Diabetic Care Plan (DCP)

This plan should be completed by the student's personal diabetes health care team, including the parent/guardian. It should be reviewed with relevant school staff and copies should be kept in a place that can be accessed easily by the school nurse, trained diabetes personnel, and other authorized personnel.

Student Information

Student Name _____ Birthdate _____ School Year _____
School _____ School Nurse _____
Bus (AM/PM) _____ □ Car Rider □ Student Driver
Afterschool Activities □ Afterschool Care □ Sports □ Band □ Other _____
Parent/Guardian _____ Phone _____
Parent/Guardian _____ Phone _____
Other Emergency Contact _____ Phone _____

Medical Information

Medical Provider _____ Preferred Hospital _____
Practice Name _____ Phone _____
Allergies _____
Diabetes Diagnosis Date _____ □ Type 1 □ Type 2

Educational Goal

Student will maintain health and well being necessary for learning. Student will attain and maintain blood glucose levels within their individual target range to enable them to achieve their academic goals and prevent crises. Staff will work with student and parent/guardian in the prevention of recurrent episodes of hypo-/hyperglycemia and will stress the importance of compliance with diabetes regimen as prescribed by the health care provider.

Parent/guardian is responsible for providing all testing/medication supplies, carbohydrate snacks, and medication/insulin.

□ I, (parent/guardian), give permission to the school nurse, another qualified health care professional or trained diabetes personnel to perform and carry out the diabetes care tasks as outlined in this Diabetic Care Plan. I also consent to the release of the information contained in this Diabetic Care Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified health care professional to contact my child's health care provider to obtain any related health care information. I agree to provide the necessary equipment and supplies to the school nurse and to provide information about student's health status and/or updated medical management.

□ **I decline to have this individualized Diabetic Care Plan for my child. In an emergency, I understand EMS (911) will be called and no medications will be administered without a medical provider's order.**

DCP APPROVED BY

Medical Provider _____ Date _____
Parent/Guardian _____ Date _____
School Nurse _____ Date _____

PRESCRIBED MEDICATIONS

□ **This Diabetic Care Plan can be modified per medical provider's order or with written notice by parent/guardian.**

□ **Student has flexible dosing** using _____ units of _____ insulin for every _____ grams of carbohydrate eaten with □ snacks □ lunch

□ Student requires assistance to count carbohydrates

□ Student can count carbohydrates unassisted

□ Special event/class food is allowed at parent/guardian's discretion

□ Special event/class food is allowed at student's discretion

□ **Student will receive corrective insulin dosing**

□ At snack

□ At lunch

□ Any time during school hours if it has been > 3 hours since last insulin dose

BG > _____ but ≤ _____, give _____u; BG > _____ but ≤ _____, give _____u

BG > _____ but ≤ _____, give _____u; BG > _____ but ≤ _____, give _____u

If BG > _____, give _____u and contact the parent/guardian.

NOTE: Confirm CGM results with blood glucose finger stick check prior to administering corrective insulin dosing.

Insulin Pump

Student has _____ insulin pump. type of infusion set _____

Basal rates _____ insulin/carbohydrate ratio _____ corrective factor _____

□ Yes □ No May disconnect from pump for sports/activities

□ Yes □ No Set a temporary basal rate: _____ % temporary basal for _____ hours

□ Yes □ No Suspend pump use

Insulin Administration

□ Student will have all insulin administered by a trained diabetic care provider

□ Student can administer all insulin with assistance/supervision by a trained diabetic care provider

□ Student can administer all insulin independently without supervision per medical provider's order and has shown themselves proficient by demonstration

□ Student can troubleshoot insulin pump alarms and malfunctions independently per medical provider's order

□ Student must keep all medication and testing supplies with them at all times

BLOOD GLUCOSE MONITORING

Target blood glucose range is _____ mg/dL.

Call parent/guardian for any blood glucose level <_____mg/dL or >_____mg/dL.

Usual times to check blood glucose level: _____; _____; _____; _____; _____.

Additional blood glucose checks: □ before exercise □ after exercise □ other_____

NOTE: A finger stick blood glucose check should always be used to check blood glucose level if hypo-/hyperglycemia is suspected. If a student experiences symptoms of hypo- or hyperglycemia, monitor student and refer to the hypoglycemia/hyperglycemia guidelines before returning to physical activity.

Brand/model of glucose meter _____

Continuous glucose monitor (CGM) □ **Yes** □ **No** Alarm setting for: low _____ high _____

NOTE: Confirm CGM results with blood glucose meter finger stick before taking action. If student has symptoms of hypo-/hyperglycemia, check finger stick blood glucose level regardless of CGM reading.

□ Student requires assistance/supervision by a trained diabetic care provider for blood glucose checks

□ Student can perform glucose checks independently without supervision per medical provider's order and has shown themselves proficient by demonstration

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HYPOGLYCEMIA (LOW BLOOD SUGAR)

Recognize the signs and symptoms of mild/moderate hypoglycemia (low blood sugar): NEVER ask students with diabetes to wait until the end of a lesson or class when they have or complain of any of these symptoms: hunger, shakiness, weakness, anxiety, paleness, irritability, dizziness, sweating, drowsiness, headache, blurry vision, poor coordination, behavior change, confusion, inability to concentrate, slurred speech, other: _____

NOTE: A finger stick blood glucose check should always be used to check blood glucose level if hypoglycemia is suspected.

If blood glucose is <_____mg/dL or there are signs of low blood sugar then provide quick-sugar source:

□ 3-4 glucose tablets □ 4oz juice □ 6oz regular soda □ 3tsp glucose gel □ other: _____

NOTE: Student must always have immediate access to snacks

- ➔ Monitor 10-15 minutes and recheck blood sugar. Repeat sugar if symptoms persist or blood glucose <_____mg/dL
- ➔ If blood sugar is > 70 mg/dL but student continues to feel low or not well, monitor and re-test in 10-15 minutes.
- ➔ If blood sugar <_____mg/dL repeat treatment for low blood sugar, monitor and notify parent/guardian immediately.
- ➔ Blood sugar must be >_____mg/dL to participate in physical activity.

IF STUDENT IS HAVING SEVERE SYMPTOMS SUCH AS: unable to swallow, seizures,; or becomes unconscious–stay with the student! Place student on their side. Have someone call 911 and the parent/guardian.

□ Administer glucagon injection/nasal spray _____mg (ordered by medical provider and supplied by the parent/guardian)

HYPERGLYCEMIA (HIGH BLOOD SUGAR)

Recognize the signs and symptoms of hyperglycemia (high blood sugar): increased thirst, blurred vision, frequent urination, dry skin, drowsiness, nausea, hunger, difficulty breathing.

NOTE: A finger stick blood glucose check should always be used to check blood glucose level if hyperglycemia is suspected.

- ➔ If blood sugar is >_____mg/dL for two consecutive tests, notify parent/guardian.
- ➔ If blood glucose remains >_____mg/dL and symptoms persist, contact parent/guardian to pick-up from school.
- ➔ If blood sugar is >_____mg/dL check urine for ketones (parent/guardian must supply strips). If ketones are present. contact the student's parent/guardian.
- ➔ Avoid physical activity if blood sugar is >_____mg/dL or if urine ketones are moderate to large.

Diabetic Care Plan (DCP)

Este plan debe ser elaborado por el equipo médico personal del estudiante con diabetes, incluidos los padres o tutores. Debe revisarse con el personal escolar pertinente y deben conservarse copias en un lugar al que puedan acceder fácilmente la enfermera del escuela, el personal formado en diabetes y demás personal autorizado.

Student Information

Nombre del estudiante _____ Fecha de nacimiento _____ Año escola _____
Nombre del escuela _____ Enfermera escolar _____
Autobús (AM/PM) _____ □ Estudiante que va en coche □ Estudiante que conduce
Afterschool Activities □ Cuidado extraescolar □ Deportes □ Banda □ Otros _____
Padre/tutor _____ Teléfono _____
Padre/tutor _____ Teléfono _____
Otro contacto de emergencia _____ Teléfono _____

Medical Information

Proveedor médico _____ Hospital preferido _____
Nombre de la clínica _____ Teléfono _____
Alergias _____
Fecha del diagnóstico de diabetes _____ □ Tipo 1 □ Tipo 2

Educational Goal

El estudiante mantendrá la salud y el bienestar necesarios para el aprendizaje. El estudiante alcanzará y mantendrá los niveles de glucosa en sangre dentro de su rango objetivo individual, lo que le permitirá alcanzar sus objetivos académicos y prevenir crisis. El personal colaborará con el estudiante y sus padres o tutores en la prevención de episodios recurrentes de hipo- o hiperglucemia y hará estrés sobre la importancia de cumplir con el tratamiento para la diabetes recetado por el proveedor de salud.

Los padres o tutores son responsables de proporcionar todo el material necesario para las pruebas y la medicación, los carbohidratos para comer y la medicación o la insulin

□ Yo, (padre o tutor), autorizo a la enfermera del escuela, a otro profesional sanitario cualificado o al personal ormado en diabetes a realizar y llevar a cabo las tareas de atención diabética tal y como se describen en este Plan de Atención Diabética. Asimismo, doy mi consentimiento para que se facilite la información contenida en este Plan de Atención Diabética a todo el personal del centro y a otros adultos que tengan responsabilidad sobre mi hijo y que puedan necesitar conocer dicha información para velar por la salud y la seguridad de mi hijo. Asimismo, autorizo a la enfermera del colegio o a otro profesional sanitario cualificado a ponerse en contacto con el profesional sanitario de mi hijo para obtener cualquier información sanitaria relacionada. Me comprometo a proporcionar el equipo y los suministros necesarios a la enfermera del colegio, así como a facilitar información sobre el estado de salud del alumno y/o sobre los cambios en su tratamiento médico.

□ **Me niego a aceptar este plan de atención diabética personalizado para mi hijo. Entiendo que, en caso de emergencia, se llamará al servicio de emergencias médicas (911) y no se le administrará ningún medicamento sin la prescripción de un profesional sanitario.**

DCP APPROVED BY (DCP APROBADO POR)

Medical Provider (Proveedor médico) _____ Date _____
Parent/Guardian (Padre/tutor) _____ Date _____
School Nurse (Enfermera escolar) _____ Date _____