Diabetes Care Plan

School Year _____

Student's Name_______________________________ Date of Birth_________________ Student ID#________________
School_________________________ Grade___________ Homeroom Teacher__________________ Bus #________
School Nurse______________________________________ Phone____________________
Date of Diabetes Diagnosis ________________ ☐ Type 1 ☐ Type 2 ☐ Other_______________
School Personnel Trained as Diabetes Care Providers____

Parent/Guardian/Health Care Provider: Complete this plan, sign and return to school. Parent/Guardian is responsible for providing necessary supplies and snacks. These supplies will be kept____
Parent/Guardian/Emergency contact 1______________________________Address__________________________________
Phone: Home # ___________________________ Cell # ________________________ Work #_______________________
Email Address: ________________________________
Parent/Guardian/Emergency contact 1______________________________Address__________________________________
Phone: Home # __________________________ Cell # ________________________ Work #_______________________
Email Address: ________________________________

Physician Treating Student for Diabetes________________________ Office #________________________
Diabetes Educator ____ Office #________________________
Primary Care Physician ____________________________________ Office #________________________

Diabetic Management/Self Care

- ☐ No blood sugar testing required at school
- ☐ Trained personnel must monitor blood sugar test
- ☐ Trained personnel must supervise blood sugar test
- ☐ Student can perform testing independently
- ☐ Total independent management
- ☐ Injections to be done by trained staff
- ☐ Self injects with trained staff supervision
- ☐ Student can administer insulin independently
- ☐ Self treats mild hypoglycemia
- ☐ Independently counts carbohydrates

**Call Parent if Values are Below _______ or Above ________

Target BS Range is ____________________________

Blood Sugar Checks

☐ Before Breakfast ☐ Before Lunch ☐ Before Snack ☐ Before PE ☐ After PE ☐ Before Dismissal/Prior to Board
☐ As needed for signs and symptoms of Low or High Blood Sugar ☐ Other____

Diet

☐ Carbohydrates per meal =_____________
☐ Snack time(s) ______ (am) & _________ (pm) Snack _______________________ Cover Carbs if snack is > than ___________
☐ No coverage for snack up to 15 gm of Carbohydrates
If BS is above _____________ withhold ☐ Meal ☐ Snack Until ____
Special Event/Party Food: ☐ Yes (Student's discretion) ☐ Yes with Parent's permission ☐ Other ________________

Medications/Equipment

☐ Insulin ____________________
☐ Pen ☐ Vial/Syringe ☐ Pump
☐ Glucagon
☐ Oral Medication at school ____________ Time: ___________ and/or ______________ Time: ___________
☐ CGM (brand)______________________________
☐ Glucometer (brand)________________________
☐ Pump (brand)

Send Copies to: 504 coordinator, Diabetes Care Manager, First Responders, Nurse, Staff involved with care of student

First Aid for Hyperglycemia (High Blood Sugar)	First Aid for Hypoglycemia (Low Blood Sugar)
● Frequent urination ● increased thirst ● nausea/vomiting ● Sleepiness, ● Confusion ● Inability to concentrate ● Irritability ● blurred vision ● Abdominal pain ● Fruity odor to breath	● Hunger ● Sweaty ● Pale ● Slurred speech ● Confusion ● Irritability/anxious ● Sleepiness ● Inability to concentrate ● Poor coordination ● Headache ● Dizziness ● Crying ● Complains of feeling low ● Behavior change ● Seizure ● Weakness/fatigue

Hyperglycemia

1. Check the blood sugar if signs & symptoms occur.
2. Notify parent/guardian if blood glucose is over ______ mg/dL
3. Check Urine Ketones if BS is above 300 mg/dl after 2 checks
4. Encourage water to drink, allow unlimited use of bathroom.
5. Administer insulin per physician's order (see insulin therapy orders)
6. Recheck blood sugar in _____________
7. Call **911** if Child
   - loses consciousness
   - unable to reach parent/guardian and symptoms worsen
8. If moderate to large Ketones, Stay with child continuously

*Pump - Check pump function
Check pump site
Check tubing
Treat for hyperglycemia as above
- Refer to **Pump Therapy Orders**

Hypoglycemia

1. Check blood sugar if signs & symptoms occur.
2. Stay with child continuously.
3. Give _____ grams carbohydrate (fast sugar) if blood sugar is less than ______ and child is conscious, cooperative and able to swallow.
   Examples: ____________________________________
4. Check blood sugar after 15 minutes.
   - If blood sugar does not improve, give fast sugar again
   - When blood sugar is over 80, provide an additional snack of _________________
   - If still no improvement after 2 fast sugars, call physician and call parent to pick up child.
5. Call **911**, parents and/or child's health care provider if
   - Child's symptoms do not subside
   - Child loses consciousness
   - Unable to reach parent/guardian and symptoms worsen
6. If Child is unconscious, experiencing a seizure or unable to swallow
   - Place student on side
   - Give **Glucagon** ☐ 1mg ☐ 0.5 mg
   - Call **911**, parent/guardian, and/or child's health care provider

*Pump - Review pump therapy guidelines

Insulin Therapy

☐ Adjustable Insulin Therapy ☐ No insulin
☐ Fixed Insulin Therapy

☐ Meal coverage plus snacks
☐ Meal coverage only ☐ Breakfast ☐ Lunch

Adjustable Insulin Therapy
Carbohydrate Correction Dose:
Breakfast: 1 unit of insulin per _______ grams of carbohydrate
Lunch: 1 unit of insulin per _______ grams of carbohydrate
Snack: 1 unit of insulin per _______ grams of carbohydrate

Calculation Example:

$$\frac{\text{Grams of Carbohydrate eaten}}{\text{Insulin to Carbohydrate ratio}} = \text{Units of Insulin}$$

☐ If blood sugar is >300 and less than 3 hours since last insulin dose, **only** cover carbs per carbohydrate correction dose

☐ Parent/guardian authorized to increase or decrease insulin to carbohydrate ratio within the following range 1 unit per prescribed grams of carbohydrate +/- _____ of carbohydrate

Fixed Insulin Therapy:
☐ Meals: _______ units of insulin given pre-meal
☐ Snack: _______ units of insulin given pre-snack

Blood Glucose Correction Factor
Blood glucose greater than_______mg/dL AND at least 3 hours since last insulin dose

Blood Glucose _____ to ______ mg/dL, give _______units
Blood Glucose _____ to ______ mg/dL, give _______units
Blood Glucose _____ to ______ mg/dL, give _______units
Blood Glucose _____ to ______ mg/dL, give _______units
Blood Glucose _____ to ______ mg/dL, give _______units
Blood Glucose _____ to ______ mg/dL, give _______units
Blood Glucose _____ to ______ mg/dL, give _______units

☐ Parent/guardian authorized to increase or decrease insulin within the following range +/- ______units of insulin for blood glucose

Pump Therapy

Basal Rates during school: Time:__________ Basal Rate:________ Time:__________ Basal Rate:________
☐ ask parent for most Time:__________ Basal Rate:________ Time:__________ Basal Rate:________
current basal rates Time:__________ Basal Rate:________ Time:__________ Basal Rate:________

☐ For blood glucose greater than _____ mg/dL that has not decreased within ______ hours after correction, consider pump failure or infusion site failure. **Notify parent/guardian**
☐ For any pump/site failure: Notify parent/guardian for correction by ☐ Pen or ☐ Vial/Syringe
☐ For infusion site failure: Student can independently insert infusion set & may give correction dose
☐ May disconnect pump for sports activities for up to ___________ hours
☐ May set a temporary basal rate up to _______% temporary basal for up to _____ hours
☐ Student can independently set temporary basal rate
☐ May suspend pump use
☐ Student can independently bolus for carbohydrates consumed
☐ Student can independently change batteries
☐ Student can independently troubleshoot alarms and malfunctions
☐ May call parent to troubleshoot alarms and malfunctions
☐ Other: ____

Continuous Glucose Monitor

Alarms set for: Severe Low ___________ Low __________ High _________
Predictive Alarm: Low ________ High ________
Rate of change: Low ________ High ________

☐ Alarms per parent setting at home
☐ May use CGM blood glucose value for treatment decision
☐ Student can independently use GCM
☐ Student knows what to do and is able to deal with ☐ Low Alarm ☐ High Alarm
☐ Student can calibrate the CGM independently
☐ Student should be escorted to the school nurse/school diabetes team member if CGM alarm goes off

For **signs and symptoms of hypoglycemia** treat a low sugar based on CGM
If blood sugar is still low on recheck, check blood sugar with glucometer
Insulin injections should at least three inches away from CGM site
Site may be reinforced with medical tape
If CGM is dislodged **do NOT throw it away**, return everything to parent/guardian

Sports/Exercise

☐ Prior to moderate or vigorous exercise if blood sugar is below **130 mg/dL;** give 10-15 gm of carbohydrates & allow exercise
☐ Avoid moderate to vigorous exercise if blood sugar is above _________ mg/dl and ketones are moderate to large
☐ Recheck after moderate to vigorous exercise
☐ Physical restrictions/ limitations/accommodations: ____
____

Permission Signatures: Parent/Guardian and Health Care Provider authorizes this health care plan, use of glucometers, listed medications for this student at school this school year. The school nurse may contact the stated health care provider(s) related to this condition. I hereby release the Winston-Salem Forsyth County School System, Board of Education, and their employees and agents from any and all liability that may result from my child taking the medications listed in this care plan or for the loss of medication by my child while at school or school activity.

Parent/Guardian Signature ____ **Date**______________
Health Care Provider/Physician Signature ____ **Date**______________