

DIABETES HEALTH CARE PLAN

Student Name _____ Birth date _____ Male OR Female
 School _____ Grade _____

Primary Physician's Name _____ Phone _____
 Endocrinologist's Name _____ Phone _____

Diabetic Emergency Contact #1 Name _____ Relationship _____
 Phone _____ Phone _____

Diabetic Emergency Contact #2 Name _____ Relationship _____
 Phone _____ Phone _____

For Emergency Transport Call 9-1-1 Children's Hospital of WI Diabetes Clinic 414-266-3380

Diagnosis: Type 1 Diabetes OR Type 2 Diabetes
 Date of Diagnosis _____ Date of last Medical Appt _____

School Diabetes Supplies/Medications

Blood Sugar Testing	Glucometer:	Lancets:
Insulin	Type: Dosage chart or Sliding Scale	Test Strips:
	Type: Dosage chart or Sliding Scale	Route: PEN SYRINGE PUMP
		Needles:
		Route: PEN SYRINGE PUMP
		Needles:
Emergency Glucose (circle where available)	Snacks Rm Student Class Rm	Glucose Tablets Health Rm Student Class Rm
		Glucagon Health Rm Student Class Rm

Insulin at School

Student will receive this insulin at lunch daily.	Humalog	Novolog	Other _____
Insulin is to be given at what time?	Before lunch (5 min.)	After lunch (10 min.)	
Insulin will be available in what dosage form?	Insulin Pen	Prefilled Syringe	Vial & Syringe
Insulin dosage will be prepared by?	Student	Parent	School Personnel
Insulin dosage will be checked by?	Student	Parent	School Personnel
Insulin will be administered by?	Student	Parent	School personnel

Insulin DOSAGE CHART

INSULIN:

Carbs at Lunch (_____ unit Insulin per 1 Carb Serv)	4	5	6	7	8
Blood Sugar	Insulin Adjustment	Total Insulin to Give	Total Insulin to Give	Total Insulin to Give	Total Insulin to Give
Less than 80					
80-150					
151-200					
201-250					
251-300					
301-350					
351-400					

Insulin Dosage Per SLIDING SCALE INSULIN: _____

Blood Sugar	Units of Insulin
_____ to _____	_____ units
_____ to _____	_____ units
_____ to _____	_____ units
_____ to _____	_____ units
_____ to _____	_____ units
_____ to _____	_____ units
_____ to _____	_____ units

Diabetic Reaction Plan

Students with diabetes can have severe reactions to low or high blood sugar levels. School personnel need to be aware of this and watch for the following signs and symptoms of low and high blood sugars. If any of the following signs and symptoms are noted, school personnel are to send the student to the health room. The student should be accompanied by another student or staff member to the health room. A student with a suspected diabetic reaction should NEVER be sent anywhere alone.

Low Blood Sugar Signs & Symptoms

Shaky	Pale	Hungry
Sweaty	Moody	Dizzy
Irritable	Unable to pay attention	Headache
Wobbly	Sleepy/Sluggish	Clumsy
Symptoms Specific to THIS STUDENT :		

Low Blood Sugar Plan of Care

If any of the above signs/symptoms of low blood sugar are identified follow this outlined plan of care.

- 1) Perform a blood sugar test, if time permits, before preceding.
- 2) Give a fast acting form of glucose (see chart below). Snacks should be available in health room.
 - a. If student feels better in 10-15 minutes.
 - i. Perform a blood sugar test to confirm rise in glucose.
 - ii. Give a follow-up snack (see chart below) or send to lunch if within 1 hour.
 - iii. **Notify parent** of low blood sugar and actions taken.
 - b. If after 15 minutes student remains the same.
 - i. Give 2 Glucose Tablets or _____ (specified by MD/parent).
 - ii. Perform a blood sugar test to confirm rise in glucose.
 - iii. Give a follow-up snack (see chart below) or send to lunch if within 1 hour.
 - iv. **Notify parent** of low blood sugar and actions taken.
 - c. If student worsens or you are unable to feed glucose by mouth.
 - i. **Call 9-1-1** immediately for medical assistance.
 - ii. **Notify parent** of worsening condition and 9-1-1 called.
 - iii. Notify Doctor / Clinic
 - d. If student becomes UNCONSCIOUS or a seizure occurs.
 - i. Get Help! Have someone **call 9-1-1** immediately for medical assistance.
 - ii. Provide FIRST AID
 1. Ease student to floor, protecting their head.
 2. Do not restrain or place anything in student’s mouth.
 3. Turn student to rest on side incase of vomiting.
 - iii. Trained personnel should administer Glucagon Injection if order and medication exist. Directions & visual aid for administration of Glucagon with Glucagon syringe.
 - iv. **Notify Parent** of student’s condition, actions taken, and 9-1-1 called.
- 3) If student has nausea, vomiting, or diarrhea – **notify parent**. Call doctor if parent unavailable.

Snacks for treatment of Low Blood Sugar

Fast Acting Glucose		Follow-up Snack	
Raisins	1 sm box	Cheese & Crackers	4-6 pk
Fruit roll up	1	Graham Crackers	2 crackers
Lifesavers	6 or 7	Granola Bar	1
Dried fruit	4 or 5 pieces	Other snacks for THIS STUDENT:	
Sugar cubes	5 sm cubes		
Fruit juice	1 juice box (1/2 c)		
Soda (not diet)	1/2 can (6 oz)		
Other snacks for THIS STUDENT:			

High Blood Sugar Signs & Symptoms

Thirsty	Frequent Urination	Hungry
Irritable	Unable to pay attention	Weak Pulse
Flushed	Dry skin	Dizzy
Deep/rapid breathing	Confused	Lethargic
Symptoms Specific to THIS STUDENT :		

High Blood Sugar Plan of Care

If any of the above signs/symptoms of high blood sugar are identified follow this outlined plan of care.

- 1) Perform a blood sugar test. High blood sugars for **THIS STUDENT** are blood sugars over _____ mg/dL.
- 2) Administer insulin if orders exist for treatment of intermittent high blood sugar (see below).
- 3) **Notify parent** if extra doses of insulin are given.
- 4) Check for urine ketones IF order and Ketone Test Strips are available at school.
 - a. If urine ketones are negative to small, student should drink extra sugar-free fluids.
 - b. If urine ketones are moderate to large, **notify parent** right away.
 - c. If student is not feeling well and/or vomiting, **notify parent** of need for medical attention.

Insulin Dosage For HIGH BLOOD SUGAR

INSULIN: _____

Blood Sugar	Units of Insulin	Criteria for Extra Insulin
_____ to _____	_____ units	- It has been more than 2 hours since last shot was given and it is NOT a meal time. - Blood sugar is over _____ mg/dL. - Blood sugar must be checked 2 hours after correction shot. - Do not exceed 2 extra dosages of insulin in one school day. - Always NOTIFY PARENT if extra doses are needed.
_____ to _____	_____ units	
_____ to _____	_____ units	
_____ to _____	_____ units	
_____ to _____	_____ units	
_____ to _____	_____ units	

Special Instructions for **THIS STUDENT**: _____

This Diabetes Health Care Plan has been completed and reviewed by physician, student, parent, and District Nurse. The information will be provided to administrators, teachers, and staff to allow for awareness and preparedness in providing the best care for the student.

This Diabetes Health Care Plan, emergency snacks/medications, and the student's Emergency Card is to accompany the student on school Field Trips to allow for the appropriate response when outside of the school building during school hours.

Physician Signature _____ Date _____

Student Signature _____ Date _____

Parent Signature _____ Date _____

District Nurse Signature _____ Date _____