SCHOOL TOWN of MUNSTER
A DISTRICT OF NATIONAL DISTINCTION
SUPPORTING EVERY CHILD EVERY DAY

PLAN OF CARE - DIABETES

Name: _____ **Grade:** _____ **Age:** _____
Last Name First MI

School: _____ **Year of Diagnosis:** _____

Parent/Guardian Name (Contact #1): _____

Home Phone: _____ **Work:** _____ _____
Phone # Company Name

Parent/Guardian Name (Contact #2): _____

Home Phone: _____ **Work:** _____ _____
Phone # Company Name

Other Emergency Contacts:

Contact #3: _____ _____ _____
Name Relationship Phone

Contact #4: _____ _____ _____
Name Relationship Phone

Physician Student Sees for Diabetes: _____ _____
Physician Name Phone

Other Physician: _____ _____
Physician Name Phone

Allergies: _____
(Food, Medication, etc.)

Student wears a diabetic ID bracelet or necklace: Yes __ No __

Insulin Pump: Yes __ No __ If yes, what kind? _____

Blood Glucose Target Range: _____

Current Insulin Treatment:

Student will need insulin injection routinely at school Yes __ No __
Student will self-prepare and inject injections needed Yes __ No __
Student will need assistance with injections Yes __ No __

Type of Insulin - Dose and Time (Please inform Health Service of changes during school year)
Pre-Breakfast _____ Lunch _____ Dinner _____ Bedtime _____

Correction rate at school for high blood sugar: _____ units for every _____ over _____
Bolus for food consumption: _____ units for every _____ CHO

Meals/Snacks - Times
Breakfast _____ AM Snack _____ Lunch _____ PM Snack _____ Dinner _____ Bedtime _____

Student will bring or have on hand in the Health Service one of the following for snack:
_____

_____

Exercise/Sport Activity:

Student may participate in regular PE classes Yes _____ No _____
Student may participate in after school sports Yes _____ No _____
Student carries _____ for treatment of Low Blood Glucose

(over)

A snack will be eaten if blood glucose is under _____. Exercise should be delayed if blood glucose is higher than _____ or lower than _____.

Blood glucose monitoring: Name of Monitor/Meter _____

Student will perform blood glucose monitoring at school: Yes ___ No ___

Student is able to perform self-blood glucose monitoring: Yes ___ No ___

Student needs assistance to test: Yes ___ No ___

Student monitors blood glucose <u>before</u> the following:

Breakfast ___ AM Snack ___ Lunch ___ Dinner ___ Bedtime ___ PM Snack ___ Exercise ____

Student monitors blood glucose at the following additional times:

After Exercise ____ Other _____

TREATMENT OF HIGH BLOOD SUGARS:

1. If blood glucose is over _____, check urine for Ketones.
2. Give sugar free liquids (such as water) _____ ounces per hour if Ketones are present.
3. Contact parent if:
   - Blood glucose result is over _____.
   - If Ketones are positive and blood glucose is over _____.
   - If child is vomiting with blood glucose is higher than 400.

Comments/Special Instructions: _____

_____

Also notify parent if: _____

TREATMENT OF LOW BLOOD SUGARS:

Symptoms student has experienced when having a low blood glucose include: (circle those that apply)

A. Trembling	E. Weak	I. Irritable
B. Shaky	F. Dizzy	J. Confused
C. Sweaty	G. Headache	K. Restless
D. Pale	H. Incoherent (as if drunk)	L. Combative

M. Other _____

Treatment for this student if blood sugar _____ or lower and student is conscious and able to swallow:
(circle those that are preferred for this student-items to be supplied by parent)

A. 3 glucose tablets	D. 1 fruit roll up	G. 2 Tbsp. cake frosting
B. 2 cup fruit juice	E. 8 life savers	H. 2 candy bars
C. 6 oz. regular soda	F. glucose gel placed between cheek and side of gum	

G. Other _____

H. Repeat treatment in 15-20 minutes if no improvement.

Notify parent of low blood glucose treatment given if: _____.

Comments/Special instruction: _____

_____

_____

Treatment for student with low blood sugar who is unconscious or unable to swallow:

1. Administer Glucagon injection (supplied by parent) Yes ___ No ___
2. Contact 911
3. Notify parent of low blood glucose
4. DO NOT give liquids to drink while unresponsive

Comments/Special instructions: _____

_____

_____

_____ _____

Physician Signature Date

_____ _____

Parent Signature Date