Diabetes Care Plan

PART A (To be completed by Parent/Guardian)

Student's Name_____ Date of Birth_____
School_____ Grade_____ Homeroom Teacher_____ Bus #_____
Parent/Guardian _____
Telephone Home #_____ Work #_____ Cell #_____
Other Emergency Contact_____ Daytime Telephone #_____
School Personnel Trained as Diabetes Care Providers_____
Physician Treating Student for Diabetes_____ Office # _____
Nurse or Diabetes Educator_____ Telephone #_____

PLEASE CIRCLE THE SYMPTOMS YOUR CHILD HAS EXPERIENCED:

Low Blood Sugar (Hypoglycemia) Symptoms

• hunger	• sweating	• trembling	• pale appearance	•slurred speech
• confusion	• irritability	• sleepiness	• inability to concentrate	•poor coordination
• headache	• dizziness	• crying	• complains of feeling "low"	•personality change

Other symptoms of low blood sugar for this student _____

High Blood Sugar (Hyperglycemia) Symptoms

•frequent urination	• excessive thirst	• nausea/vomiting	• sleepiness
• blurred vision	• confusion	• irritability	• inability to concentrate

Other symptoms of high blood sugar_____

If your child is Independent please sign below. Independent Management of Diabetes:
I give permission for my child to determine the correct time of administration, calculate amount of carbohydrates/diet consumed, calculate the dose of insulin and administer his/her own insulin. I will instruct my child to notify school personnel whenever his/her blood sugar is above or below safe levels.

Parent/Guardian Signature _____**Date** _____
***Health Care Provider/Physician Signature** _____**Date** _____
***Required noting agreement with independence**

PART B (To be completed by Health Care Provider)

Diabetic Management to Include:

Blood Sugar (BS) Testing at School:
□ No blood sugar testing required at school.
□ Trained personnel must monitor blood sugar test.
□ Student can perform testing independently.

Times To Do Blood Sugar:
□ Before meal _____
□ Before PE_____
□ Before snack _____
□ As needed for signs/symptoms of low or high blood sugar
□ Prior to boarding after school bus

Continuous Glucose Monitor (CGM): □Yes □No Brand/Model:_____. Readings to be used for dosing.

□ Call parent if values are below _____ or above _____**Target BS Range**_____
□ Confirm CGM results with fingerstick if blood glucose is less than _____

DIET: □ Carbs per meal = _____ **or** □ As selected by parent
Snack time(s)_____ a.m._____ p.m. Amount/type snack_____ Cover Carbs if snack > than_____
If BS above_____, withhold snack **OR** cover BS per correction table_____
□ Student needs assistance with carb count and insulin dose calculation

Medications to Be Given During School Hours:
Times to be administered: ☐ Before Breakfast ☐ Before lunch ☐ As needed for high blood sugar
☐ After Breakfast ☐ After lunch ☐ Other _____
Insulin (subcutaneous injection) using (circle type): Humalog / NovoLog / Regular / Apidra / _____
Insulin Pen OR **Vial** & Syringe
Oral Diabetic Medications at School_____

OVER →

□ **Two component plan:**

a. Measure the Finger-Stick Blood Glucose (FSBG) 0-15 minutes prior to the meal. Use the **"Correction Dose Table"** below to determine the Correction Dose, the dose of _____ insulin needed to bring your blood sugar down to a baseline of _____.

Correction Dose Table

FSBG	Insulin units	FSBG	Insulin units

b. Estimate the number of grams of carbohydrates you will be eating (carb count) Use the **"Food Dose Table"** below to determine the dose of insulin needed to compensate for the carbs in the meal.

Food Dose Table

Carbs gms	Insulin units	Carbs gms	Insulin units

c. Add up the Correction Dose plus the Food Dose = "Total Dose" of insulin to be taken.

OR:

□ **Sliding Scale:**

___ Unit(s) if lunch blood sugar is between___ and___ ___ Unit(s) if lunch blood sugar is between___ and___
___ Unit(s) if lunch blood sugar is between___ and___ ___ Unit(s) if lunch blood sugar is between___ and___
___ Unit(s) if lunch blood sugar is between___ and___ ___ Unit(s) if lunch blood sugar is between___ and___

□ **If there is a change in insulin dosage the school requires a health care provider/physician note.**

- ❑ **Parent may make change in regimen based on communication with provider. *Changes must be made in writing via email and/or written note to school nurse for review.**

□ Adult must draw up and administer insulin
□ Student can draw up and inject own insulin
□ Trained adult will monitor insulin calculation and administration
□ Student is on insulin pump – see supplemental pump information sheet
□ **Glucagon** (intramuscular injection) dosage = _____ cc Glucagon located_____
□ Oral diabetes medication(s)/dose given at home.
□ Check ketones if BG > _____

- ❑ **See standard protocols for hypoglycemia and/or hyperglycemia.**

PERMISSION SIGNATURES: Parent/Guardian and Health Care Provider authorizes this health care plan, use of glucometers, listed medications for this student at school for this school year. The school nurse may contact the stated health care provider(s) related to this condition.

Parent/Guardian Signature_____ Date_____

Health Care Provider/Physician Signature_____Date_____