State of Hawaii — Department of Education

DIABETES EMERGENCY ACTION PLAN for HYPERGLYCEMIA (High Blood Sugar)

more than ________ mg/dl

School: ____________________ SY _______ - _______ Grade/Rm _________ Date _________

Student's Name: ____ Date of Birth ______________

Emergency Contacts: Allergies: ______________________________

____

Mother/Legal Guardian (W) Day Phone Cell/Pager Home

____

Father/Legal Guardian (W) Day Phone Cell/Pager Home

____

Alternate (W) Day Phone Cell/Pager Home

____

Physician / Health Care Provider Treating Student for Diabetes Phone Fax

Warning Signs and Symptoms: Check or write in previous signs. Look for any of the following listed below.

	Behavioral Symptoms:	**Physical Symptoms:**		
(Mild)	_ Lack of Concentration	_ Thirst / Dry Mouth	_ Blurred Vision	
	_ Fatigue / Sleepiness	_ Flushing of Skin	_ Hunger	
		_ Frequent Urination	_ Stomach Ache	_ Sweet Fruity Breath
(Moderate)		_ Nausea	_ Vomiting	_ Stomach Cramps
(Severe)	_ Confused	_ Rapid Labored Breathing		
	_ Unconscious / Comatose	_ Very Weak		

IF STUDENT IS SICK, HAS A STOMACH ACHE, OR VOMITING;
ASSIST STUDENT TO CHECK KETONES* AND CALL PARENT/LEGAL GUARDIAN

Hyperglycemia usually develops slowly.
Student may return to class if there are no warning signs or symptoms

Check if Student has Insulin Pump. Call Parent/Legal Guardian Immediately.

Intervention at mild – moderate level will prevent progression to more severe symptoms

1. Timing is important. Eat on time, take insulin on time, and check blood glucose on time.
2. Ensure insulin dosing is accurate. Right dose and right time.
3. Supervise and guide student about food choices, including monitoring what is being eaten.
4. Consult with parent/legal guardian when there will be changes in classroom snacks, meals, or exercise activities.

TREATMENT OF HYPERGLYCEMIA

1. Keep student calm; have student sit down.
2. Check blood glucose. Meter and test strips are located ________________.
   - Start written record with time, signs & symptoms, and results.
   - Notify parent/legal guardian if over _____ mg/dl.
3. Allow free use of the bathroom.
4. Encourage drinking water or sugar-free drinks.
5. **For Students on Insulin Pump: Check for tubing kinks, wetness and infusion set for dislodgement.**
   - **Call parent/legal guardian.**
6. *Assist student to check ketones, if blood glucose is more than 300 mg/dl twice in a row (2 hours apart).
   - If moderate or more (urine) OR 0.6 or more (blood), call parent/legal guardian to pick up.

Call 911 if vomiting with confusion, labored breathing, lethargic and / or comatose.

* Contract Nurse can check ketones

State of Hawaii | Department of Education

DIABETES EMERGENCY ACTION PLAN for HYPOGLYCEMIA (Low Blood Sugar)

School: ____________ SY: ______ - ______ Grade/Rm: ________ Date: ________

Student's Name: ______________________________ Date of Birth: __________

Emergency Contacts: Allergies: ______________________

Mother/Legal Guardian	(W) Day Phone	Cell/Pager	Home
Father/Legal Guardian	(W) Day Phone	Cell/Pager	Home
Alternate	(W) Day Phone	Cell/Pager	Home

Physician / Health Care Provider Treating Student for Diabetes	Phone	Fax

Warning Signs and Symptoms: Check or write in common signs. Look for any of the following listed below.

Behavioral Symptoms:
- X Irritable
- _ Anxious
- _ Drowsy
- _ Crying
- _ Unable to Concentrate
- _ Erratic Behavior
- _ Sleepiness
- _ Combative
- _ Confusion

Physical Symptoms:
- _ Hunger
- _ Weak
- _ Shakiness
- _ Dizziness
- _ Pale Appearance
- _ Slurred Speech
- _ Headache
- _ Sweatiness
- _ Numbness of Lip & Tongue
- _ Blank Stare
- _ Poor Coordination
- _ Unable to Swallow
- _ Unconscious
- _ Convulsion-Like Movements

IF STUDENT IS ILL, CHECK BLOOD GLUCOSE AND CALL PARENTS

NEVER SEND A STUDENT WITH SUSPECTED LOW BLOOD SUGAR ANYWHERE ALONE

******IF blood glucose meter not available, treat anyway!**

Standard Treatment of HYPOGLYCEMIA

Blood Glucose (BG) Level	Actions
	• Keep student quiet; have student sit down. • Test student's blood sugar. Meter, test strips and supplies, i.e. glucose tablets or gel, and/or glucagon are located at ____________________.
If at any time the child is unconscious or cannot swallow	→ **Lie student on side. Keep airway clear. Call 911. Administer glucagon (by trained adult)**
Initial check: If BG is **less than** ____ mg/dl	→ GIVE: 4 glucose tabs **or** 1 tube glucose gel into side of cheek **or** ½ cup juice **or** ½ cup soda (regular not sugar-free). **Recheck blood glucose in 15 min.**
Recheck: If BG is still **less than** ____ mg/dl	→ Give a 2nd dose of glucose source above and contact parent/legal guardian. Repeat the blood glucose recheck procedure every 15 minutes. As long as child is able to swallow, continue to give glucose source by mouth, if indicated.
OR	
If BG is ____ **mg/dl or greater**	→ GIVE: 2 crackers and cheese **or** peanut butter **or** give meal if mealtime is soon. Recheck blood glucose in 15 minutes. If blood glucose stays above ____ mg/dl, student may return to class.

STATE OF HAWAII
DEPARTMENT OF EDUCATION

REQUEST FOR DIABETES CARE/INSULIN ADMINISTRATION IN SCHOOL

School:____School Year:________________
____

Please complete form in ink Student Name (Last, First):			DOB:
Address:			Grade/Homeroom #:
Parent 1 Name:	Cell:	Work:	Home:
Parent 2 Name:	Cell:	Work:	Home:
Legal Guardian's Name:	Cell:	Work:	Home:

Medical Insurance	(Check one) ☐ QUEST ☐ Medicaid ☐ Tricare ☐ HMSA-Private ☐ Kaiser-Private Other (specify): ____________________________ ☐ None

I. PARENT'S / LEGAL GUARDIAN'S REQUEST, AUTHORIZATION and WAIVER OF LIABILITY

Request and Authorization:

I, the undersigned, request and authorize the following individuals to administer medication to my child as prescribed by my child's physician or other practitioner with prescribing authority in a medication order: personnel of the Department of Education (DOE), personnel of the Department of Health (DOH), and nurses assigned by the DOE pursuant to written agreement.

I request and authorize the release of health information among the DOE, the DOH Public Health Nurse (PHN), the prescribing physician or other practitioner with prescribing authority, and the dispensing pharmacist pertinent to my child's condition. I understand that I will be informed by the PHN, the prescribing physician or other practitioner with prescribing authority if there are any changes to my child's medication order.

☐ **I have read the instructions on page 3 of this form, "Notice to Parents/Legal Guardians and Physicians."**
☐ **I will provide a recent photograph of my child.**
☐ **I agree I am responsible to provide appropriately labeled medications in accordance with the instructions on page 3.**

PARENTS/ LEGAL GUARDIANS SIGNATURE: __________________________ **DATE:** ____________

Waiver of Liability:

NOTICE: The DOE, the DOH, and their employees and/or agents shall not incur any liability as a result of any injury arising from the administration of the emergency rescue medications or daily, routine, scheduled medications specified on this form.

My signature below indicates that:

- I understand and I agree that the medication may be administered by a specifically trained non-health care professional; and
- I agree that the DOE and the DOE and their employees or agents, including nurses assigned by the DOE pursuant to this written agreement, shall not incur any liability as a result of any injury arising from the administration of the emergency rescue medications or daily, routine, scheduled medications specified on this form.

PARENTS/ LEGAL GUARDIANS SIGNATURE: __________________________ **DATE:** ____________

REQUEST FOR DIABETES CARE/INSULIN ADMINISTRATION IN SCHOOL

School:______________________________ **Grade**__________ **School Year:**____________

Name: **DOB:**

II. PROVIDER'S REQUEST

1. **Blood Glucose Testing**
   - ☐ Before lunch / meals
   - ☐ For suspected hypoglycemia
   - ☐ No blood glucose testing at school
   - ☐ Use continuous glucose monitor (CGM) readings unless <____ or > ___ please check glucose with a finger stick.

   Expected blood glucose range while at school:

   ____

2. **Hypoglycemia - Refer to EAP** – Assistance for all lows
   - ☐ OK to use glucose gel inside cheek; if conscious
   - ☐ Glucagon (BAQSIMI) nasal powder 3mg
   - ☐ Glucagon * IM ☐ 0.5 mg wt ≤ 44 pounds
   - ☐ 1.0 mg wt ≥ 45 pounds

3. **Hyperglycemia - Refer to EAP**
   If glucose > ____mg/dl, recheck in 2 hours, if > ___ mg/dl,

   ☐ Check **ketones**: ☐ Urine ☐ Blood

   If Ketones are moderate / 0.6 or greater, then: call parent

   ☐ **Other**: Rest, drink water & have parent pick up within *one hour.*

4. **Meal/Snacks**
   - ☐ Adult supervision to assure student eating
   - ☐ AM snack time: _______ ☐ PM snack time: _______
   - ☐ Other: ______________________________
   - ☐ Extra food allowed:
     - ☐ Vigorous exercise
     - ☐ Bus rides over 30 minutes

5. ☐ **NO Insulin Order: STUDENT/ PARENT CAN SELF-MANAGE**

6. ☐ **Insulin Orders:** Provider to complete if student is not able to self-manage.

   Administration Time: _________**(to be determined by school)**
   - ☐ Before breakfast ☐ Before AM snack
   - ☐ Before lunch ☐ PM snack
   - ☐ Other:______________________________

   Insulin administration via:
   Insulin type: ______________________________

   ☐ Syringe and vial ☐ Insulin pen ☐ Insulin pump

   **** Dosage:** ☐ As per pump ☐ If pump fails use CF / CR

   ☐ **Correction Factor** (CF) based on Blood Glucose:

   from _______ to _______ = _______ units
   from _______ to _______ = _______ units
   from _______ to _______ = _______ units
   from _______ to _______ = _______ units
   from _______ to _______ = _______ units
   from _______ to _______ = _______ units

   ☐ **Carbohydrate Ratio** (CR): **1 unit for _______carbs**
   Insulin dosage is based on carbohydrate count.
   Carbohydrate count + insulin calculation shall be the responsibility of parents/ legal custodian /student.

   ☐ **Standard** lunchtime dose: ____________ units

**If insulin dosage adjustment is needed, Parent / legal guardian will Instruct the student of change.

Provider Signature: ______________________ **Date:** ______________
Provider Name (type/print): ______________________ **Phone:** __________ **FAX:** __________
Address: ______________________ **City:** __________ **Zip:** __________

III. PARENT'S REQUEST AND AUTHORIZATION (Public Health Nursing Services):

I, the undersigned, request and authorize the Department of Education to provide health services to my child with diabetes. I request and authorize release of health information between the school, Public Health Nurse (PHN), prescribing provider, and pharmacist pertinent to my child's condition. **I will provide necessary supplies and equipment**, and notify School Health Aide, School Administrator and consulting PHN if there is a change in my child's health status or attending provider. (**I have read the instructions on page 3**.)

Parent/Guardian Signature:______________________________ Date:______________

IV. PARENT'S REQUEST AND AUTHORIZATION (Skilled Nursing Services):

I, the undersigned, request and authorize the Department of Education and nursing personnel to provide health services to my child with diabetes. I request and authorize release of health information between the school, Registered Nurse (i.e. DOH PHN, agency RN), prescribing provider, and pharmacist pertinent to my child's condition. **I will provide necessary supplies and equipment** and notify DOE and nursing personnel if there is a change in my child's health status, attending provider, or health services in school. (**I have read the instructions on page 3**.)

Parent/Guardian Signature:______________________________ Date:______________

The Administrator's initial confirms that the Department of Health PHN's Recommendation form is attached	☐ **Approved by Agency RN:**
____________ Administrator's Initials ________ Date	____________ RN's Signature ________ Date

REQUEST FOR DIABETES CARE/INSULIN ADMINISTRATION IN SCHOOL

GENERAL INSTRUCTIONS

Please note: School health assistants are unlicensed non-health professionals who are specifically trained in medication administration. They are not able to perform clinical assessments necessary to determine the need for medication or response to medication, but they are provided with protocols to follow in situations where medication is needed.

1. Medications that are provided by the parents/legal guardians pursuant to this form, shall be stored in the school health room or skilled nursing classroom. No other medications will be stored in school.

2. Medications should be given at home as much as possible unless physician or other practitioner with prescriptive authority provides reasons on this form why medications must be given during the school day or at a beyond-the-school day event/program. In that event, emergency rescue medications and daily, routine, scheduled medications shall be administered as prescribed and requested by this form.

3. Glucagon, defined as an emergency rescue medication, may be administered on an emergency basis if it has been prescribed by a physician or other practitioner with prescriptive authority. Revised Statutes (HRS) §302A-853.

   Glucagon: When administered, the school will call "911" and notify the parent/legal guardian. The school will defer to Emergency Medical Services (EMS) personnel with respect to whether transport to a medical facility is needed. If EMS personnel determine that transport to a medical facility is not needed, the parent/legal guardian to pick up student.

4. *No medications will be administered* by the authorized DOE and the DOH and their employees or agents including nurses assigned by the DOE *without the completion of this SH 38 DM, Revised 2021, which includes the following requirements:*
   a) Parents/Legal Guardians must complete Section I, PARENTS/LEGAL GUARDIANS REQUEST, AUTHORIZATION, and WAIVER of LIABILITY;
   b) Physician or other practitioner with prescriptive authority must complete Section II, Provider's Request;
   c) DOH PHN and/or Agency RN must approve the form; and
   d) The completed form must be submitted by the PHN to the School Health Assistant and maintained on file in the school health room. For students with SNS, completed form to go to agency RN.

5. For medication to be stored and administered in school, the medication must:
   a) Be dispensed by a pharmacist in accordance with HRS §328-16 (a)(10);
   b) Be in a container/vial labeled "**FOR SCHOOL USE.**"
   c) Include the name of the student, name of the medication, dosage, strength, time of administration, and name of prescribing physician or other practitioner with prescribing authority. The instructions on the container must state, "**FOR SCHOOL USE**;"

6. Parents/Legal Guardians are responsible for providing an appropriately labeled supply of medications, diabetes care supplies, and a recent photo of their child to the health room at school. Send refills in properly labeled container/vial before medications and diabetes care supplies run out. Students receiving SNS, the Agency RN shall inform parents/legal guardians. Medications that are discontinued or unused must be picked up by the parents/legal guardians.

7. Should there be any change in medication order(s) by the physician or other practitioner with prescribing authority, a new "Request for Diabetes Care/Insulin Administration in School" (SH 36DM, Rev. 2021) must be completed and submitted as specified in this form. The form may be sent to school with the new container/vial of medication to reflect the new order(s) using the process specified on this form. Prescription refills based on the prescription on file do not require a new form.

8. If your child is off campus during the regular school day to participate in a DOE sponsored activity, prior arrangements must be made between the parents/legal guardians and the school for your child to be able to receive prescribed medications. Otherwise, your child will **NOT** be able to receive prescribed medication for the day.

9. **This form is only applicable for the current school year and will MUST be renewed by the start of each school year. Parents/legal guardians are responsible for submitting new forms each school year.**

ACT 207: ADMINISTRATION OF GLUCAGON IN AN EMERGENCY BY VOLUNTEER DEPARTMENT OF EDUCATON EMPLOYEES AND AGENTS
Parent(s)/Legal Guardian(s) and Physician Form
FOR SY ______________ to ______________

A. Parent(s)/Legal Guardian(s) Request and Authorization

for my child, ____,with the diagnosis of Diabetes
(Name)

I, THE UNDERSIGNED, agree to the following:

- request and authorize the Department of Education (DOE) employees and agents to volunteer to administer glucagon in an emergency situation to my child, as named above;
- supply the school with the glucagon kit required to administer the glucagon;
- acknowledge that the DOE and its employees or agents shall not incur any liability as a result of any injury arising from compliance with Act 207, passed by the 2005 Hawaii State Legislature and signed into law on July 8, 2005 by the Governor, State of Hawaii;
- shall indemnify and hold harmless the DOE and its employees or agents against any claims arising out of compliance with Act 207; and
- understand that this authorization shall be effective for the school year for which it is granted and shall be renewed for each subsequent school year.

Parent(s)/Legal Guardian(s) Signature: ______________________________ Date: _____________

****

B. Physician's Certification

I, THE UNDERSIGNED, certify

- and provide this order that glucagon may be administered by DOE employees and agents to the student named above;
- that the form, PHN 36-Diabetes "Request for Diabetes Care in School, " for the current school year provides the order for the administration of glucagon in an emergency situation to the student, named above; and
- understand that the DOE employees and agents who volunteer shall receive instruction in the proper administration of glucagon by a qualified health care professional.

Physician's Name: ______________________________________ (type/print)

Physician's Signature: ______________________________

Address: ______________________________________

Telephone:_____________ Date: ___________

Reviewed/Accepted by: ____ Date: ___________________
Principal or DOE Designee

Reviewed/Accepted by PHN: ______________________________________ Date: ___________________

And filed in the Student's Health Record