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

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<tr>
<th>Name</th>
<th>Telephone Number</th>
<th>Relationship</th>
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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

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

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

Document all blood sugars and treatment
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
Give___ units per _______ grams
Give___ units 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

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<td>Carbohydrate Counting</td>
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<td>Selection of snacks and meals</td>
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<td>Insulin Dose calculation</td>
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<td>Insulin injection Administration</td>
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<tr>
<td>Test Urine/Blood for Ketones</td>
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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

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