Low Blood Glucose)

If hypoglycemia is suspected, check the blood glucose level with finger check.

Hypoglycemia (Low Blood Glucose): Any blood sugar below _____ mg / dL. Signs may include:

Hunger	Sweating	Shakiness	Paleness	Dizziness
Confusion	Loss of coordination	Fatigue	Irritable	Crying
Day-dreaming	Inability to concentrate	Anger	Passing-out	Seizure

Refer to page 2 for patient specific signs and symptoms

Mild to Moderate Hypoglycemia:

Blood glucose is < _____ mg / dL and student is conscious and able to swallow

1. Immediately give 15 grams fast-acting carbohydrate (example - 3-4 glucose tablets; 4 ounces of regular soda/juice or one small tube glucose/cake gel)
2. Repeat blood glucose check in 15 minutes
3. If blood glucose still < _____ mg / dL, then re-treat with 15 grams of fast-acting carbohydrates and repeat blood glucose in 15 minutes.
4. Once blood glucose is > _____ mg / dL
 - If at lunch or snack time, let student eat and cover carbohydrate per orders
 - If not at lunch or snack time, provide student slowly-released carbohydrate snack (example: 3-4 peanut butter crackers, 3-4 cheese crackers or ½ sandwich)
 - Resume normal activity
5. **If unable to raise blood glucose above _____ mg / dL after providing 3 treatments with fast acting glucose**
 - Call parent/guardian
 - If unable to reach parent/guardian, call Health Care Provider
 - If unable to reach Health Care Provider, **call 911**

Severe Hypoglycemia:

If student is unconscious, semi-conscious, unable to control his/her airway, unable to swallow and/or seizing

1. Reconstitute glucagon per medication instructions
2. Administer glucagon intramuscularly
3. Roll student to side-lying position as medication increases risk for vomiting
4. **Call 911** for emergency assistance
5. Call parent/guardian
6. **If on INSULIN PUMP**, Stop insulin pump by any of the following methods:
 - Place pump in “suspend” or “stop mode” (See manufacturer’s instructions)
 - Disconnect at site
 - Cut tubing
 - ALWAYS send pump with EMS to hospital

Hyperglycemia Management (High Blood Glucose)

If hyperglycemia is suspected, check the blood glucose level with finger check.

Hyperglycemia (High Blood Glucose): Any blood sugar above _____ mg / dL. Signs may include:

Extreme thirst	Frequent urination	Blurry Vision	Hunger	Headache
Nausea	Hyperactivity	Irritable	Dizziness	Stomach ache

Refer to page 2 for patient specific signs and symptoms

If hyperglycemia is suspected

1. Check the blood glucose level with finger check.
2. Encourage student to drink fluids, 8 oz of water when hyperglycemia is present.

If blood glucose is > _____ mg/dL - two times in a row, at least one hour apart, and / or when student complains of nausea, vomiting, or abdominal pain –

1. Check ketones
2. **If unable to check ketones:**
 - Give 8 oz of water and retest blood glucose in 1 hour
 - If student complains of nausea, vomiting, or abdominal pain, call parent to pick up the student
 - If student exhibiting emergency symptoms (see below), **call 911**

If urine ketones are negative to small (blood ketones < 0.6 mmol/L - 1.0 mmol/L)

1. Give 8-16 ounces of water
2. If insulin has not been administered within 3 hours, provide correction insulin according to student's correction factor and target pre-meal blood glucose (see page 4)
3. Return student to his / her classroom
4. Recheck blood glucose and ketones in 3 hours after administering insulin

If urine ketones are moderate to large (blood ketones >1.0 mmol/L)

1. Call parent/guardian
2. If unable to reach parent/guardian, call Health Care Provider
3. Give 8-16 ounces of water
4. If insulin has not been administered within 3 hours, provide correction insulin according to student's correction factor and target pre-meal blood glucose (see page 4)
5. If unable to reach parent/guardian or Health Care Provider, **call 911**
6. **IF ON INSULIN PUMP:**
Follow the above instructions, plus give insulin correction by insulin vial and syringe and / or insulin pen, not by insulin pump bolus.
7. **HYPERGLYCEMIA EMERGENCY** For students with large ketones and the below symptoms
 - Depressed level of consciousness
 - Increasing sleepiness or lethargy
 - Heavy breathing or shortness of breath
 - **Call 911**

PERMISSION TO BE INDEPENDENT

Permission for student to independently monitor blood glucose on a school bus, school property, or at a school sponsored activity.

Permission for student to independently calculate and administer insulin on a school bus, school property, or at a school sponsored activity.

- My child has been instructed in and understands his/her diabetes self-management. My child understands that he/she is responsible and accountable for carrying and using his/her medication and equipment and for proper disposal of supplies.
- I hereby give permission for the school to administer the medications as prescribed in the care plan if indicated (ie. student requests assistance or becomes unable to perform self-care).
- I also give permission for the school to contact the student's physician / diabetes management team regarding my child's diabetes care (authorization required if contact is other than the school nurse).

Parent/Guardian Signature _____ Date _____

Student Signature _____ Date _____

I have assessed this student and agree the he / she is capable to be independent as noted above. It is understood that I may revoke permission to possess and self-administer said diabetes medication at any point during the school year if it is determined that he / she has abused the privilege of possession and self-administration or if he / she is not safely and effectively self-administering the medication.

Healthcare Provider Signature _____ Date _____

**AUTHORIZATION TO TREAT AND ADMINISTER MEDICATION
FOR THE ABOVE
VIRGINIA SCHOOL DIABETES MANAGEMENT PLAN**

My signature below provides authorization for the Virginia Diabetes Medical Management Plan contained herein. I/We understand that all treatments and procedures may be performed by the school nurse, the student, and/or trained, unlicensed designated school personnel as allowed by school policy or by Emergency Medical Services in the event of loss of consciousness or seizure.

I also give permission for the school and school nurse to contact the health care provider regarding these orders and administration of these medications.

A health condition may be considered a disability. If you suspect your child may have a disability, request a referral to consider eligibility for 504 or special education services.

Parent / Guardian Name	Signature	Date
School Representative Name	Signature	Date
Healthcare Provider Name	Signature	NPI # Date