Bryan ISD Nursing Services

Diabetes Management Plan

Student Name:_____ **DOB:** _____ **ID Number:** _____

Parent/Guardian (*Padre/Tutor)*_____ Phone (*Teléfono)* _____

Emergency Contact (Contacto de Emergencia) _____ Phone (*Teléfono)* _____

Parent/Guardian Consent to Diabetes Medical Management Plan and treatment by Unlicensed Diabetes Care Assistant (UDCA)
Autorización de los padres/tutores para el plan de administración médico de la diabetes y el tratamiento por parte de un asistente no licenciado para el cuidado de la diabetes (UDCA, por sus siglas en inglés)

I, the parent/guardian of the named student, give permission to the school's registered nurse, licensed vocational nurse or UDCA of Bryan ISD to administer medication and perform and carry out the diabetes care tasks as outlined in their Diabetes Medical Management Plan provided by their physician. The UDCA may perform tasks provided by Section 168.007. I understand that an UDCA is not liable for civil damages as provided in Section 168.009.

Yo, el padre/tutor del estudiante nombrado, doy permiso a la enfermera registrada de la escuela, a la enfermera vocacional licenciada o a un UDCA de Bryan ISD para administrar la medicación y realizar y llevar a cabo las medidas de cuidado de la diabetes como se indican en su Plan de Administración Médico de la Diabetes que es proporcionado por su médico. El UDCA puede realizar las medidas previstas en la Sección 168.007. Entiendo que un UDCA no es responsable de daños civiles según la Sección 168.009

I agree to (*Estoy de acuerdo con):*

1. **Provide necessary supplies, equipment, and medications as outlined in the student 's Diabetes Medical Management Plan**. *(Proporcionar los materiales, el equipo y los medicamentos necesarios, tal y como se indica en el Plan de Administración Médico de la Diabetes del estudiante.)*
2. **Notify the school nurse of any changes in the student 's health status and complete a new consent form if any changes in the orders are made from the physician.** (*Informar a la enfermera de la escuela de cualquier cambio en el estado de salud del estudiante y completaré un nuevo formulario de consentimiento si hay cambios en las órdenes del médico.)*
3. **Authorize the school nurse to communicate verbally and in writing with the student 's health care provider about this condition and corresponding orders/management plan.** *(Autorizar a la enfermera de la escuela para que se comunique verbalmente y por escrito con el proveedor de atención médica del estudiante sobre esta condición y las órdenes/el plan de administración que corresponda.)*
4. **School staff interacting directly with my child may be informed about his/her condition and corresponding medical needs while at school.** *(El personal de la escuela que interactúa directamente con mi hijo puede ser informado sobre su condición y sus necesidades médicas correspondientes mientras está en la escuela.)*

_____ _____ _____

Parent/Guardian Signature *Firma del padre/tutor* **Date** *Fecha* **Phone** *Teléfono*

To Be Completed by Physician

- **Blood Glucose Monitoring**
  Target range for blood glucose: _____
  Times to check blood glucose at school:
  ☐Before Snacks ▫Before Breakfast ▫Before Lunch ▫Before PE ▫After PE ▫2hrs after correction dose for hyperglycemia
  ▫ PRN if symptomatic ▫ Other:_____
  Type of blood glucometer student uses: _____

- **Insulin**
  Brand of insulin: _____
  ▫ Give _____ units of _____ insulin SQ at _____ (time)
  ▫ Give _____ units of _____ insulin SQ at _____ (time)
  Mealtime insulin/carbohydrate ratio:
  ▫ Give _____ units of _____ insulin SQ per _____ gms carbohydrate meal intake
  Mealtime correction factor:
  ▫ Give _____ units of _____ insulin SQ for every _____ mg/dl above _____ mg/dl

- **Insulin Correction Doses**
  Parental authorization should be obtained before administering a correction dose for hyperglycemia. ▫ Yes ▫ No
  ▫ Give _____ units of _____ insulin SQ for every _____ mg/dl above _____ mg/dl
  Parents are authorized to adjust insulin dosage under the following circumstances and parameters: _____
  _____

- **Insulin Pump**
  Brand of insulin pump: _____ Type of insulin in pump: _____
  Infusion settings: _____
  Bolus administration times: _____ Insulin/carbohydrate ratio: _____ Correction Factor: _____
  Additional orders:_____

Bryan ISD Nursing Services

Diabetes Management Plan

- **Oral Diabetes Medication**

Medication *(provided by parent/guardian)*	**Dose**	**Instructions**

- **Meals and Snacks at school**

Meal/Snack	**Time**	**Carb total/range**
Breakfast		
Lunch		
Snack		

- **Exercise and Sports**

  Student should not exercise if blood glucose level is below _____ mg/dl or above _____ mg/dl or if moderate to large urine ketones are present.

  Other activity restrictions: _____

- **Hypoglycemia (Low Blood Sugar)**

Glucose Level	**Action**	**Treatment Options**	**Follow-up**
Mild Low Less than or equal to _____ mg/dl			
Critical Low Unresponsive or vomiting			

- **Hyperglycemia (High Blood Sugar)**

  Continue glucose check and correction dose every _____ until glucose is less than _____ mg/dl

  Treatment instructions for glucose greater than or equal to _____ mg/dl, or vomiting, or unresponsive: _____

  _____

  _____

  Urine should be checked for ketones when blood glucose levels are greater or equal to _____ mg/dl

  Treatment of ketones: _____

- **Supplies to be kept at school**

  ▢ Glucometer, lancet and test strips ▢ Urine ketone strips ▢ Insulin (pen/vial/cartridge) ▢ Snacks ▢ Glucagon

  ▢ Other: _____

- **Student abilities and skills : Can the student do the following?**

  Perform own glucose checks ▢ Yes ▢ No; Determine and draw correct dose of insulin ▢ Yes ▢ No

  Give own insulin injections ▢ Yes ▢ No; Count carbohydrates ▢ Yes ▢ No

  If using a pump, can operate and set pump ▢ Yes ▢ No

Physician Name (printed): _____ Phone number: _____

Physician Signature: _____ Date: _____

This plan is valid for current school year including summer school unless changes are made

REV 1/10/25