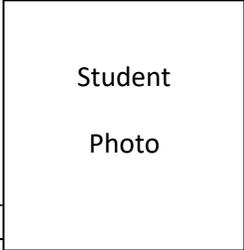


Diabetes Health Care Plan for Insulin Administration via Syringe or Pen

School: _____

Start Date: _____ End Date: _____

Name _____ Grade/ Homeroom _____ Teacher _____



Transportation: Bus Car Van Type 1 Type 2

Parent/ Guardian Contact: Call in order of preference

Name Telephone Number Relationship

1. _____
2. _____
3. _____

Prescriber Name _____ Phone _____ Fax _____

Blood Glucose Monitoring: Meter Location _____ Student permitted to carry meter Yes No

Testing Time Before Breakfast/Lunch 1-2 hours after lunch Before/after snack Before/after exercise Before recess
 Before bus ride **Always** check when student is feeling high, low and during illness Other _____

Snacks

Please allow a _____ gram snack at _____ before/after exercise

Snacks are provided by parent /guardian and are located in _____

Treatment for Hypoglycemia/Low Blood Sugar

If student is showing signs of low blood sugar or if blood sugar is below _____ mg/dl

Treat with 10-15 grams of quick-acting glucose:

4oz juice or _____ glucose tablets or Glucose Gel or Other _____

Retest blood sugar every 15 minutes, repeat treatment until blood sugar level is above target _____ mg/dl

If no meal or snack within the hour give a 15 gram snack

If student unconscious or having a seizure: Give Glucagon Yes No

Amount of Glucagon to be administered: _____ mg(s) IM, SC, and call 911 and parents

Notify parent/guardian for blood sugar below _____ mg/dl

Signs of Low Blood Sugar

personality change, feels funny, irritability, inattentiveness, tingling sensations headache, hunger, clammy skin, dizziness, drowsiness, slurred speech, seeing double, pale face, shallow fast breathing, fainting

Treatment for Hyperglycemia /High Blood Sugar

If student showing signs of high blood sugar or if blood sugar is above _____ mg/dl

Allow free access to water and bathroom

Check ketones for blood sugar over _____ mg/dl Notify parent/guardian if ketones are **moderate to large**

Notify parent/guardian for blood sugar over _____ mg/dl

See insulin correction scale (next page)

Call 911 and parent/guardian for hyperglycemia emergency. Symptoms may include nausea & vomiting, heavy breathing, severe abdominal pain, chest pain, increased sleepiness or lethargy, or loss of consciousness.

Document all blood sugars and treatment

Name: _____

Insulin

Insulin is administered via: **Vial/Syringe** **Insulin Pen**

Can student draw up correct dose, determine correct amount and give own injections?

Yes **No** **Needs supervision (describe)** _____

Insulin Administration: **Not taking insulin at school**

Insulin Type: _____ Student permitted to carry insulin & supplies: **Yes** **No**

Flexible Insulin Dose (mealtime dose):

Insulin to Carbohydrate Ratio _____ unit/s per _____ #grams

Give _____ units per _____ grams

ADD: Insulin to carbohydrate ratio dose and Correction/Adjustment scale dose

Correction/Adjustment Scale _____ unit/s per _____ over _____ mg/dl

If blood glucose is _____ to _____ mg/dl Give _____ units

If blood glucose is _____ to _____ mg/dl Give _____ units

If blood glucose is _____ to _____ mg/dl Give _____ units

If blood glucose is _____ to _____ mg/dl Give _____ units

Other: _____

Give mealtime dose: before meals immediately after meals

Parental authorization should be obtained before administering a correction dose for high blood glucose level (excluding mealtime) **Yes** **No**

Parents are authorized to adjust the insulin dosage +/- by _____ units for the following reasons:

Increase/Decrease Carbohydrate Increase/Decrease Activity Parties Other _____

Student self-care task	Independent	School Assistance
Blood Glucose Monitoring		
Carbohydrate Counting		
Selection of snacks and meals		
Insulin Dose calculation		
Insulin injection Administration		
Treatment for mild hypoglycemia		
Test Urine/Blood for Ketones		

Authorization for the Release of Information:

I hereby give permission for _____ (school) to exchange specific, confidential medical information with _____ (Diabetes healthcare provider) on my child _____, to develop more effective ways of providing for the healthcare needs of my child at school

Prescriber Signature _____ Date _____

Parent Signature _____ Date _____

Reviewed by Dr. Carly Wilbur

April 2019

