Revised 10/30/2020
Diabetes Care Plan
To Be Completed by a Healthcare Provider

Student:	DOB:	
Teacher:	Grade:	Bus Number:
Parent/Guardian:	Contact Number(s):	
Today's Date:		

Parent/Guardian: Complete this plan with the assistance of your child's health care provider and the school nurse. The diabetes care plan requires the signature of the student's parent/guardian and health care provider. Return the completed, signed plan to the school. Attach other instructions/forms if needed.

Health Care Provider: Review this diabetes care plan and make any necessary changes or additions. Sign and return the plan to parent/guardian or school.

Health Care Provider Training Student for Diabetes: _____Telephone: _____

Diabetic Care Managers @ school & location: _____

Location at school of diabetes supplies: _____Does the student wear a medic alert? YES/NO

EMERGENCY ACTION PLAN

LOW BLOOD SUGAR (Hypoglycemia)

Symptoms (Circle common/usual symptoms for student)

Hunger, sweating, trembling, pale appearance, inability to concentrate, confusion, irritability, sleepiness, headache, dizziness, crying, slurred speech, poor coordination, personality change, complains of feeling "low", blood sugar below _____(mg/dl)

- Call parent/guardian and/or health care provider if blood sugar below _____(mg/dl)
- Times student is most likely to experience low blood sugar: _____
- Where are glucose tablets/snacks kept? _____

Has health care provider authorized use of glucagen? YES/NO Where is glucagon kept? _____

TREATMENT FOR LOW BLOOD SUGAR

If student is conscious, cooperative, and able to swallow:

- Give fast sugar immediately (fruit juice, regular soda, raisins, glucose tabs, etc…)
- If symptoms do not improve in _____ minutes, give fast sugar again
- When symptoms improve, provide an additional snack of _____
- Check blood sugar every _____minutes until it is above _____
- Do not leave student alone or allow him/her to leave the classroom alone. Remain with student until fully recovered.
- Contact diabetes care manager or school nurse as soon as possible. Notify parent of low blood sugar episode.
- ***If symptoms worsen, call 911, parent/guardian, and health care provider.***

If student is conscious, experiencing a seizure, or unable to swallow:

- Call 911, parent/guardian, and health care provider
- Contact trained diabetic care manager or school nurse immediately to give glucagon if ordered. Glucagon dose: _____
- Turn student on side and keep airway clear. Do not insert objects into mouth or between teeth.
- Other instructions for treating low blood sugar: _____

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HIGH BLOOD SUGAR (Hyperglycemia)

Symptoms (Circle common/usual symptoms for student)

Frequent urination, excessive thirst, nausea, vomiting, dehydration, sleepiness, confusion, blurred vision, inability to concentrate, irritability, blood sugar above _____(mg/dl)

- Call parent/guardian and/or health care provider if blood sugar over _____(mg/dl)
- Where are insulin and ketone testing supplies kept? _____

TREATMENT FOR HIGH BLOOD SUGAR

- Contact diabetic care manager or school nurse who will provide insulin administration, insulin pump care, ketone testing.
- Give insulin:_____units for every _____mg/dl over _____
- Check for ketones if blood sugar is above _____ Check blood sugar in _____(min) and at _____ (min) intervals.
- Allow free and unlimited use of bathroom. Encourage student to drink water or other sugar-free liquid.
- If moderate or high ketones are present, call health care provider and parent/guardian immediately.
- If symptoms worsen or student begins vomiting call health care provider and parent/guardian immediately.
- Other instructions for treating high blood sugar: _____
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BLOOD SUGAR MONITORING

Target range of blood sugar: ____ to _____ Type of meter: _____Logbook kept @ school? YES/NO

What help will student need with blood sugar testing? _____

Usual times to test blood sugar? _____

Other times when blood sugar testing may be needed? _____

Other instructions: _____

INSULIN AND ORAL MEDICATIONS

Time (for insulin at school)	***Type of Insulin***	***Insulin Dosage***
Insulin needed at school? Yes/No		
Where is the insulin kept at school?	Insulin/carbohydrate ratio for meals/snacks: ____ units for every ____carbs	High blood sugar correction ratio: ____ units for every ____ mg/dl over ____
For Students on Insulin Pumps		
Type of pump:	Type of insulin used in pump:	Insulin/carbohydrate ratio for meals/snacks: ____ units for every ____ carbs
High blood sugar correction ratio: ____ units for every ____ mg/dl over ____	Back-up means of insulin administration:	What help will students need with pump:

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DOES STUDENT KNOW HOW TO?	
INSULIN INJECTIONS	***INSULIN PUMPS***
Give own injections? Yes/No	Operate pump without assistance? Yes/No
Determine correct insulin dose? Yes/No	Change the infusion site? Yes/No
Draw up correct insulin dose? Yes/No	Change the tubing? Yes/No
Handle/dispose of needles safely? Yes/No	Change the batteries? Yes/No
	Change insulin cartridge? Yes/No
	Determine bolus amount? Yes/No
	Give bolus? Yes/No
	Adjust basal rates? Yes/No

Oral medications: _____

FOOD AND EXERCISE		
MEAL/SNACK	***TIME***	***FOOD CONTENT/AMOUNT***
BREAKFAST		
MID-MORNING		
LUNCH		
MID-AFTERNOON		
BEFORE EXERCISE		
AFTER EXERCISE		
OTHER		
PREFERRED SNACKS:		
FOODS TO AVOID:		

Student should not exercise if blood sugar is below ____ (mg/dl OR above ____ (mg/dl).

Other exercise/activity instructions: _____

Parent/Guardian Signature: _____ Date: _____

Healthcare Provider Signature: _____ Date: _____

Nurse Signature: _____ Date: _____