Diabetes

Individual Health Plan / Emergency Action Plan

***Parent/Guardian*:** Complete this plan with the assistance of your child's health care provider. Return the completed, signed plan to the school nurse. This information will be shared with appropriate school staff unless you state otherwise.

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

Student's Name: _____ Date of Birth: _____ Effective Dates: _____

School: _____ Grade: _____ Homeroom Teacher: _____

Transportation / Bus #: _____ Date of Diabetes Diagnosis: _____

Physical Condition: ☐ Diabetes type 1 ☐ Diabetes type 2

Contact Information

Parent/Guardian #1: _____ Address: _____

Telephone: Home _____ Work _____ Cell_____

Parent/Guardian #2: _____ Address: _____

Telephone: Home _____ Work _____ Cell_____

Physician Treating Student for Diabetes:_____ Telephone: _____

Other Physician:_____ Telephone: _____

Diabetes Nurse or Diabetes Educator:_____ Telephone: _____

Other Emergency Contact:

Name: _____ Relationship: _____

Telephone: Home _____ Work _____ Cell_____

Emergency Notification: Notify parents of the following conditions:

a. Loss of consciousness or seizure (convulsion) immediately after administering Glucagon and calling 911
b. Blood sugars in excess of _____ mg/dl
c. Positive urine ketones
d. Abdominal pain, nausea/vomiting, fever, diarrhea, altered breathing, altered level of consciousness

Trained School Diabetes Care Providers: _____

_____

_____

Where are student's diabetes supplies kept? _____

Does the student wear a medic alert? ☐ Yes ☐ No

504 Accommodations are in place? ☐ Yes ☐ No Date Received: _____

Reasonable accommodations for this student include but are not limited to:

- Bathroom privileges: Allow free and unlimited us of bathroom facility.
- Unrestricted access to water: Student should be allowed to carry water bottle if desired.
- Glucose monitoring: Allow student to monitor glucose in classroom as needed.

Blood Glucose Monitoring

Target range for blood glucose is _____

Times for blood glucose checks (*check all that apply*)

☐ before lunch ☐ when student exhibits symptoms of hyperglycemia

☐ before exercise ☐ when student exhibits symptoms of hypoglycemia

☐ after exercise ☐ other (explain): _____

Can student perform own blood glucose checks? ☐ Yes ☐ No

Type of blood glucose meter student uses: _____

Insulin Administration

Insulin delivery system: ☐ Syringe ☐ Pen ☐ Pump

Before Meal Insulin

Type of Insulin: _____

☐ Give_____ units

☐ Insulin to Carbohydrate Ratio: _____ units of insulin per _____ grams carbohydrate.

Insulin Correction Doses for High Blood Sugar (Check only those which apply)

☐ Use the following correction ratio: _____ units of insulin for every _____ mg/dl for glucose over _____mg/dl

☐ Sliding Scale _____ 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

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

Can student give own injections? ☐ Yes ☐ No

Can student determine correct amount of insulin? ☐ Yes ☐ No

Can student measure correct dose of insulin? ☐ Yes ☐ No

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

For Students with Insulin Pumps

Type of pump: _____ Type of insulin in pump: _____ Type of infusion set: _____

Basal rate: _____

Maximum units of insulin pump will administer per entry_____ per 24 hours_____

Insulin to Carbohydrate Ratio: _____ units of insulin per _____ grams carbohydrate.

High Blood Sugar correction ratio: _____ units of insulin for every _____ mg/dl for glucose over _____ mg/dl

Back up means of insulin administration? _____

What help will student need with pump? _____

Student Competence With Pump (Check all that apply)

☐ Operate pump without assistance ☐ Give bolus ☐ Change infusion site ☐ Change insulin cartridge

☐ Count carbohydrates ☐ Adjust basal rates ☐ Troubleshoot alarms and malfunctions

☐ Determine bolus amount ☐ Change tubing ☐ Disconnect/reconnect pump

For Students Taking Oral Diabetes Medications

Type of Medication: _____ Timing:_____

Other Medication: _____ Timing:_____

Meals and Snacks Eaten at School

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	_____	_____
Before Exercise	_____	_____
After Exercise	_____	_____
Other	_____	_____

Foods to avoid, if any: _____

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

Exercise

Items to be readily available during exercise include: fast acting carbohydrates, snacks, BG monitoring equipment, and sugar-free liquids.

☐ Student should not exercise if blood glucose levels are below _____ mg/dl **or** above _____ mg/dl.

☐ Student should not exercise if moderate to large amount urine ketones present.

☐ Check blood glucose just before PE to determine need for additional snack.

☐ If BG is less than target range, student should have a snack such as _____.

☐ Student may disconnect insulin pump for _____ hours during exercise.

☐ Student may decrease basal rate by _____ during exercise.

Management of Low Blood Glucose (Hypoglycemia)

Common signs and symptoms of low blood glucose include: shaky, hunger, sweating, dizzy, fast heartbeat, anxious, weakness, headache, irritable, blurry vision, poor coordination, crying, sleepiness, confusion, difficulty concentrating.

MILD: Blood Glucose (BG) less than _____ mg/dl

(Student is conscious, cooperative, and able to swallow)

- Never leave student alone.
- Give fast sugar; recheck BG in 15 min.
- If BG less than _____, retreat and recheck in 15 min. x 3.
- Notify parent if not resolved.
- Provide snack with carb, fat, protein if meal not scheduled.

SEVERE: Loss of Consciousness or seizure

- Administer Glucagon injection as ordered.
- Call 911.
- Notify parent/guardian.
- Stop insulin pump by stopping or removing.
- Turn student on side and keep airway clear.
- If pump was removed, send with EMS to hospital.

Examples of 15 grams of carbohydrates:

- 15 grams of carbohydrate from glucose tablets
- ½ cup regular soda (not diet) or juice
- 1 Fruit Roll-Up
- 6-7 Lifesavers™
- 1 cup milk (skim)
- 1 small box (2 tbsp) raisins

Management of High Blood Glucose (Hyperglycemia)

Common signs and symptoms of high blood glucose include: extreme thirst, frequent urination, nausea, vomiting, dehydration, hunger, confusion, drowsy, blurred vision, irritable, difficulty concentrating.

Blood sugar greater than _____ mg/dl

- ☐ Provide sugar-free fluids and frequent bathroom privileges.
- ☐ Administer insulin correction dose (located on page 2).
- ☐ Check for ketones if BG is greater than _____ mg/dl.
- ☐ Recheck BG in _____ hr until BG less than _____ mg/dl.
- ☐ **Call parent/guardian if BG is greater than _____mg/dl or if student is vomiting and/or has moderate to high ketones.**
- ☐ Other: _____

Supplies to Be Kept at School

- ☐ Blood glucose meter, blood glucose test strips, batteries for meter
- ☐ Lancet device, lancets.
- ☐ Urine ketone strips
- ☐ Insulin pump and supplies, trouble shooting instructions (if available)
- ☐ Insulin pen, pen needles, insulin cartridges
- ☐ Fast-acting source of glucose
- ☐ Carbohydrate containing snack
- ☐ Glucagon emergency kit

This Diabetes Care Plan has been approved by:

_____ _____

Physician/Health Care Provider Signature Date

I give permission to the school nurse, trained diabetes personnel, and other designated staff members to perform and carry out the diabetes care tasks as outlined by above. I also consent to the release of the information contained in this Diabetes Care Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

_____ _____

Parent/Guardian Signature Date

_____ _____

Translator Signature (if applicable) Date

Reviewed by:

_____ _____

School Nurse Signature Date

Office Use Only Notification to:

- ☐ Teacher
- ☐ Specials
- ☐ Bus
- ☐ First Responders
- ☐ EAP/IHP Notebook
- ☐ Original to Health Folder