LOS ANGELES UNIFIED SCHOOL DISTRICT
Medical Services Division
District Nursing Services Branch

Hyperinsulinemia Management Plan Related to Non-Diabetes Conditions for School & School-Sponsored Events
Individualized School Healthcare Plan (ISHP) will provide details for implementation.

HealthCare Provider Authorization and Parent Consent

Student:_____ DOB: _____ Gender (*Select One): ☐ Male ☐ Female ☐ Non-binary
School:_____ Grade: _____ Diagnosis: _____

Student is capable of independent self-management (Ind), With supervision (Sup), or total care (Total) for the following:

- ○ Blood glucose monitoring (BGM):
  ☐ Independent ☐ Supervised ☐ Total Care
- ○ Continuous Glucose Monitor (CGM)
  ☐ Independent ☐ Supervised ☐ Total Care
- ○ Carbohydrate counting
  ☐ Independent ☐ Supervised ☐ Total Care

Blood Glucose Monitoring: Desired range _____mg/dL

- ☐ Before breakfast
- ☐ Before snacks/recess/mid-am
- ☐ Before lunch
- ☐ For symptoms of high/low (feeling ill)
- ☐ Before physical activity (> ___ min.)
- ☐ Before end of school ☐ After school program
- ☐ Other times: _____

Instructions:

_____
_____

CGM: Brand/Model: _____
Alert setting: _____ low

Confirm CGM with BGM if:

- ☐ CGM alert for hypo/hyperglycemia
- ☐ CGM sensor glucose (SG) levels which is not the same as the blood glucose (BG) or there is no sensor glucose value.
- ☐ The child is symptomatic
- ☐ There are 2 arrows down
- ☐ When in doubt

Instructions:

_____
_____

Care of Hypoglycemia (Treatment of low blood glucose)
Student must never be alone when hypoglycemia is suspected and needs continuous adult supervision & assistance.

Treatment for blood glucose <____ mg/dL.
Treat with **____ gm/CHO** of the following: ____*oz*. juice or regular soda, ____*tabs*. glucose tabs, ____ *tube* glucose gel, ____ *pcs.* hard candy, ____*tbsp* sugar, or ____ *tbsp* honey

Recheck blood glucose in 15 minutes

- ●Repeat treatment if blood glucose <_____ mg/dL

NOTE: If still hypoglycemic after 3 treatments: CALL PARENTS*
If lunch or snack is more than an hour away, post hypoglycemia
treatment, give____ gm complex CHO without insulin.

Emergency Care for Severe Hypoglycemia:
Symptoms: **seizure, loss of consciousness, and unable to swallow. Give one of the following:**

- ☐ Glucagon IM ___mg into the arm or thigh.
- ☐ Glucagon Auto injection SQ (Gvoke)___mg into the upper arm or thigh.
- ☐ Glucagon NAS (Baqsimi) 3mg (one spray) into one nostril.

If glucagon was administered:

1. **Call 911**
2. Call parent/guardian to contact student's HCP to review severe low, potential causes, and discuss any necessary changes or next steps.

Exercise/Sport Guidelines:
Student may participate in sports ☐ Yes ☐ No

- ☐ Fast-acting carbs should always be readily available for hypoglycemia.
- ☐ If BG is less than _____ mg/dL prior to PE, with steady or Falling arrow on CGM, give _____ gm snack.
- ☐ Before PE: If BG is less than _____ mg/dL, give _____ gm of CHO
- ☐ **No exercise for blood glucose <_____ mg/dL;**

<u>CARBOHYDRATE COUNTING</u>:
Meal carb count: _____gm
Snack carb count: _____gm
Disaster Plan:

- Check BG every ____ hour(s)
- Feed student with _____ gm CHO every _____ hours

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Student:_____ DOB: _____ Grade: _____

Authorized Health Care Provider Authorization for Management of Hyperinsulinemia Related to Non-Diabetes Conditions at School & School-Sponsored Events

My signature below provides authorization for the above written order. I acknowledge that all procedures will be implemented in accordance with state laws and regulations.

I understand that specialized physical health care services may be performed by unlicensed designated school staff.

Authorized Healthcare Provider Name/Title: _____ Signature: _____ Date: _____

Phone: _____ Address: _____ City: _____ Zip: _____

*Nurse Practitioner, Nurse Midwife, Physician Assistant Furnishing Number: _____

Parent Consent for Management of Hyperinsulinemia Related to Non-Diabetes Conditions at School & School-Sponsored Events

I give permission to the licensed nurse and other designated staff members to perform and carry out the hyperinsulinemia care tasks outlined in this form in accordance with Education Code Section 49423.5. I also consent to the release of the information contained in this plan to all staff members and other adults who have custodial care of my child who may need to know this information to maintain my child's health and safety.

1. **Provide the necessary supplies and equipment.**
2. **Notify the school nurse if there is a change in pupil health status or attending Healthcare Provider.**
3. **Notify the school nurse immediately and provide new written consent/authorization for any changes in the above authorization.**
4. **Provide new written consent/authorization yearly.**

I (we) give consent for the school nurse to communicate with the authorized healthcare provider when necessary.

Consentimiento de los padres para el control de la hiperinsulinemia relacionado a una condición no diabética en la escuela y en eventos patrocinados por la escuela

Le otorgo permiso a la enfermera con licencia y a otros miembros del personal designados para realizar y llevar a cabo las tareas de cuidado de la hiperinsulinemia descritas en este formulario de acuerdo con la Sección 49423.5 del Código de Educación. También doy mi consentimiento para que se divulgue la información contenida en este plan a todos los miembros del personal y a otros adultos que estén al cuidado de mi hijo y que puedan necesitar esta información para mantener la salud y seguridad de mi hijo.

1. *Proporcionar los insumos y equipos necesarios.*
2. *Notificar a la enfermera de la escuela si hay un cambio en el estado de salud del estudiante o en el prestador de servicios médicos que lo atiende.*
3. *Notificar inmediatamente a la enfermera de la escuela y proporcionar un nuevo consentimiento/autorización por escrito para cualquier cambio en la autorización anterior.*
4. *Proporcionar anualmente un nuevo consentimiento/autorización por escrito.*

Yo otorgo mi (nosotros otorgamos nuestro) consentimiento para que la enfermera de la escuela se comunique con el prestador de servicios médicos autorizado cuando sea necesario.

Parent/Guardian Name: _____ **Signature:**_____ **Date:** _____
(Nombre del Padre de Familia/Guardian) *(Firma)* *(Fecha)*

Home phone: _____ **Work phone:** _____ **Cell phone:** _____
(Telefono de casa) *(Telefono del trabajo)* *(Telefono movil)*

Licensed Nurse Acknowledgement of Completeness and Meets District Guidelines

Printed Name of Nurse	**Signature**	**Title (RN/LVN)**	**Date**