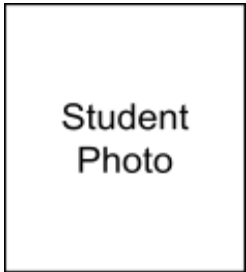




Diabetes Injection Care Plan



LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
SCHOOL		GRADE	STUDENT ID

EQUIPMENT *(provided by parent/guardian to school nurse)*

- Insulin Type _____
 Emergency meds
 Snacks *(fast acting carbs, protein)*
 CGM Type _____
 Backup Glucometer
 Glucometer strips
 Lancets
 Ketone test strips
 Other _____

SCHEDULED CARE

Step 1. Blood Glucose Correction (BGC) Insulin Dose *(parameters and formula OR sliding scale)*

Check Current Blood Glucose and give BGC Dose May use CGM for BGC dosing

Before Breakfast
 Before Lunch
 Other: _____

Using the following parameters and formula:
 Target Blood Glucose: _____ mg/dL Insulin Sensitivity Factor: _____

$$\frac{\text{(Current Blood Glucose - Target Blood Glucose)}}{\text{Insulin Sensitivity Factor}} = \text{Units of Insulin}$$

Using the Sliding Scale

BG Range	Units
mg/dL	
mg/dL	
mg/dL	
mg/dL	
mg/dL	

DO NOT GIVE BGC MORE THAN ONCE EVERY THREE HOURS

Step 2. Carbohydrate Coverage Insulin Dose

Calculate Carbohydrate Intake Before consuming carbs After consuming carbs

And give Carbohydrate Coverage Insulin Dose for:

All carb intake
 Breakfast
 Lunch
 Snacks
 Other: _____

Using the following parameters and formula:

Time/Meal: _____ 1 U Insulin per _____ grams of CHO
 Time/Meal: _____ 1 U Insulin per _____ grams of CHO
 Time/Meal: _____ 1 U Insulin per _____ grams of CHO
 Time/Meal: _____ 1 U Insulin per _____ grams of CHO

$$\frac{\text{Total grams of Carbohydrates to be eaten}}{\text{Grams of CHO per 1 unit of insulin}} = \text{Units of Insulin}$$

If BG <70 before a meal, follow Algorithms for Blood Glucose Results.

Step 3. BGC + Carbohydrate Coverage = Insulin Dose

Round dose to the nearest Half Unit Whole Unit



Fairbanks North Star Borough School District Diabetes Injection Care Plan

PRN CARE

Check Blood Glucose using CGM

- Before Exercise/PE/Gym/Recess
 After Exercise/PE/Gym/Recess
 Before leaving school

Check Blood Glucose using Glucometer

- For signs and symptoms of hyper/hypoglycemia
 To confirm hypo- or hyperglycemia
 CGM indicates rapid change prior to BGC dose
 To calibrate CGM
 Other: _____

Check Ketones

- For BG >250 mg/dL, repeat in 2 hours. If still >250 mg/dL, check urine ketones and refer to Algorithm.
 For signs of DKA ("three P's" - polyuria, polydipsia, polyphagia, abdominal pain, vomiting)

Exercise/PE/Gym/Recess

A quick-acting source of glucose such as a glucose tab or sugar-containing juice should be available at the site of the physical activity.

- Student should eat _____ grams of CHO
 Before
 Q30min
 Q1H
 After activity
 If pre-exercise blood glucose is **less than 70 mg/dL**, student can participate in physical activity once blood glucose is corrected and **above 120 mg/dL**.
 If pre-exercise blood glucose is **less than 120 mg/dL**, student can participate in physical activity once they **consume 15 grams CHO** with protein.
 If student is to exercise right after lunch, student should subtract _____ gm from their Carbohydrate coverage.
 Student should monitor blood glucose hourly.

Other Care

- Yes
 No
 Parents/Guardians are allowed to adjust insulin doses 20% higher or lower.

OTHER MEDICATION

- Tresiba (Insulin glargine) _____ units SQ DAILY to be witnessed or performed by nurse or trained staff.
 Baqsimi 3 mg Intranasal PRN for hypoglycemia <70 and unable to swallow. Recheck BG in 15 min and if <70, give a second dose and call 911.
 Glucagon _____ mg IM or SQ PRN for hypoglycemia <70 and unable to swallow. Recheck BG in 15 min and if <70, call 911.

NOTES

MEDICAL PROVIDERS ASSESSMENT OF STUDENT'S DIABETES MANAGEMENT SKILLS

Skill	Independent	With Supervision*	Cannot Do	Notes
Check Blood Glucose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Count carbohydrates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Calculate insulin dose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Insulin administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Troubleshoot CGM alarms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

*The nurse or other trained staff are expected to observe for accuracy and completion of skills "with supervision."

MEDICAL PROVIDER NAME/TITLE	PHONE
MEDICAL PROVIDER SIGNATURE	DATE



Fairbanks North Star Borough School District
Diabetes Injection Care Plan

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
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PARENT/GUARDIAN AGREEMENT AND AUTHORIZATION

I request that the medication(s) and diabetes care outlined on this plan be given to my child. I will provide needed medications or supplies for care in school.

Employees and agents of the Fairbanks North Star Borough School District ("FNSBSD") strive to provide treatment consistent with the appropriate standard of care, but are not infallible. I agree to release, defend, indemnify, and hold harmless FNSBSD from any liability for the risks or results of the care provided, the self-management or storage of diabetes medications and blood glucose products, which may include INJURY, ILLNESS, or DEATH, or the manner in which it is administered, including for NEGLIGENCE. I understand and authorize that, in the absence of Health Services personnel, other designated and trained Fairbanks North Star Borough School District ("FNSBSD") personnel may provide and administer care. I will notify FNSBSD immediately if the medications or protocols change. I give permission for the exchange or release of health information between the medical provider listed above and FNSBSD as part of the provision of my child's care. I agree for the health office to share health information with FNSBSD staff on a need-to-know basis for my child's safety and to foster academic success.

I understand that ANY remaining diabetes care supplies will be disposed of at the end of the school year, unless I pick up the remaining supplies by the last school day, as indicated on the FNSBSD school year calendar.

THIS CARE PLAN EXPIRES AT THE END OF THE CURRENT SCHOOL YEAR AND MUST BE RENEWED EACH FALL.

PARENT/GUARDIAN NAME	RELATIONSHIP TO STUDENT	PHONE NUMBER
PARENT/GUARDIAN SIGNATURE		DATE

AGREEMENT FOR STUDENTS INDEPENDENTLY MANAGING THEIR DIABETES

Student Agreement: I agree to safely dispose of any sharps either by keeping them in my kit to take home or by placing them in the designated sharps container provided at school. If specified in my Individualized Healthcare Plan, I will notify the health office if my blood sugar falls below _____ mg/dl or rises above _____ mg/dl. I understand that my diabetes supplies are for my use only and will not allow anyone else to use them. I understand that being allowed to manage my diabetes independently at school is a privilege, and I agree to follow the expectations outlined in this agreement.

Parent/Guardian Agreement: I agree that my child is capable of self-managing his/her diabetes and can recognize when to seek help from a staff member. I authorize my child to carry and self-administer diabetes medications and management supplies, I will provide backup supplies to the health office in case of emergencies. I understand that this agreement remains in effect for the current school year unless it is revoked by my child's physician or if my child fails to meet the safety guidelines outlined above.

PARENT/GUARDIAN SIGNATURE	
STUDENT SIGNATURE	DATE

NURSE PLAN REVIEW

I have reviewed the Diabetes Injection Care Plan for accuracy and ensure that all required fields and signatures are completed before providing care to a student. I approve of the agreement arranged between the healthcare practitioner, parent/guardian, health office, and student for the management of the student's health needs. I will conduct training with school staff, as needed, to ensure the safety and well-being of the student in the school setting.

NURSE NAME	
NURSE SIGNATURE	DATE

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