PHOTO OF STUDENT PASTED HERE

Student's Name _____ **ID #** _____ **DOB** _____
School _____ **Grade** _____ **Homeroom Teacher** _____
Bus # / Transportation _____ **Date of Diabetes Diagnosis** _____
Effective Dates for Plan: ____/____/____ **to** ____/____/____ **Type** _____ **Diabetes**

Diabetes Care Plan

Parent/Guardian: Complete this plan with the assistance of your child's health care provider and the school nurse/administrator. The diabetes care plan requires the signature of the student's parent/guardian and health care provider. Return the completed, signed plan to the school. Attach other instructions/ forms if needed.
Health Care Provider: Review this diabetes care plan and make any necessary changes or additions. Sign and return the plan to parent/guardian or school.

Parent/Guardian #1 _____ Address _____
Telephone (Home) _____ (Work) _____ (Cell) _____
Parent/Guardian #2 _____ Address _____
Telephone (Home) _____ (Work) _____ (Cell) _____
Physician Treating Student for Diabetes _____ Telephone _____
Other Physician _____ Telephone _____
Nurse or Diabetes Educator _____ Telephone _____
Other Emergency Contact _____ Relationship _____
Telephone (Home) _____ (Work) _____ (Cell) _____
Trained School Diabetes Care Providers _____
Where are student's diabetes supplies kept? _____ Does the student wear a medic alert? **YES NO**
Notify parents in the following situations _____

EMERGENCY ACTION PLAN

LOW BLOOD SUGAR (Hypoglycemia)

SYMPTOMS: Hunger, sweating, trembling, pale appearance, inability to concentrate, confusion, irritability, sleepiness, headache, dizziness, crying, slurred speech, poor coordination, personality change, complains of feeling "low," blood sugar below _____ mg/dl.
Call parent/guardian and health care provider if blood sugar below _____ mg/dl.

Symptoms of low blood sugar for this student: _____
Times student is most likely to experience a low blood sugar: _____
Where are glucose tablets and snacks kept? _____

Has health care provider authorized use of glucagon? YES NO Where is glucagon kept? _____
Name(s) of school diabetes care provider trained to administer glucagon/How to locate trained school diabetes care provider(s):
_____
_____
_____

TREATMENT FOR LOW BLOOD SUGAR (Hypoglycemia)

If student is conscious, cooperative, and able to swallow:

- ❑ Give fast sugar immediately, such as glucose tablets, fruit juice, regular soda, glucose gel, or _____.
- ❑ Amount of fast sugar to be given _____
- ❑ If symptoms do not improve in _____ minutes, give fast sugar again.
- ❑ When symptoms improve, provide an additional snack of _____
- ❑ Check blood sugar level every _____ minutes until it is above _____.
- ❑ Do not leave student alone or allow him/her to leave the classroom alone. Remain with student until fully recovered.
- ❑ Contact trained school diabetes care provider or school nurse as soon as possible. Notify parents of low blood sugar episode.
- ❑ **If symptoms worsen, call 911, parent/guardian, and health care provider. Glucagon, if authorized by student's health care provider, may be needed if student becomes unconscious, has a seizure, or is unable to swallow.**

Student's Name _____

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If student is unconscious, experiencing a seizure, or unable to swallow:

- ❑ **Contact trained school diabetes care provider or school nurse immediately to inject emergency glucagon, if authorized for student.**
- ❑ **Call 911, parent/guardian, and health care provider. Glucagon dosage (if authorized) _____**
- ❑ Turn student on side and keep airway clear. Do not insert objects into student's mouth or between teeth.
- ❑ Student may vomit. Keep student on side to prevent choking on vomit. Keep airway clear.
- ❑ **Other instructions for treating low blood sugar: _____**

HIGH BLOOD SUGAR (Hyperglycemia)

SYMPTOMS: Frequent urination, excessive thirst, nausea, vomiting, dehydration, sleepiness, confusion, blurred vision, inability to concentrate, irritability, blood sugar above _____mg/dl.
Call parent/guardian and health care provider if blood sugar is over _____ mg/dl.

Symptoms of high blood sugar for this student: _____
Where are insulin and ketone testing supplies kept? _____

TREATMENT FOR HIGH BLOOD SUGAR (Hyperglycemia)

- ❑ Contact trained school diabetes care provider who will provide insulin administration, insulin pump care, and ketone testing.
- ❑ To correct high blood sugar, give insulin _____ units for every _____ mg/dl over _____.
- ❑ Check for ketones if blood sugar is above _____. Check blood sugar again in _____ and at _____ intervals.
- ❑ Allow free and unlimited use of bathroom. Encourage student to drink water or other sugar-free liquid.
- ❑ **If moderate or higher ketones are present, call health care provider and parent/guardian immediately.**
- ❑ **If symptoms worsen or the student begins vomiting, call health care provider and parent/guardian immediately.**
- ❑ **Other instructions for treating high blood sugar _____**

BLOOD SUGAR MONITORING

Target range of blood sugar: _____ to _____ Type of Meter _____ Logbook kept at school? **YES NO**
What help will student need with blood sugar testing? _____
Usual times for student to test blood sugar _____
Other times when blood sugar testing may be needed _____
Other instructions _____

INSULIN AND ORAL MEDICATIONS

TIME (for insulin at school)	**TYPE OF INSULIN**	**INSULIN DOSAGE**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

INSULIN INJECTIONS

Does student know how to:		
Give own injections?	**YES**	**NO**
Determine correct insulin dose?	**YES**	**NO**
Draw up correct insulin does?	**YES**	**NO**
Handle and dispose of needles safely?	**YES**	**NO**

Will student need insulin at school? **YES NO** Where is insulin kept at school? _____
What help will student need with insulin injections? _____
Insulin/carbohydrate ratio for meals/snacks: _____ units for every _____
High blood sugar correction ratio: _____ units for every _____ mg/dl over _____

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FOR STUDENTS ON INSULIN PUMPS:

Type of pump _____
Type of insulin used in pump _____
Insulin/carbohydrate ratio for meals/snacks: _____ units for every _____
High blood sugar correction ratio _____ units for every _____ mg/dl over _____
Backup means of insulin administration? _____
What help will student need with pump? _____

ORAL MEDICATIONS: _____

INSULIN PUMPS		
Does student know how to:		
Operate the pump without assistance?	**YES**	**NO**
Change insulin site?	**YES**	**NO**
Change tubing?	**YES**	**NO**
Change batteries?	**YES**	**NO**
Change insulin cartridge?	**YES**	**NO**
Determine bolus amounts?	**YES**	**NO**
Give bolus?	**YES**	**NO**
Adjust basal rates?	**YES**	**NO**

FOOD AND EXERCISE

MEAL/SNACK	**TIME**	**FOOD CONTENT/AMOUNT**
Breakfast		
Mid-Morning		
Lunch		
Mid-Afternoon		
Before Exercise		
After Exercise		
Other		

Student should not exercise if blood sugar is below _____ mg/dl OR above _____ mg/dl.
Other exercise/activity instructions _____

PREFERRED SNACKS
FOODS TO AVOID

Parent/Guardian (Signature) Date	Health Care Provider (Reviewed and signed) Telephone No.	School Nurse/Administrator Date

One copy to be kept by parent/guardian *One copy to be kept with student's diabetes care plan*

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