Wyandotte Public Schools
School Based Health Plan for the Student with Diabetes

School: _____ School Year: _____

Section 1
TO BE COMPLETED BY PARENT/GUARDIAN

Student Name: _____ DOB: _____

Address: _____

Parent/Guardian: _____

Home Phone: _____ Work: _____ Cell: _____

Symptoms: (check student's usual symptoms)

Hypoglycemia (low blood sugar		Hyperglycemia (high blood sugar	
☐ Shakiness	☐ Paleness	☐ Headache	☐ Tiredness/fatigue
☐ Weakness	☐ Dizziness	☐ Blurred vision	☐ Dry, itchy skin
☐ Sweating	☐ Tiredness	☐ Flu-like aches	☐ Sweet, fruity breath
☐ Behavior changes	☐ Hunger	☐ Stomach pain/nausea/vomiting	
☐ Headache	☐ Rapid heart beat	☐ Loss of consciousness/coma	
☐ Lack of coordination		☐ Increased thirst/increased urination	
☐ Irritability/personality changes		☐ Increased or decreased appetite	
☐ Confusion/unclear thinking		☐ Other _____	
☐ Loss of consciousness/seizure			
☐ Other _____			

Section 2
TO BE COMPLETED BY STUDENT'S PHYSICIAN

Target glucose range: _____

Glucose testing to be done:

☐ Prior to lunch ☐ Before to Physical Education

☐ Prior to snack ☐ After Physical Education

☐ When symptomatic ☐ Other (please explain) _____

Can student perform their own blood glucose checks? ☐ Yes ☐ No
Exceptions: May need help if blood glucose is low.

Does student need supervision for glucose checks? ☐ Yes ☐ No

Low Blood Sugar:

1. Test blood sugar
    a. If blood sugar is under _____, treat with _____ grams of quick carbohydrates.
    b. If blood sugar is under _____, treat with _____ grams of quick carbohydrates.
    c. If blood sugar is under _____, treat with _____ grams of quick carbohydrates.
2. Recheck blood sugar and treat every 15 minutes until above _____.

4 oz of juice = 3-4 glucose tablets = 15 grams of quick carbohydrates
8 oz of juice = 6-7 glucose tablets = 30 grams of quick carbohydrates

Severe Low Blood Sugar: Unconsciousness, seizure

1. Stay with student, place on side, protect from injury
2. Do not put anything in student's mouth
3. Administer Glucagon, if ordered. (Please see school district medication form)
4. Call 911
5. Suspend or remove insulin pump (if worn)
6. Call parents

For students of insulin shots:

Lunchtime dose: Type: _____Pen _____ Syringe _____

_____ Sliding Scale (Physician needs to specify on attached medication authorization form)

_____ Set dose: _____ units

_____ Flexible dose: insulin/carbohydrate ratio _____ Correction factor _____

Can student determine correct amount of insulin? ☐ Yes ☐ No
Can student draw correct dose of insulin? ☐ Yes ☐ No
Can student give own injections? ☐ Yes ☐ No
Are parents authorized to adjust the insulin dosage? ☐ Yes ☐ No

For students of insulin pumps:

Type of pump: _____ Type of insulin in pump: _____

Insulin/carbohydrate ratio: _____ Correction factor _____Insulin sensitivity _____

Can student do the following pump skills?

Count carbohydrates	☐ Yes ☐ No	Disconnect pump	☐ Yes ☐ No
Bolus for carbohydrates	☐ Yes ☐ No	Reconnect pump	☐ Yes ☐ No
Bolus for correction	☐ Yes ☐ No	Set temporary basal	☐ Yes ☐ No
Insert infusion set	☐ Yes ☐ No	Manage pump problems	☐ Yes ☐ No

For Students on oral antidiabetic medication:
Medication Name_____ Dose _____ Time given_____

High Blood Sugar readings:

If blood sugar is above _____,

☐ no intervention at this time, return to class
☐ give extra insulin based upon correction factor
☐ give extra water or sugar free drinks
☐ allow use of bathroom as needed
☐ encourage exercise
☐ inform parents

In addition to the above instructions, if blood sugar is above _____,

☐ Have student check urine ketones if strips are available. If positive,
- ☐ call parent
- ☐ recheck ketones at next urination
- ☐ give at least 8 ounces of water every hour
- ☐ no exercise or physical education

_____ _____
Physician Signature Date Parent Signature Date

_____ _____