

ROCORI AREA SCHOOLS

ISD #750

Diabetes Care Plan

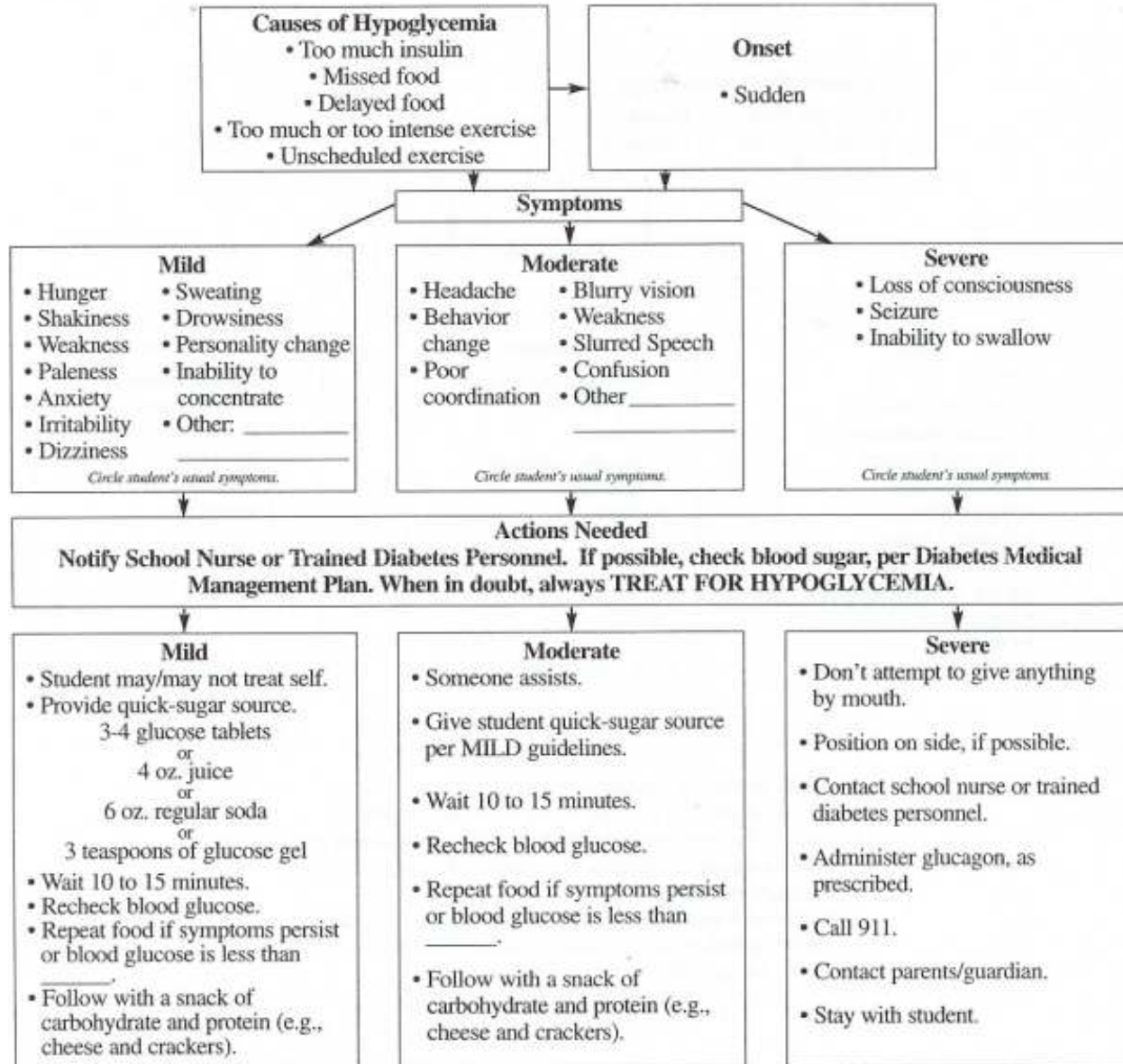
Student's Name: _____ Birth Date: _____

Grade: _____ School Year: _____

School: _____

Hypoglycemia (Low Blood Sugar) Emergency Protocol

Never send a child with suspected low blood sugar anywhere alone.



Treatment of hypoglycemia: _____

Glucagon should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow. Route _____, Dosage _____, Site for glucagon injection: _____ arm, _____ thigh, _____ other.

If glucagon is required, administer it promptly. Then, call 911 and the parents/guardian.

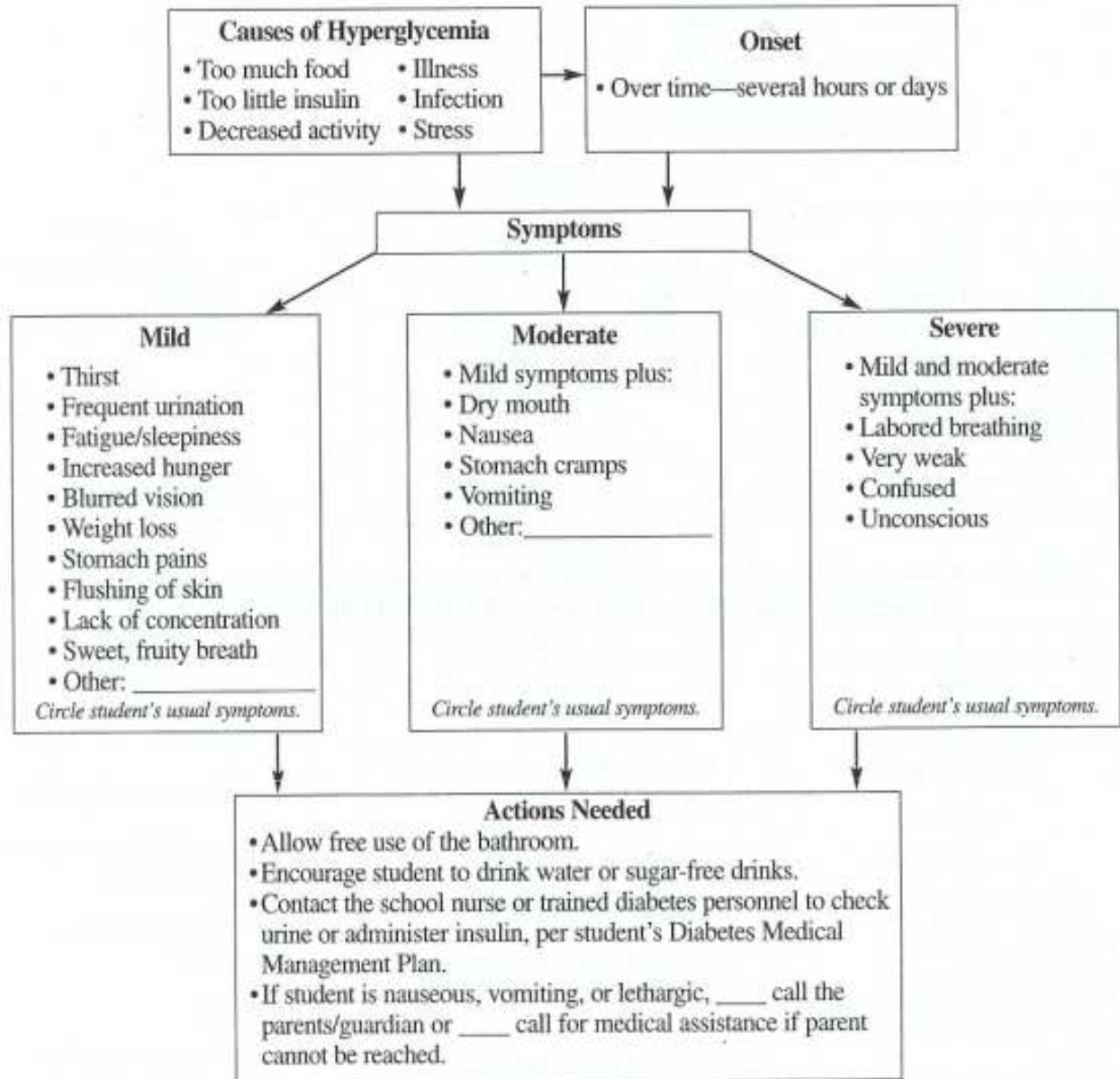
ROCORI AREA SCHOOLS
ISD #750
Diabetes Care Plan

Student's Name: _____ Birth Date: _____

Grade: _____ School Year: _____

School: _____

Hyperglycemia (High Blood Sugar) Emergency Protocol



Treatment of hyperglycemia: _____

Urine should be checked for ketones when blood glucose levels are above _____ mg/dl.

Treatment for ketones: _____

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Student's Name: _____ Birth Date: _____

Grade: _____ School Year: _____

School: _____

Blood Glucose Monitoring

Target range for blood glucose is 70-150 70-180 Other _____

Usual times to check blood glucose _____

Times to do extra blood glucose checks (Check all that apply):

- Before exercise
- After exercise
- When student exhibits symptoms of hyperglycemia
- When student exhibits symptoms of hypoglycemia
- Other (explain): _____

Can student perform own blood glucose checks? Yes No

Exceptions: _____

Type of blood glucose meter student uses: _____

Insulin

Usual Lunchtime Dose

Base dose of Humalog / Novolog / Regular (circle type of rapid- / short-acting insulin used)
insulin at lunch:

_____ units or does flexible dosing using _____ units/ _____ grams carbohydrate.

Use of other insulin at lunch (circle type of insulin used):

Intermediate / NPH / Lente _____ units or Basal / Lantus / Ultralente _____ units.

Insulin Correction Doses

Parental authorization should be obtained before administering a correction dose for high blood
glucose levels: Yes No

_____ units if blood glucose is _____ to _____ mg/dl

_____ units if blood glucose is _____ to _____ mg/dl

_____ units if blood glucose is _____ to _____ mg/dl

_____ units if blood glucose is _____ to _____ mg/dl

_____ units if blood glucose is _____ to _____ mg/dl

Can student give own injections? Yes No

Can student determine correct amount of insulin? Yes No

Can student draw correct dose of insulin? Yes No

_____ Parents are authorized to adjust the insulin dosage under the following circumstances:

Insulin Pumps

Type of pump: _____ Basal rates: _____ 12 am to _____
 _____ to _____
 _____ to _____

Type of insulin in pump: _____

Type of infusion set: _____

Insulin/carbohydrate ratio: _____ Correction factor: _____

Student Pump Abilities/Skills	Needs Assistance	
Count carbohydrates	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bolus correct amount for carbohydrates consumed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculate and administer corrective bolus	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculate and set basal profiles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculate and set temporary basal rate	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Disconnect pump	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reconnect pump at infusion set	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prepare reservoir and tubing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Insert infusion set	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Troubleshoot alarms and malfunctions	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Oral Medications

Medication	Dose	Route	Frequency	Administer at School?

** If a prescription medication is to be administered at school, this diabetes care plan needs to be signed by prescribing physician*

Meals and Snacks

Is student independent in carbohydrate calculations and management? Yes No

Meal/Snack	Time	Food Content/Amount
Breakfast		
Mid-morning snack		
Lunch		
Mid-afternoon snack		
Dinner		

Other times to give snack and content/amount: _____

Preferred snack foods: _____

Foods to avoid, if any: _____

Instructions for when food is provided to the class (e.g., class party or food sampling event):

Exercise and Sports

A fast-acting carbohydrate such as _____ should be available at the site of exercise or sports.

Restrictions on activity, if any: _____

Student should not exercise if blood glucose level is below _____ mg/dl or above _____ mg/dl or if moderate to large urine ketones are present.

School Supplies

<p>_____ Blood glucose meter, blood glucose test strips, batteries for meter</p> <p>_____ Lancet device, lancets, gloves, etc.</p> <p>_____ Urine ketone strips</p> <p>_____ Insulin vials and syringes</p> <p>_____ Insulin pump and supplies</p>	<p>_____ Insulin pen, pen needles, insulin cartridges</p> <p>_____ Fast-acting source of glucose</p> <p>_____ Carbohydrate containing snack</p> <p>_____ Glucagon emergency kit</p>
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Diabetes History

Date of diabetes diagnosis: _____

Physical condition: Diabetes type 1 Diabetes type 2

Diabetes currently being treated by Dr. _____

Emergency Contact Information

In the event of an emergency, the following individuals should be contacted:

	Name	Relationship	Phone Number(s)
1.	_____	_____	H: _____ W: _____ C: _____
2.	_____	_____	H: _____ W: _____ C: _____
3.	_____	_____	H: _____ W: _____ C: _____

Hospital of choice: _____

Physician Consent

This diabetes care plan has been approved by:

Physician Signature

Date

Parent/Guardian Consent

I will notify the health office immediately of any medication changes. I will advise the school of changes in contact information, emergency contact persons, or physician/hospital preferences.

Parent Signature

Date