



ZIONSVILLE COMMUNITY SCHOOLS

Educational Services Center

Department of Unified Student Services

900 Mulberry Street

Zionsville, IN 46077

Phone: 317.873.2858

Fax: 317.873.8003



Diabetes Care Plan

Student Name:	DOB:	Grade:
Diabetes: Type 1 Type 2	Date of Diagnosis:	

Student wears a diabetic identification bracelet or necklace: Yes No

Parent Name:	Phone Number:
Parent Name:	Phone Number:
Treating Physician:	Phone Number:
Address:	
Emergency Contact and Phone Number:	

Blood Glucose Target Range:

mg/dl

Check blood glucose level:

() Hours after breakfast	2 hours after a correction dose	Before lunch
After lunch	() Hours after lunch	Before dismissal
Mid-morning	Before PE	After PE
As needed for signs/symptoms of illness	Suspected hyper/hypoglycemia	

Student's Level of Diabetes Self Care

Student's blood glucose checking skills:

Independent	With supervision
Requires School Nurse/trained diabetes personnel	Uses smartphone or other monitoring technology (CGM)

Student's self-care nutrition skills:

Independently counts carbohydrates	May count carbohydrates with supervision
Requires school nurse/trained diabetes personnel to count carbohydrates	

Student's self-care insulin administration:

Independently calculate and gives own injections
May calculate/give own injections with supervision
Requires school nurse/trained diabetes personnel to calculate and student can give own injection with supervision
Requires school nurse/trained diabetes personnel to calculate dose and give the medication



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Exercise/Physical activity:

Student may participate in regular physical education classes: Yes No

Student should not participate if blood glucose level is below mg/dl or above mg/dl.

Snack before exercise: Yes No As needed | Snack after exercise: Yes No As Needed

Instructions for when food is provided to the class (e.g., class party, food sampling):

Field Trip: Staff will inform parent of all field trips.

Insulin Therapy

Insulin delivery device:

Syringe | Insulin pen | Insulin pump

Type of insulin therapy at school:

Adjustable (basal-bolus) insulin | Fixed insulin therapy | No insulin

Carbohydrate Coverage/Correction Dose: Name of Insulin:

Carbohydrate Coverage: Insulin-to-carbohydrate ratio:

Lunch: 1 unit of insulin per grams of carbohydrate
Snack: 1 unit of insulin per grams of carbohydrate

Carbohydrate Dose Calculation Example
Total Grams of Carbohydrate to be Eaten = Units of Insulin
Insulin-to-Carbohydrate Ratio

Correction Dose: Blood glucose correction factor (insulin sensitivity factor) = Target blood glucose = mg/dl

Correction Dose Calculation Example
Current Blood Glucose - Target Blood Glucose = Units of Insulin
Correction Factor



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Correction Dose Scale

Parental authorization should be obtained before administering a correction dose for high blood glucose levels.

Yes No

units if blood glucose is less than		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
units if blood glucose if over		mg/dl

Lunch:	Carbohydrate coverage only
	Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dl and _____ hours since last insulin dose.
Other:	
Snack:	No coverage for snack
	Carbohydrate coverage only
	Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dl and _____ hours since last insulin dose.
	Correction dose only: For blood glucose greater than _____ mg/dl AND at least _____ hours since last insulin dose.
Other:	

Hypoglycemia treatment (low blood sugar)

= _____ mg/dl or lower and/or physical symptoms

****Never send a student with actual or suspected low blood glucose anywhere alone****

Student's usual symptoms of hypoglycemia:

If exhibiting symptoms of hypoglycemia, OR if blood glucose level is _____ mg/dl or below, give 15 grams of fast-acting carbohydrate.

If blood glucose level is _____ mg/dl or below, give 30 grams of fast-acting carbohydrate.

*Recheck blood glucose in 15 minutes and repeat treatment if blood glucose level is less than _____ mg/dl.

Additional treatment:

If student is unable to eat or drink, is unconscious or unresponsive or is having seizure activity or convulsions:

*Position the student on his or her side to prevent choking.

*Give _____ mg **Diabetic Emergency Medication (Glucagon by injection or nasal powder)**

*Call 911 and the student's parent immediately.

*Stay with the student.



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Hyperglycemia Treatment (high blood sugar)

= **mg/dl or higher**

Student's usual symptoms of hyperglycemia:

*Give extra water and/or non-sugar containing drinks (not fruit juice): _____ ounces per hour.

*Allow unrestricted access to the bathroom.

*Check urine for ketones every _____ hours when blood glucose levels are above _____ mg/dl.

*For blood glucose greater than _____ mg/dl AND at least _____ hours since last insulin dose, give correction dose of insulin.

(Please see individual student orders)

*Notify parent if blood glucose if over _____ mg/dl.

Additional treatment:

For a hyperglycemia emergency, call 911 and contact the student's parents. Hyperglycemia emergency may include: dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increased sleepiness or lethargy or depressed level of consciousness.

Other diabetes medications

Name:	Dose:	Route:	Times given:
Name:	Dose:	Route:	Times given:

Supplies to be kept at School

Water Bottles	Blood glucose meter, test strips, extra batteries for meter
Lancet device, lancets	Urine ketone strips
Insulin pump supplies	Insulin pen, pen needles, extra insulin cartridges
Fast-acting source of glucose	Long-acting carbohydrate/protein
Glucagon emergency kit	CGM supplies, adhesive
Other:	

****Please attach current Physician orders.**

I, the parent of _____, authorize the release and exchange of medical information between any of my child's health care providers and St. Vincent. I understand that this is for continuity of care purposes and may occur as needed without any prior notification or additional authorization throughout my child's care in the school system.

Parent Name:

Parent Signature:

Date: