Diabetes Emergency Care Plan

This form is to be filled out and signed by a physician (medical doctor). If there is additional information regarding your child's diabetes needs that do not fit on this document, all additional pages must be submitted on the physician's letterhead and each page signed by the physician. Please submit the DMMP and the medication authorization form also completed by a physician, to studenthealth@flvs.net.

All documents are required for the care plan to be put in place.

Student Name: _____ DOB: _____ Student ID: _____ Grade: _____

Parent/Guardian: _____ Phone: _____

Other Emergency Contact: _____ Phone: _____

Part to be completed by a Physician:

Physician Name: _____ Phone: _____ Date: _____

Allergies: _____

Blood Glucose Monitoring

Contact parent if blood sugar is below _____mg/dL or above _____mg/dL

Child's ability to check blood sugar: □ Independent □ Needs assistance

Continuous glucose monitoring device: □ No □ Yes; name_____

How is blood sugar monitored:_____

Insulin administration

My child's insulin is administered via:

□ Needle/Syringe □ Insulin pen □ Insulin pump □ Oral medication.

Current level of student's ability to administer insulin:

□ Independent □ Staff to perform □ Staff to supervise student

For students on insulin pumps only:

Type of pump: _____

User's manual from the pump company will be provided to school staff: □ NO □ YES

Troubleshooting the pump alarms and codes: □ Student is independent □ Student requires assistance.

Insulin administered by: □ Bolus □ Dual wave

Student's ability to administer bolus: □ Student is independent □ Student requires assistance

List child's usual symptoms of Hypoglycemia:

_____

_____

_____

If the student exhibits the above signs/symptoms he/she should check blood sugar and/or be accompanied to trained staff to check the students blood sugar.

Notify parent/guardian if blood sugar is < _____ mg/dl

• Treatment for low blood sugar of <70mg/dL: (15 grams of fast acting carbohydrates) other:

_____

_____

_____

Recheck blood sugar 15 minutes after treatment. If blood sugar is not >70mg/dL then repeat treatment for low blood sugar. Call parent to inform them of the event.

If student is conscious, but unable to swallow, 15 grams of instant glucose gel or glucose source provided by the parent will be placed inside the cheek.

The same will be done for an **unconscious student** if hypoglycemia is suspected, **911 will be called, and the parent will be notified.**

List child's usual symptoms of Hyperglycemia:

_____

_____

_____

Notify parent/guardian if blood sugar is > _____ mg/dl (>300 mg/dL)

Treatment for hyperglycemia: _____

_____

_____

_____

Severe Symptoms:	**Actions:**
Unresponsive Unconscious Seizure	1. Call 911 IMMEDIATELY 2. Give emergency medication per this Emergency Care Plan 3. Call Parents/Emergency Contact 4. Stay with student. Place them on their side if seizing.

	5. Perform CPR if necessary

The child's meter, insulin and a sugar source should always accompany the child with diabetes on any field trip, in-person event or testing center. • A Trained Diabetic Care Personnel will be present on field trips, at a testing center or FLVS in-person events.
• Other necessary accommodations: _____ _____
Snacks: Student will be permitted to carry snacks on his/her person and be permitted to eat a snack whenever needed. These snacks will be student provided.

Physician signature: **Physicians Stamp:**

I certify that I am the parent or guardian of the above-named student, I approve this emergency care plan and understand that this plan will be shared with necessary Florida Virtual School ("FLVS"), state testing site personnel, county health department, medical personnel, and their employees and volunteers to ensure the safety of the student with a health condition. I authorize the above-medication to be administered as described or prescribed during FLVS in-person events or state testing. With full understanding of the risks involved, on behalf of myself and my child, I hereby release, hold harmless and indemnify FLVS, state testing site personnel, county health department, medical personnel, and their employees and volunteers for damages, payments, fees, and any other monetary obligations and indebtedness of any form caused by or arising from my child's personal injury or death arising from my child's self-administration of medication. I agree that I am responsible for providing the school with my emergency contact information, and my child's Emergency Care Plan, medication, and Medication Authorization

form completed by the physician. By signing this form, I acknowledge that I have read and understand this form in its entirety.

Parent/Guardian Signature: _____Date: _____