McHenry School District 15
420 N. Front Street, McHenry, Illinois 60050
www.d15.org

DIABETIC TREATMENT PLAN

Student Name:_________________________________ Date:__________________

School:______________________ Grade:_____ Teacher:______________________

CONTACT INFORMATION:

Emergency Contact #1:_____________________________ Relationship:_____________

Primary #:_______________________ Secondary #:_______________________

Emergency Contact #2:_____________________________ Relationship:_____________

Primary #:_______________________ Secondary #:_______________________

MD/HEALTH CARE PROVIDER:

Name:____

Address:____

Phone #:__________________________ Fax #:_______________________

BLOOD GLUCOSE GUIDLINES:

Target Range for Blood Glucose:

☐ 50-70 ☐ 70-180 Other:____

Usual times to check blood glucose:

____

____

____

____

Times to do extra blood glucose:

☐

☐ Before exercise

☐ After exercise

☐ Before unscheduled snacks/party

Other (explain)________________

____

Can student perform own glucose checks? ☐ Yes ☐No

Type of glucose meter:____

INSULIN:

Lunchtime Dose:

Rapid-/Short- acting insulin:

☐Humalog

☐Novolog

☐Other:______________

Base Dose: _______units

or Flexible Dose: ________units/_________grams carbohydrate

Other insulin:

☐NPH _____units

☐Lente

☐Other:______________

☐Lantus _____units

☐Ultralente

☐Other:_____________

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Insulin Correction Doses:
Parental notification prior to administering correction dosage: ☐ Yes ☐ No

_______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

Can student determine correct amount of insulin? ☐Yes ☐No
Can student draw up correct dose of insulin? ☐Yes ☐No
Can student give own injections? ☐Yes ☐No

Oral Diabetic Medication:
Medication:________________________ Dosage:_______ Administer Time:_________

Medication:________________________ Dosage:_______ Administer Time:_________

INSULIN PUMP:
Type of Pump:___________________________Basal Rate:_______________________

Insulin/Carbohydrate ratio:_________________Correction factor:___________________

Comments:____

____

Student Pump Abilities/Skills:
Count carbohydrates ☐Yes ☐No
Bolus correct amount for carbohydrates consumed ☐Yes ☐No
Calculate and administer corrective bolus ☐Yes ☐No
Calculate and set basal profiles ☐Yes ☐No
Calculate and set temporary basal rate ☐Yes ☐No
Disconnect pump ☐Yes ☐No
Reconnect pump at infusion set ☐Yes ☐No
Prepare reservoir and tubing ☐Yes ☐No
Insert infusion set ☐Yes ☐No
Troubleshoot alarms and malfunctions ☐Yes ☐No

Meals/Snacks:
Is student independent in carbohydrate calculations and management? ☐Yes ☐No
Breakfast time_____________________ Midmorning snack time______________________
Lunch time_______________________ Midafternoon snack time_____________________
Snack before exercise: ☐Yes ☐No Type & Amount:___________________________
____
Snack after exercise: ☐Yes ☐No Type & Amount:___________________________
____

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Instructions for when food is provided to class (e.g., parties, class projects):
____
____

Exercise & Sports:
Restrictions on activity, if any:____
Student should not exercise if blood glucose level is less then________mg/dl or greater then______mg/dl or if moderate to large ketones are present.

Hypoglycemia (Low Blood Sugar):
Usual symptoms seen:____
Treatment of hypoglycemia:____
Administer Glucagon if student unconscious, having seizure(convulsion), or unable to swallow.
Route:____,Dosage:_____, site for injection:☐arm ☐thigh ☐other:_______________________

Hyperglycemia (High Blood Sugar):
Usual symptoms seen:____
Treatment of hyperglycemia:____
Urine ketone check if blood glucose greater then_________mg/dl
Treatment for ketones:____

Supplies at school (provided and maintained by parent and/or guardian):

- ☐Blood glucose meter (test strips and batteries)
- ☐Lancet device, lancets
- ☐Urine ketone strips
- ☐Insulin vials and syringes
- ☐Insulin pump and supplies
- ☐Insulin pen, pen needles, insulin cartridge
- ☐Fast-acting source of glucose
- ☐Carbohydrate containing snacks
- ☐Glucagon emergency kit

Parent/Guardian Consent:
I give permission to the school nurse and other designated staff members of McHenry School District 15 to perform and carry out the diabetes care tasks as outlined by this Diabetic Treatment Plan. I also give permission for the nurse to contact the student's physician in regard to any medication and/or health concerns.

____ ____________________

Parent/Guardian Date

Parent/Guardian Date

____ ____________________

This Diabetic Treatment Plan is approved by:

____

Student's Physician/Health Care Provider Date

____

Director of Health Services Date

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