



Reading Elementary School  
632 VT Route 106, P.O. Box 176  
Reading, Vermont 05062  
802-484-7230 or Fax 802-484-3818

CODE: F 26

## READING SCHOOL DISTRICT

### DIABETES POLICY

The Reading School District 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 if she is present in the building, 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.

**Approved for Warning by Reading Board: August 18, 1999; January 21, 2004**

**Adopted by Reading Board: February 17, 2004**



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**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

\_\_\_\_\_. Call Emergency Response Number: \_\_\_\_\_.

Amount

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 \_\_\_\_\_

School Nurse

Physician

for medical information related to my child's diabetes from \_\_\_\_\_ to \_\_\_\_\_ school year.



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**BLOOD GLUCOSE TESTING – DISTRICT USE OF FAMILY-OWNED MACHINE**

Permission is hereby granted for the Reading 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

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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