The partnership and communication between Bedford County Public Schools (BCPS) and families is especially important when dealing with health and medical needs of the school age population. In order for the school staff to assist with the specific medical needs of your child, your assistance is required. Please read the parent responsibilities, fill out the Diabetes Care Plan, and obtain the necessary signatures. BCPS will accept your child's medical doctor diabetic care plan if answers all the information that is in our diabetic care plan.

Parent Responsibilities:

- Parent or guardian and the child's health care provider fill out and sign the diabetic care plan and medication authorization form.
- Parent needs to arrange a meeting with the nurse prior to school starting to review the care plan and discuss any medical concerns with the teachers.
- Parent provides a properly labeled and unopened insulin and glucagon kit to the school clinic.
- Parent supplies syringes, blood glucose meter and testing supplies, pump equipment, snacks, drinks, ketone strips, and hypoglycemic supplies(glucose tablets/gels) as indicated per individual child.
- Parent gives the first dose of any new medicine at home.
- Parent transports medicine and medical supplies to school.
- Parent informs and supplies classroom teachers and bus driver with emergency snacks.
- Parent provides special diet instructions to cafeteria manager and school nurse.
- Parent picks up medicine and supplies at the end of the school year.
- Parents will be called when the child does not have the supplies needed at school to manage their diabetes or if the nurse does not have clear doctors' orders to follow.

Planning for Disasters and Emergencies:

- In the unfortunate event of a natural disaster or other emergency situation your child may need to remain at school longer than expected. In order to be prepared for this we are requesting that you supply a 72 hour emergency kit containing extra items to help meet this need if such an emergency ever occurs.
- It is highly encouraged that your child carry some form of medical alert bracelet or ID card.

BEDFORD COUNTY PUBLIC SCHOOL
DIABETES HEALTH CARE PLAN & MEDICATION AUTHORIZATION

Name_____Age____Grade____Teacher_____

Parent/Guardian_____TP#_____

Other Emergency Contact_____TP#_____

Health Care Provider_____TP#_____

Type of Diabetes_____Date of Diagnosis_____

Blood Glucose Monitoring: Times to Check_____

This child ____Needs Supervision ____Needs Assistance____Is Independent with this task.

This child will need a snack around the following times_____.

Instructions for food during classroom parties_____.

Insulin: Type of delivery:____ Insulin Pump____Insulin Pen____Syringe____No Insulin

Oral Hypoglycemic Medicine_____Dose_____Time_____

Type of Insulin and times to be given at school: _____

_____Units per _____grams carbohydrate or other base dose of insulin. _____

Insulin Correction Doses:

Give ____units if blood glucose is ____to____mg/dl

Give ____units if blood glucose is ____to____ mg/dl

Give ____units if blood glucose is ____to____mg/dl

Give ____units if blood glucose is ____to____mg/dl

Give ____units if blood glucose is ____to____mg/dl

This Child ____Needs Supervision____Needs Assistance____Is Independent with this task.

Insulin pump use: Type_____Basal Rate_____

Type of Insulin in the pump_____

Type of Infusion set_____

Insulin/carbohydrate ratio_____Correction factor_____

This Child ____Needs Supervision____Needs Assistance____Is Independent with all pump care.

Hypoglycemia (Low Blood Sugar) This child's usual symptoms of hypoglycemia are:

_____

_____

_____

Treatment:_____

_____

Glucagon should be given if the student is unconscious, having a seizure or unable to swallow. If glucagon given 911 and parents should be called.

Hyperglycemia (High Blood Sugar): This child's usual symptoms of hyperglycemia are:

_____

_____

_____

Treatment:_____

_____

Check urine for ketones when blood glucose is above_____mg/dl.

Treatment for ketones_____.

Student should not exercise if blood glucose level is below_____mg/dl or above _____mg/dl or if moderate to large ketones are present.

Additional Information: _____

_____

This Diabetes Health Care Plan has been approved by:

_____   _____

Physician/Health Care Provider   **Date**

I give permission for the school personnel to follow this medical plan, administer emergency care for my child, and contact the physician if necessary. I assume full responsibility for providing the school with the medication and supplies needed, and providing medical updates as indicated. I also consent to the release of the information contained in this plan to any staff members that may need to know this information to maintain my child's health and safety. I understand that this care plan is valid for the current school year only. I give permission to fax this form to my child's medical office and school clinic.

_____   _____

Parent/Guardian Signature   **Date**