Mukwonago Area School District – Health Services Department
District Nurse – Park View Middle School, 930 N. Rochester, Mukwonago, WI 53149
Phone: (262)363-6292 x 27515 Fax: (262)363-6320

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: Test Strips:
Insulin	Type: Dosage chart or Sliding Scale	Route: PEN SYRINGE PUMP Needles:
	Type: Dosage chart or Sliding Scale	Route: PEN SYRINGE PUMP Needles:
Emergency Glucose (circle where available)	Snacks: Health 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		**4**	**5**	**6**	**7**	**8**
(___ unit Insulin per 1 Carb Serv)						
Blood Sugar	**Insulin Adjustment**	**Total Insulin to Give**	**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

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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)	½ can (6 oz)		
Other snacks for THIS STUDENT:			

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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	
_____ 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_____