



Diabetes Care Plan

School Year ...

Student's Name _____ Date of Birth _____ Student ID# _____
 School _____ Grade _____ Homeroom Teacher _____ Bus# _____
 School Nurse _____ Phone _____
 Date of Diabetes Diagnosis _____ D Type 1 Type 2 Other _____
 School Personnel Trained as Diabetes Care Providers _____

***Parent/Guardian/Health Care Provider:** Complete this plan, sign and return to school. Parent/Guardian is responsible for providing necessary supplies and snacks. These supplies will be kept _____

Parent/Guardian/Emergency contact 1 _____ Address _____
 Phone: Home# _____ Cell# _____ Work# _____
 Email Address: _____
 Parent/Guardian/Emergency contact 2 _____ Address _____
 Phone: Home# _____ Cell# _____ Work# _____
 Email Address: _____

Physician Treating Student for Diabetes _____ Office# _____
 Diabetes Educator _____ Office# _____
 Primary Care Physician _____ Office# _____

Diabetic Management/Self Care

Bc V'ccX'g [Uf hYgh]b['fYei]fYX' UhgW'cc''
 HfUJbYX' dYfgcbbY' 'a i gh' a cb]hcf V'ccX' g [Uf hYgh
 \$' HfUJbYX' dYfgcbbY' 'a i gh' g dYfj]gY' V'ccX' g [Uf hYgh
 \$' Gh XYbh'Wb' dYfZcfa 'hYgh]b[']bXYdYbXYbh'm
 HcU']bXYdYbXYbh'a UbU[Ya Ybh'
 b'YVh]cbg]hc' W' XcbY' VmhfUJbYX' gLUZ'
 GY'Z']b'YVh]k]h' hfUJbYX' gLUZ' g dYfj]g]cb'
 Gh XYbh'Wb' Uxa]b]ghYf']bg ']b']bXYdYbXYbh'm
 GY'ZhfYUhg'a]X' \n'c['nW'a]U'
 bXYdYbXYbh'mV'ei bhg'WfVc\nXfUHYg'

ff7U' 'DUfYbh]ZJU'i YgUFY' 6Y'ck 'SSS' ' cf'5Vcj Y'SSS' ' S' **Target BS Range**]gSSSSSSSSSSSS' S'

Blood Sugar Checks

8' 6YzcfY' 6fYU_ZUgh' 6YzcfY' @ bW' 6YzcfY' GbUW' 6YzcfY' D9' 5Zhf' D9' 6YzcfY' 8]ga]ggJ #Df]cf'hc' 6cUf'
 5g'bYYX'Zcf'g]]bg'UbX' gna dhca g'cZ'@ck 'cf'<] [\ '6'ccX' G [Uf' ChYfSSSSSSSSSSSSSSSSSSSS' S'

Diet

7UfVc\nXfUHYg'dYf'a YU' 1SSSSS' S'
 GbUW' hja Yf]t' SSS' fUa E/ 'SSSS' fUa E' GbUW' SSSSSSSSSSS' 7cj Yf'7UfVg]ZgbUW']g2h'Ub' SSSS' S'
 Bc' V'ej YfU[Y'Zcf' gbUW' i d'hc' %] [a 'cZ7UfVc\nXfUHYg'
 'Z6G]gUVcj Y SSSSSS' k]h' \c'X' AYU' GbUW' i bh' SSSSSSSSSSSSSSSSSSS' S'
 GdYU' 'g Ybh' #DUf'm: ccX' M'g fGh XYbh]g X]gWYh]cbE' M'g k]h' DUfYbh]g dYfa]gg]cb' ChYf' SSSSSSSSS' !!!%

Medications/Equipment

bg']b' SSSSSSSSS' S' 7; A' fVfUbX' E SSSSSSSSSSS' S'
 Dyb' 8' J]U' #Gmf]b[Y' 8' Di a d' ; 'i V'ea YhfY' fVfUbX' E SSSSSSSSSSS' S'
 ; 'i WU[cb' Di a d' fVfUbX' E'
 CfU' AYX]W]h]cb' UhgW'cc'' SSSS' S' Hja Y. 'SSSS' S' UbX'#cf' SSSSS' S' Hja Y. SSSS' S'

Pump Therapy

Basal Rates during school: Time:_____ Basal Rate:_____ Time:_____ Basal Rate:_____
 Ask parent for most current basal rates Time:_____ Basal Rate:_____ Time:_____ Basal Rate:_____
 Time:_____ Basal Rate:_____ Time:_____ Basal Rate:_____

- For blood glucose greater than ___ mg/dL that has not decreased within ___ hours after correction, consider pump failure or infusion site failure. **Notify parent/guardian**
- For any pump/site failure: Notify parent/guardian for correction by Pen or Vial/Syringe
- For infusion site failure: Student can independently insert infusion set & may give correction dose
- May disconnect pump for sports activities for up to _____ hours
- May set a temporary basal rate up to ___ % temporary basal for up to ___ hours
- Student can independently set temporary basal rate
- May suspend pump use
- Student can independently bolus for carbohydrates consumed
- Student can independently change batteries
- Student can independently troubleshoot alarms and malfunctions
 May call parent to troubleshoot alarms and malfunctions
- Other:-----

Continuous Glucose Monitor

Alarms set for: Severe Low _____ Low _____ High _____
 Predictive Alarm: Low _____ High _____
 Rate of change: Low _____ High _____

- Alarms per parent setting at home
- May** use CGM blood glucose value *for* treatment decision
- Student can independently use GCM
- Student knows what to do and is able to deal with Low Alarm High Alarm
- Student can calibrate the CGM independently
- Student should be escorted to the school nurse/school diabetes team member if CGM alarm goes off

For **signs and symptoms of hypoglycemia** treat a low sugar based on CGM

If blood sugar is still low on recheck, check blood sugar with glucometer

Insulin injections should at least three inches away from CGM site

Site may be reinforced with medical tape

If CGM is dislodged **do NOT throw it away**, return everything to parent/guardian

Sports/Exercise

- Prior to moderate or vigorous exercise if blood sugar is below **130 mg/dl**; give 10-15 gm of carbohydrates & allow exercise
- Avoid moderate to vigorous exercise if blood sugar is above _____ mg/dl and ketones are moderate to large
- Recheck after moderate to vigorous exercise
- Physical restrictions/ limitations/accommodations: _____

Permission Signatures: Parent/Guardian and Health Care Provider authorizes this health care plan, use of glucometers, listed medications for this student at school this school year. The school nurse may contact the stated health care provider(s) related to this condition. I hereby release the Winston-Salem Forsyth County School System, Board of Education, and their employees and agents from any and all liability that may result from my child taking the medications listed in this care plan or for the loss of medication by my child while at school or school activity.

Parent/Guardian Signature _____ **Date** _____
Health Care Provider/Physician Signature _____ **Date** _____

First Aid for Hyperglycemia (High Blood Sugar)	First Aid for Hypoglycemia (low Blood Sugar)	
<ul style="list-style-type: none"> • Frequent urination • Increased thirst • nausea/vomiting • Sleepiness, • Confusion • Inability to concentrate <ul style="list-style-type: none"> • Irritability • blurred vision • Abdominal pain • Fruity odor to breath 	<ul style="list-style-type: none"> • Hunger • Sweaty • Pale • Slurred speech • Confusion • Irritability/anxious • Sleepiness • Inability to concentrate 	<ul style="list-style-type: none"> • Poor coordination • Headache • Dizziness • Crying • Complains of feeling low • Behavior change • Seizure • Weakness/fatigue
<p style="text-align: center;"><u>Hyperglycemia</u></p> <ol style="list-style-type: none"> 1. Check the blood sugar if signs & symptoms occur. 2. Notify parent/guardian if blood glucose is over ___ mg/dl 3. Check Urine Ketones if BS is above 300 mg/dl after 2 checks 4. Encourage water to drink, allow unlimited use of bathroom. 5. Administer insulin per physician's order (see insulin therapy orders) 6. Recheck blood sugar in _____ 7. Call 911 if Child <ul style="list-style-type: none"> • loses consciousness • unable to reach parent/guardian and symptoms worsen 8. If moderate to large Ketones, Stay with child continuously <p>*Pump• Check pump function Check pump site Check tubing Treat for hyperglycemia as above - Refer to Pump Therapy Orders</p>	<p style="text-align: center;"><u>Hypoglycemia</u></p> <ol style="list-style-type: none"> 1. Check blood sugar if signs & symptoms occur. 2. Stay with child continuously. 3. Give ___ grams carbohydrate (fast sugar) if blood sugar is less than ___ and child is conscious, cooperative and able to swallow. Examples: _____ 4. Check blood sugar after 15 minutes. <ul style="list-style-type: none"> • If blood sugar does not improve, give fast sugar again • When blood sugar is over 80, provide an additional snack of _____ • If still no improvement after 2 fast sugars, call physician and call parent to pick up child. 5. Call 911, parents and/or child's health care provider if <ul style="list-style-type: none"> • Child's symptoms do not subside • Child loses consciousness • Unable to reach parent/guardian and symptoms worsen 6. If Child is unconscious, experiencing a seizure or unable to swallow <ul style="list-style-type: none"> • Place student on side • Give Glucagon D 1mg D 0.5 mg • Call 911, parent/guardian, and/or child's health care provider <p>*Pump - Review pump therapy guidelines</p>	

Insulin Therapy	
<p>D Adjustable Insulin Therapy D No insulin D Fixed Insulin Therapy</p> <p>Adjustable Insulin Therapy Carbohydrate Correction Dose: Breakfast: 1 unit of insulin per ___ grams of carbohydrate Lunch: 1 unit of insulin per ___ grams of carbohydrate Snack: 1 unit of insulin per ___ grams of carbohydrate</p> <p style="text-align: center;">Calculation Example: <u>Grams of Carbohydrate eaten</u> = Units of Insulin Insulin to Carbohydrate ratio</p> <p>D If blood sugar is >300 and less than 3 hours since last insulin dose, only cover carbs per carbohydrate correction dose</p> <p>D Parent/guardian authorized to increase or decrease insulin to carbohydrate ratio within the following range 1 unit per prescribed grams of carbohydrate +/- ___ of carbohydrate</p>	<p><input type="checkbox"/> Meal coverage plus snacks <input type="checkbox"/> Meal coverage only D Breakfast D Lunch</p> <p>Fixed Insulin Therapy: D Meals: ___ units of insulin given pre-meal D Snack: ___ units of insulin given pre-snack</p> <p>Blood Glucose Correction Factor Blood glucose greater than ___ mg/dl AND at least 3 hours since last insulin dose</p> <p>Blood Glucose ___ to ___ mg/dL, give ___ units Blood Glucose ___ to ___ mg/dl, give ___ units Blood Glucose ___ to ___ mg/dl, give ___ units Blood Glucose ___ to ___ mg/dl, give ___ units Blood Glucose ___ to ___ mg/dl, give ___ units Blood Glucose ___ to ___ mg/dl, give ___ units Blood Glucose ___ to ___ mg/dl, give ___ units</p> <p>D Parent/guardian authorized to increase or decrease insulin within the following range +/- ___ units of insulin for blood glucose</p>