Student's Name _____ **Student ID # _____**

Date of Birth _____ **Date of Diabetes Diagnosis _____**

School _____ **Grade _____**

Bus #/Transportation _____ **Homeroom Teacher _____**

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

Photo of Student Pasted Here When Available

DIABETES CARE PLAN

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 the 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.

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 #)_____

There will be trained school personnel to assist with diabetic care.

Where are student's daily 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. If this is being abused please contact school nurse.
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 glucagons kept? _____

BLOOD SUGAR MONITORING

TREATMENT FOR LOW BLOOD SUGAR (Hypoglycemia)

If student is 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 trained school diabetes care provider or 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 trained school diabetes care provider or school nurse immediately to inject emergency <u>glucagon</u>, if authorized for student.**
- **Call 911, parent/guardian, and health care provider. Glucagon dosage (if authorized):** _____
- 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, 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 ketone testing supplies kept? Daily _____ Back-up _____

TREATMENTS FOR HIGH BLOOD SUGAR (Hyperglycemia) & LUNCH TIME INSULIN

- Contact trained school diabetes care manager who will provide insulin administration, insulin pump care, and ketone testing.
- To correct high blood sugar, give insulin: _____ units for every _____ mg/dl over _____.

Sliding Scale
_____ to _____ = _____ units
_____ to _____ = _____ units
_____ to _____ = _____ units
_____ to _____ = _____ units

INSULIN INJECTIONS
Does student know how to:

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

- Insulin correction for hyperglycemia should be given every _____ hours until the target range of _____ is reached.
- 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 of 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 _____

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: _____

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

What help will 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 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? _____

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 # Date	School Nurse Date Received