SCHOOL HEALTH CARE PLAN

BLUFFTON-HARRISON MSD

DIAGNOSIS: DIABETES (Type 1___ or Type 2___)

Name_____ Grade____ DOB_____

MONITORING (Physician to complete)

Target blood sugar range: _____ - _____ mg/dl

Blood sugar monitoring to be done (please check options that apply): Before meals___ For symptoms of hypo/hyperglycemia & anytime student does not feel well___ Before gym/activity___ After gym/activity___ Before dismissal___ Other_____

Monitoring to be performed: Clinic___ Classroom___ Other_____

Notify parent/guardian if blood sugar is over_____ or below _____mg/dl

KETONE TESTING: Check ketones if blood sugar is over _____mg/dl. Also check when student is ill or complains of nausea/vomiting/abdominal pain. **Notify parent/guardian and physician if ketones are moderate or large.**

MEDICATION/INSULIN (Physician to complete)

Insulin to be given during school hours: YES____ NO____ If yes, may student calculate/give own injections? YES____ NO____

Insulin to be given by: Syringe & vial ___ Pen ___ Pump ___

Rapid-acting insulin type: Humalog____ Novolog____ Apidra____

Insulin per fixed dose: Name of insulin_____ Time_____ Dose_____

Insulin using carbohydrate counting: 1 unit of _____insulin per_____grams of carbohydrate

Correction for high blood sugars: YES____ NO____ When?_____

Correction per **formula:** Blood sugar -_____+_____ = units of insulin needed

OR

Correction per **sliding scale: (Physician to complete)**

HIGH BLOOD SUGAR (HYPERGLYCEMIA) BS over_____mg/dl (Physician to complete)

Signs & Symptoms: Increased thirst, increased urination, sleepiness, blurred vision, rapid breathing, increased appetite, warm & dry skin, fruity breath, nausea/vomiting, abdominal pain

Treatment: Check blood sugar, check for ketones, have student drink 6-8 oz. of non-carb liquid every hour, notify parents & physician if ketones are moderate or large

LOW BLOOD SUGAR (HYPOGLYCEMIA) BS under_____mg/dl (Physician to complete)

Signs & Symptoms: Weak/shaky, hunger, rapid heartbeat, cool/clammy skin, tired/pale, personality change, slurred speech, inattention or confusion, dizzy/staggering, seizure, loss of consciousness

Treatment: Check blood sugar, give 15 grams of fast-acting carbohydrate if blood sugar is **below____** and if the student is conscious and able to swallow, **DOUBLE** the amount of carbohydrates to 30 grams if blood sugar is **below_____,** retest blood sugar 15 minutes after treating, repeat treatment if needed until blood sugar is above target blood sugar goal, if more than 1 hour until next meal/snack, or if going to activity, may follow treatment with a protein-containing snack.

Glucagon Emergency Injection: YES____ NO____ (Physician to complete) If "yes", glucagon must be provided by parent/guardian.

EMERGENCY CONTACTS

Name_____ Relationship_____

Phone Number (s)_____

Name_____Relationship_____

Phone Number (s)_____

Name_____Relationship_____

Phone Number(s)_____

DIABETES PHYSICIAN NAME _____

Phone Number (s)_____

Preferred Medical Facility_____

I hereby give permission for this careplan to be shared with appropriate school staff.

Physician signature_____Date_____

Parent/Guardian signature_____Date_____

School Nurse signature_____Date_____