



BRIDGEWATER VILLAGE SCHOOL
P.O. Box 31, Bridgewater, VT 05034
Phone - 802-672-3464
Fax - 802-672-5061



DIABETES POLICY

CODE: F26

The Windsor Central Supervisory Union services a number of juvenile diabetic students. This memorandum serves to inform parents and guardians of juvenile diabetics of the procedures employed by the school nurse in providing medical services to a student who has juvenile diabetes.

INTRODUCTION

The school nurse is a registered nurse, licensed by the State of Vermont. As such, she is only permitted to execute medical regimens prescribed by a licensed physician or nurse practitioner. The parent/guardian of the juvenile diabetic must give the school authorization to provide medical services which are unique to a juvenile diabetic. The parent/guardian of the student should notify the school of the student's condition. The parent/guardian should include in the notification a request for specific medical services for the student. Such request will be reviewed by the school. The school nurse and the administrator will meet with the family of the juvenile diabetic to develop a plan of care.

REQUEST FOR DAILY MEDICAL SERVICES AND THE LEGAL LIMITATIONS OF THE NURSE

The School nurse is limited in the services she/he can provide to the juvenile diabetic. The nurse is only permitted to administer the prescribed treatment of the physician if properly equipped to do so. Many juvenile diabetics must have their blood glucose levels tested at regular intervals. The school nurse is permitted to test the student's blood glucose level subject to the following restrictions:

1. The nurse must have authorization from the attending physician to perform this test. Such authorization must include the prescribed frequency with which such test is administered and a statement from the physician as to how much insulin the student should take based on her/his blood glucose results.
2. If the school does not own a machine which tests blood glucose levels, the parent/guardian may authorize the school nurse to use a machine owned by the parent/guardian for this purpose. The parent/guardian must sign a form consenting to the use of this machine. Such consent form shall include the following provisions: "Any inspection and maintenance of the machine used to test blood glucose levels is the sole responsibility of the parent/guardian. The school is not liable for the malfunction of this machine."

Students who are knowledgeable of blood-glucose level testing and self-administration of insulin, will complete and file in the health office a medication self-administration form. This will be completed at the beginning of each school year.

If the student's blood glucose level as tested requires the student to administer to her/himself an injection of insulin, it shall be administered in the nurse's office in the presence of the nurse, unless a self-administration permission form has been completed. The hypodermic needle and insulin of the student shall be stored in the nurse's office and the nurse shall record the amount of insulin taken in the student's medical records, unless extenuating circumstances have been explored and documented.

The school nurse will contact the parent and the physician, unless otherwise indicated by the student's physician, if the blood glucose readings are below 70 or above 250.

EMERGENCY PROCEDURES

The parent/guardian shall provide the school nurse with the following information: (1) name, address and phone number of the juvenile diabetic's attending physician; (2) phone numbers where the parent/guardian can be reached in case of any emergency. It is of utmost importance that the parent/guardian keep the school and the school nurse apprised of any change in the above information. If the information changes during the school year, the parent/guardian should immediately notify the school nurse and the school. In cases of emergency, the parent/guardian will be contacted immediately.

<u>Unit: Board of:</u>	<u>Warned</u>	<u>Adopted</u>	<u>Re-warned:</u>	<u>Re-adopted</u>
Bridgewater	8/16/99	9/20/99		

STUDENT ACTION PLAN DIABETES

Name: _____ Grade: _____ Age: _____

Teacher: _____

Parent/Guardian:

Name: _____ Phone: (H) _____

Address: _____ Phone: (W) _____

Name: _____ Phone: (H) _____

Address: _____ Phone: (W) _____

Emergency Phone Contact:

(1) Name: _____ Relationship: _____ Phone: _____

(2) Name: _____ Relationship: _____ Phone: _____

Physician Student Sees for Diabetes: _____ Phone: _____

Other Physician: _____ Phone: _____

DAILY DIABETES MANAGEMENT PLAN

Insulin Morning: _____
Type and Amount

_____ Type and Amount

Insulin Evening: _____
Type and Amount

_____ Type and Amount

If _____ experiences any of the following symptoms, he/she may have low blood sugar (Hypoglycemia):

- Shakiness
- Sweating
- Pale Skin Color
- Hunger
- Sudden Mood or Behavior Changes
- Nervousness or Trembling
- Drowsiness
- Abdominal Pain

If these symptoms or behavior should occur, immediately feed him/her the following: _____

If the symptom(s) do not improve within 15 minutes, she/he should have the following: _____

This may be followed with a snack of: _____

If she/he does not improve after eating the snack, call the parent or physician.

If _____ is unresponsive or unconscious, give GLUCAGON by injection _____

Amount

Call Emergency Response Number: _____

Notify Parent/Guardian if Glucometer Reading is below _____ or above _____.

MONITORING BLOOD SUGAR

_____ should use his/her glucometer at _____.
Student's Name Time of Day

Blood Glucose Testing – method of testing/apparatus to be used: _____.

Glucometer: reading should be between: _____.

Notify physician and parent/guardian if Glucometer reading is below ____ or above ____.

ADDITIONAL INFORMATION

DIET: Lunch Time: _____

Snack Time: _____

Preferred Treats for Parties: _____

PHYSICAL EDUCATION: Scheduled at _____.

Snack is _____ is not _____ necessary before Physical Education.

PLAN FOR AFTER SCHOOL SPORTS: _____

Physician's Signature Date

Parent/Guardian's Signature Date

I give my permission for _____ to contact _____

for medical information related to my child's diabetes from _____ to _____
School Nurse Physician

_____ school year.

WINDSOR CENTRAL SUPERVISORY UNION

BLOOD GLUCOSE TESTING – DISTRICT USE OF FAMILY-OWNED MACHINE

Permission is hereby granted for the (Name) School District to utilize my son's/daughter's blood glucose testing machine (Glucometer):

Brand: _____
Type: _____
Serial #: _____

As Parent/Guardian, I understand the inspection and maintenance of this machine is my sole responsibility. The District is not liable for the malfunction of this machine.

Signature of Parent/Guardian

Date

I hereby give my permission to the school nurse, or whomever is her/his designate, for blood glucose testing of _____, as prescribed by: _____, M.D.
Student's Name

Signature of Parent/Guardian

Date