SURRY COUNTY SCHOOLS
SCHOOL HEALTH PROGRAM

Diabetes: Care Plan
To be completed by Healthcare Provider

Student: Date of Birth:	Parent/Guardian:
Today's Date:	Home Phone:
School: Bus#	Work Phone:
Grade: Teacher:	Cell Phone:

Parent/Guardian: Complete this plan with the assistance of your child's health care provider and the school nurse. 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.

Health Care Provider Training Student for Diabetes: _____Telephone: _____

Diabetic Care Managers @ school & location: _____

Location at school of diabetes supplies: _____Does the student wear a medic alert? YES/NO

EMERGENCY ACTION PLAN

LOW BLOOD SUGAR (Hypoglycemia)

Symptoms (Circle common/usual symptoms for student)

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/or health care provider if blood sugar below _____(mg/dl)
- Times student is most likely to experience low blood sugar: _____
- Where are glucose tablets/snacks kept? _____

Has health care provider authorized use of glucagen? YES/NO Where is glucagon kept? _____

TREATMENT FOR LOW BLOOD SUGAR

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

- Give fast sugar immediately (fruit juice, regular soda, raisins, glucose tabs, etc…)
- If symptoms do not improve in _____ minutes, give fast sugar again
- When symptoms improve, provide an additional snack of _____
- Check blood sugar 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 diabetes care manager or school nurse as soon as possible. Notify parent of low blood sugar episode.
  If symptoms worsen, call 911, parent/guardian, and health care provider.

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

- Call 911, parent/guardian, and health care provider
- Contact trained diabetic care manager or school nurse immediately to give glucagons if ordered. Glucagon dose: _____
- Turn student on side and keep airway clear. Do not insert objects into mouth or between teeth.
- Other instructions for treating low blood sugar: _____

HIGH BLOOD SUGAR (Hyperglycemia)

Symptoms (Circle common/usual symptoms for student)

Frequent urination, excessive thirst, nausea, vomiting, dehydration, sleepiness, confusion, blurred vision, inability to concentrate, irritability, blood sugar above _____(mg/dl)

- Call parent/guardian and/or health care provider if blood sugar over _____(mg/dl)
- Where are insulin and ketone testing supplies kept? _____

TREATMENT FOR HIGH BLOOD SUGAR

- Contact diabetic care manager or school nurse who will provide insulin administration, insulin pump care, ketone testing.
- Give insulin:_____units for every _____mg/dl over _____
- Check for ketones if blood sugar is above _____Check blood sugar in _____(min) and at _____ (min) intervals.
- Allow free and unlimited use of bathroom. Encourage student to drink water or other sugar-free liquid.
- If moderate or high ketones are present, call health care provider and parent/guardian immediately.
- If symptoms worsen or 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 @ school? YES/NO
What help will student need with blood sugar testing? _____
Usual times 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 needed at school? YES/NO Where is insulin kept at school? _____
Insulin/carbohydrate ratio for meals/snacks: ____units for every _____ carbs
High blood sugar correction ratio: ____ units for every _____mg/dl over _____

For students on insulin pumps:
Type of pump: _____ Type of insulin used in pump _____
Insulin/carbohydrate ratio for meals/snacks: _____units for every _____ carbs
High blood sugar correction ratio: _____ units for every _____ mg/dl over _____
Back-up means of insulin administration: _____
What help will student need with pump: _____

INSULIN INJECTIONS

Does student know how to:
Give own injections? YES/NO
Determine correct insulin dose? YES/NO
Draw up correct insulin dose? YES/NO
Handle/dispose of needle safely? YES/NO

INSULIN PUMPS

Does student know how to:
Operate pump without assistance? YES/NO
Change the infusion site? YES/NO
Change tubing? YES/NO
Change batteries? YES/NO
Change insulin cartridge? YES/NO
Determine bolus amount? YES/NO
Give bolus? YES/NO
Adjust basal rates? YES/NO

Oral medications: _____

FOOD AND EXERCISE

MEAL/SNACK TIME		FOOD CONTENT/AMOUNT
Breakfast	_____	_____
Mid-mornin	_____	_____
Lunch	_____	_____
Mid-afternc	_____	_____
Before exe	_____	_____
After exerc	_____	_____
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 _____

Healthcare Provider Signature _____ Date _____

Nurse Signature/Date: _____