Student's Name _____ **Student ID #** _____**Date of Birth** _____

School _____**Grade**_____ **Homeroom Teacher**_____

Bus # / Transportation _____ **Date of Diabetes Diagnosis**_____

Effective Dates for Plan: ___/___/___ to ___/___/___ **Type _____ Diabetes**

Special Ed: _____ 504 _____ **Allergies:** _____

Photo of Student Pasted Here

DIABETES CARE PLAN

Parent/Guardian: Complete this plan with the assistance of your child's health care provider and the school nurse/administrator. The diabetes care plan requires the signature of the student's parent/guardian and health care provider. Return the completed, signed plan to the school. Attach other instructions/forms if needed.
Health Care Provider: Review this diabetes care plan and make any necessary changes or additions. Sign and return the plan to parent/guardian or school.

Parent/Guardian 1:_____Address_____

Telephone (Home #)_____(Work #))_____(Cell #)_____

Parent/Guardian #2:_____Address_____

Telephone (Home #)_____(Work #)_____ (Cell #)_____

Physician Treating Student for Diabetes:_____ Telephone _____

Other Physician:_____ Telephone _____

Nurse or Diabetes Educator:_____ Telephone_____

Other Emergency Contact:_____ Relationship_____

Telephone (Home #)_____(Work #)_____ (Cell #)_____

Trained School Diabetes Care Providers: _____

Where are student's diabetes supplies kept?_____ Does the student wear a medic alert? **YES NO**

Notify parents in the following situations: □ Persistent Low Readings □ BG >300 □ ^ T & N/V □ Supplies Needed □ Ketones > Trace □ Other _____

EMERGENCY ACTION PLAN

Warning Signs of Insulin Reaction, LOW BLOOD SUGAR (Hypoglycemia)

Sudden hunger	**Headache**	**Sweating**	**Shakiness**	**Nervousness**
Paleness	**Fatigue**	**Unusual Drowsiness**	**Crying**	**Irritable**
Confusion	**Concentration**	**Inappropriate Actions**	**_____**	**_____**

Treatment

Hypoglycemia is a medical emergency and requires immediate treatment! If possible, test the blood glucose. If less than target give one of the following items. If you do not know how to test or there is no meter to test with…TREAT anyway.

The best rule is "When in doubt TREAT!"

1. Give one of the following:
- **Juice ½ cup (4-6 oz.)**
- **Milk 1 cup or 1 school sized carton**
- **Regular soda pop (NOT DIET), ½ can**
- **Glucose tablets, chew 2-3 followed by water**

2. Stay with the child, repeat the treatment if necessary in 15 minutes, follow with lunch or a snack.

3. If found unresponsive call 911. Administer Glucagon if included in student's Diabetes Care Plan.

Hypoglycemia is most likely to occur:

1. **When meals or snacks are missed or delayed**
2. **When participating in a strenuous activity just before lunch**
3. **During a lengthy field trip or field day activity.**

HIGH BLOOD SUGAR (Hyperglycemia)

SYMPTOMS

Frequent urination, excessive thirst, nausea, vomiting, dehydration, sleepiness, confusion, blurred vision, inability to concentrate, irritability, blood sugar above _____mg/dl.

Call parent/guardian and health care provider if blood sugar is over _____ mg/dl.

Symptoms of high blood sugar for this student: _____

Where are insulin and ketone testing supplies kept? _____

TREATMENT FOR HIGH BLOOD SUGAR (Hyperglycemia)

- Contact trained school diabetes care provider who will provide insulin administration, insulin pump care, and ketone testing.
- To correct high blood sugar, give insulin: _____units for every _____mg/dl over _____
- Check for ketones if blood sugar is above _____. Check blood sugar again in _____and at _____ intervals.
- Allow free and unlimited use of bathroom. Encourage student to drink water or other sugar-free liquid
- **If moderate or higher ketones are present, call health care provider and parent/guardian immediately.**
- **If symptoms worsen or the student begins vomiting, call health care provider and parent/ guardian immediately.**
- **Other instructions for treating high blood sugar**_____

BLOOD SUGAR MONITORING

Target range of blood sugar: _____ to _____ Type of Meter:_____ Logbook kept at school? **YES NO**

What help will student need with blood sugar testing? _____

Usual times for student to test blood sugar: _____

Other times when blood sugar may need testing: □Before Meals □ Every 2 hrs. if ill □ Before Exercise □ After Exercise □ Before Snack □ Other

Other instructions: _____

INSULIN AND ORAL MEDICATIONS

TIME (For insulin at school)	**TYPE OF INSULIN**	**INSULIN DOSAGE**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

INSULIN INJECTIONS
Does student know how to:

Give own injections?	**YES**	**NO**
Determine correct insulin dose?	**YES**	**NO**
Draw up correct insulin dose?	**YES**	**NO**
Handle and dispose of needles safely?	**YES**	**NO**

Will student need insulin at school? **YES NO** Where is insulin kept at school?_____

What help will student need with insulin injections? □ Supervision □ Assistance □ Completely Dependent □ Independent

Insulin/carbohydrate ratio for meals/snacks: _____ units for every _____

High blood sugar correction ratio: _____units for every _____ mg/dl over _____

FOR STUDENTS ON INSULIN PUMPS:

Type of pump:_____ Type of insulin used in pump:_____

Insulin/carbohydrate ratio for meals/snacks: _____units for every _____

High blood sugar correction ratio: _____units for every _____ mg/dl over_____

Back-up means of insulin administration? _____

What help will student need with pump? _____

INSULIN PUMPS
Does student know how to:

Operate the pump without assistance?	**YES**	**NO**
Change infusion site?	**YES**	**NO**
Change tubing?	**YES**	**NO**
Change batteries?	**YES**	**NO**
Change insulin cartridge?	**YES**	**NO**
Determine bolus amount?	**YES**	**NO**
Give bolus?	**YES**	**NO**
Adjust basal rates?	**YES**	**NO**
Determine when to give insulin by Syringe if ^ BG?	**YES**	**NO**

ORAL MEDICATIONS:_____

FOOD AND EXERCISE

MEAL/SNACK	**TIME**	**FOOD CONTENT / AMOUNT**
Breakfast	_____	_____
Mid-Morning	_____	_____
Lunch	_____	_____
Mid-Afternoon	_____	_____
Before Exercise	_____	_____
After Exercise	_____	_____
Other	_____	_____

PREFERRED SNACKS:

FOODS TO AVOID:

Student should not exercise if blood sugar is below _____mg/dl OR above _____mg/dl.

Other exercise/activity instructions:_____

Parent/Guardian *(Signed)* Date	Health Care Provider *(Reviewed and signed)* Telephone Number Date	School Nurse/Administrator Date Received