DIABETES CARE PLAN

Student's Name______________________________ Date of Birth____________________

School_____________________ Grade______________ Type_____ Diabetes

Effective Dates for Plan: ____/____/____ to ____/____/____

Parent/Guardian: Complete this plan with the assistance of your child's health care provider and the school nurse. The diabetes care plan requires the signature of the student's parent/guardian **and** health care provider. Return the completed, signed plan to school. Attach other instructions/forms if needed. This information will be shared with appropriate school staff unless you state otherwise.
Health Care Provider: Review and authorize this diabetes care plan and make any necessary changes or additions. Sign and return the plan to parent/guardian or school nurse.
Where are student's diabetes supplies kept? ______________________________________

Does the student wear a medic alert? **YES NO**

Notify parents in the following situations: ______________________________________

____

504 Accommodations are in place **YES NO**
Date Received________________
Reasonable accommodations for this student include but are not limited to:

- **Bathroom privileges**: Allow free and unlimited use of bathroom facility.
- **Access to water**: Student should be allowed to carry water bottle if desired.
- **Testing concerns**: Academic performance may be adversely affected due to fluctuations in blood sugar levels. Therefore, additional accommodations may be necessary

EMERGENCY ACTION PLAN

LOW BLOOD SUGAR (HYPOGLYCEMIA)

SYMPTOMS

Hunger, sweating, trembling, pale appearance, inability to concentrate, confusion, irritability, sleepiness, headache, dizziness, crying, slurred speech, poor coordination, personality change, complains of feeling "low", blood sugar below ________________mg/dl.
Call parent/guardian and health care provider if blood sugar below_________mg/dl.

Symptoms of low blood sugar for this student: ____________________________________

Times student is most likely to experience a low blood sugar: _______________________
Where are glucose tablets and snacks kept?
____

Has Health care provider authorized use of glucagon? YES NO
Where is glucagon kept? ____

BLOOD SUGAR MONITORING

TREATMENT FOR LOW BLOOD SUGAR (HYPOGLYCEMIA)

If student conscious, cooperative, and able to swallow:

- Give fast sugar immediately, such as glucose tablets, fruit juice, regular soda, glucose gel, or ____
- Amount of fast sugar to be given: _____________________________________
- If symptoms do not improve in __________ minutes, give fast sugar again.
- When symptoms improve, provide an additional snack of ____________________
- Check blood sugar level every _________minutes until it is above ___________.
- Do not leave student alone or allow him/her to leave the classroom alone. Remain with student until fully recovered.
- Contact school nurse as soon as possible. Notify parents of low blood sugar episode.
- **If symptoms worsen, call 911, parent/guardian, and health care provider. Glucagon, if authorized by student's health care provider, may be needed if student becomes unconscious, has a seizure, or is unable to swallow.**

If student is unconscious, experiencing a seizure, or unable to swallow:

- **Contact school nurse immediately to inject emergency glucagon, if authorized for student. Glucagon Dosage (if authorized)__________________**
- **Call 911, parent/guardian, and health care provider.**
- Turn student on side and keep airway clear. Do not insert objects into student's mouth or between teeth.
- Student may vomit. Keep student on side to prevent choking on vomit. Keep airway clear.
- Other instructions for treating low blood sugar:_____________________________

HIGH BLOOD SUGAR (Hyperglycemia)

SYMPTOMS

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

Symptoms of high blood sugar for this student:
____

Call parent/guardian and health care provider if blood sugar is over___________ mg/dl.
Where are insulin and ketene testing supplies kept? ____________________________

TREATMENTS FOR HIGH BLOOD SUGAR & LUNCH TIME INSULIN

- To correct high blood sugar, give insulin:____________units for every _________mg/dl over____________

Sliding Scale ____ to ____ = ____ unit
____ to ____ = ____ units
____ to ____ = ____ units

____ to ____ = ____ units

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 & dispose of needles safely?
Yes No

- 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 and 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:___________________________
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Target range of blood sugar: ____to ____ Type of Meter: _____________ Logbook kept at school? **Yes No**
What help will the student need with blood sugar testing? _____________________
Usual times for the student to test blood sugar: ______________________________
Will student need insulin at school? YES NO Where is the insulin kept at school?
____
What help will the student need with insulin injections? _______________________

Insulin/carbohydrate ratio for meals/snacks: ____________units for every ___________

FOR STUDENTS ON INSULIN PUMPS

Type of pump:___________ Type of insulin used in pump: _____________________
Insulin/carbohydrate ration 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? _____________________________________
ORAL MEDICATIONS:____

FOOD AND EXERCISE

Meal/Snack	Time	Food Content/ Amount
Breakfast	_____	____________________
Mid-Morning	_____	____________________
Lunch	_____	____________________
Mid-afternoon	_____	____________________
Before Exercise	_____	____________________
After Exercise	_____	____________________
Other	_____	____________________

Preferred Snacks:

Student should not exercise if blood sugar is below_____mg/dl
OR above _______ mg/dl.

Foods to Avoid:

Other exercise/activity instructions:__________________________

Parent/guardian Date (Signed)	Health Care Provider Tel. # (Reviewed & signed) Date	School Nurse Date Received