Wayzata Schools Health Office • Diabetic Health Plan

Student _____ Date of Birth _____ Grade _____

School _____ Teacher _____ Date of Plan _____

Physical Condition ☐ Type 1 ☐ Type 2 Date of Diabetes Diagnosis _____

Contact Information

Parent/Guardian _____ Address _____

Telephone Home _____ Work _____ Cell _____

Parent/Guardian _____ Address _____

Telephone Home _____ Work _____ Cell _____

Student's Health Care Provider _____ Phone _____

Nurse Educator _____ Phone _____

Other Emergency Contact _____ Relationship _____

Telephone Home _____ Work _____ Cell _____

Hospital Preference _____

Notify parents/guardian or emergency contact in the following situations: _____

_____

Medical Management at School

Blood Glucose Monitoring

Target range for blood glucose monitoring is _____ mg/dl to _____ mg/dl

Usual times to test blood glucose _____

Times to do extra blood glucose tests (check all that apply)

☐ before exercise ☐ when student exhibits signs of hyperglycemia

☐ after exercise ☐ when student exhibits signs of hypoglycemia

☐ other (explain) _____

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

Exceptions: _____

Insulin

Times, types and dosages of insulin injections to be given during school

	Times	Type of Insulin	Fixed or Flexible Dosing
Insulin to carbohydrate ratio: _____			

Insulin Correction Doses

_____ Units if blood glucose is _____ to _____ mg/dl

_____ Units if blood glucose is _____ to _____ mg/dl

_____ Units if blood glucose is _____ to _____ mg/dl

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_____ 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 give own injections? ☐ Yes ☐ No

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

Student can draw correct dose of insulin? ☐ Yes ☐ No

Treatment for elevated ketones:

Mild-Moderate _____

Moderate-Severe _____

For Students with Insulin Pumps

Type of pump _____ Type of insulin in pump _____

Basal rates _____

Insulin to carbohydrate ratio _____ Correction factor _____

Student Pump Abilities/Skills	Needs Assistance
Count carbohydrates	☐ Yes ☐ No
Bolus correct amount for carbohydrates consumed	☐ Yes ☐ No
Calculate and administer corrective bolus	☐ Yes ☐ No
Disconnect pump	☐ Yes ☐ No
Reconnect pump at infusion set	☐ Yes ☐ No
Insert infusion set	☐ Yes ☐ No
Troubleshoot alarms and malfunctions	☐ Yes ☐ No

Meals and Snacks Eaten at School

Is student independent in carbohydrate calculations and management? ☐ Yes ☐ No

	Time	Food content/amount
Breakfast		
Mid-morning snack		
Lunch		
Mid-afternoon Snack		

Snack before exercise? ☐ Yes ☐ No Snack after exercise? ☐ Yes ☐ No

Other times to give snacks and content/amount _____

Preferred snack foods _____

Foods to avoid _____

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

Exercise and Sports

Student should not exercise if blood glucose is below _____ mg/dl or above _____ mg/dl or if moderate to large urine ketones are present.

A fast acting carbohydrate such as _____ should be available at the site of exercise or sports.

Response to Diabetic Emergencies at School

Hypoglycemia (Low Blood Sugar)

Usual symptoms of hypoglycemia _____

Treatment of Hypoglycemia _____

Glucagon available? ☐ Yes ☐ No Glucagon should be given if the student is unconscious, having a seizure (convulsion) or unable to swallow.

Route _____, dosage _____, site for glucagon injection: ___ arm, ___ thigh, _____ other.

If glucagon is required, administer it promptly. Then call 911, the LSN and notify parents.

Hyperglycemia (High Blood Sugar)

Usual symptoms of hyperglycemia _____

Treatment of hyperglycemia _____

Urine should be checked for ketones when blood glucose levels are above _____ mg/dl.

Treatment for ketones _____

Authorization for Diabetes Medical Management Plan

_____ _____

Licensed Healthcare Provider's Signature Date

Parent signature gives permission for school staff, that have been medication trained by the nurse, to administer prescribed medication and gives permission for the release of information to/from the healthcare provider.

_____ _____

Parent/Guardian Signature Date

_____ _____ _____ _____

Licensed School Nurse Work Phone Pager Date