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Student Photo

Diabetes Health Care Plan for Insulin Administration via Syringe or Pen

School:_____

Start Date: _____ End Date: _____

Name:_____ Grade/ Homeroom: ____ Teacher:_____

Transportation: ☐ Bus ☐ Car ☐ Van ☐ Type 1 ☐ Type 2

Parent/ Guardian Contact: Call in order of preference

Name *Telephone Number* *Relationship*

1._____

2._____

3. _____

Prescriber Name _____Phone_____Fax_____

Blood Glucose Monitoring: Meter Location _____ Student permitted to carry meter and check in classroom ☐ Yes ☐ No

BG= Blood Glucose **SG**= Sensor Glucose

Testing Time ☐ Before Breakfast/Lunch ☐ 1-2 hours after lunch ☐ Before/after snack ☐ Before/after exercise ☐ Before recess ☐ Before bus ride/walking home ☐ **Always** check when student is feeling high, low and during illness ☐ Other_____

Snacks: ☐ Please allow a _____gram snack at_____ ☐ before/after exercise, if needed.

Snacks are provided by parent /guardian and are located in _____

Signs of Low Blood Sugar personality change, feels funny, irritability, inattentiveness, tingling sensations headache, hunger, clammy skin, dizziness, drowsiness, slurred speech, seeing double, pale face, shallow fast breathing, fainting

Treatment for Hypoglycemia/Low Blood Sugar

If student is showing signs of hypoglycemia or if BG/SG is below _____mg/dl

☐ **Treat with _____ grams of quick-acting glucose:**

☐ __oz juice or ☐ ____ glucose tablets or ☐ Glucose Gel or ☐ Other _____

☐ Retest blood sugar every 15 minutes, repeat treatment until blood sugar level is above target ____mg/dl

☐ If no meal or snack within the hour give a 15-gram snack

☐ If student unconscious or having a seizure (severe hypoglycemia): Call 911 and then parents

☐ Give Glucagon: Amount of Glucagon to be administered: _____ (0.5 or 1 mg) IM, SC **OR** ☐ Baqsimi 3 mg intranasally

☐ **Notify parent/guardian for blood sugar below _____mg/dl**

Treatment for Hyperglycemia /High Blood Sugar

If student showing signs of high blood sugar or if blood sugar is above _____mg/dl

☐ Allow free access to water and bathroom

☐ Check ketones for blood sugar over 250 mg/dl, Notify parent/guardian if ketones are **moderate to large**

☐ **Notify parent/guardian for blood sugar over** _____mg/dl

☐ Student does not have to be sent home for trace/small urine ketones

☐ See insulin correction scale (next page)

☐ **Call 911 and parent/guardian for *hyperglycemia emergency*. Symptoms may include nausea &vomiting, heavy breathing, severe abdominal pain, chest pain, increased sleepiness or lethargy, or loss of consciousness.**

Document all blood sugars and treatment

Name: _____

Orders for Insulin Administration

Insulin is administered via: ☐**Vial/Syringe** ☐**Insulin Pen** ☐ **Not taking insulin at school**

Can student draw up correct dose, determine correct amount and give own injections?

☐**Yes** ☐**No** ☐**Needs supervision (describe)**_____

Insulin Type: _____ Student permitted to carry insulin & supplies: ☐ **Yes** ☐**No**

Calculation of Insulin Dose: A+B=C

A. Insulin to Carbohydrate Ratio: 1 unit of Insulin per _____ grams of carbohydrate

Give ___ units for ____ grams
Give ___ units for ____ grams
Give ___ units for ____ grams
Give ___ units for ____ grams

OR

_____ ÷ _____ = _____ **Units of Insulin (A)**
Carbohydrates To Eat | **Carbohydrate Ratio** | **Carbohydrate Bolus**

B. Correction Factor: _____ unit/s of insulin for every ____ over _____ mg/dl
Target BG

If BG/SG is _____ to _____mg/dl Give____ units
If BG/SG is _____ to _____mg/dl Give____ units
If BG/SG is _____ to _____mg/dl Give____ units
If BG/SG is _____ to _____mg/dl Give____ units
If BG/SG is _____ to _____mg/dl Give____ units
If BG/SG is _____ to _____mg/dl Give____ units
If BG/SG is _____ to _____mg/dl Give____ units
If BG/SG is _____ to _____mg/dl Give____ units

OR

_____ - _____ = _____ ÷ _____ = _____ **Units of Insulin (B)**
Current BG/SG | **Target BG** | **Amount to Correct** | **Correction Factor**

C. Mealtime Insulin dose = A + B

☐Other:_____

Give mealtime dose: ☐ before meals ☐ immediately after meals ☐ If blood glucose is less than 100mg/dl give after eating

☐ Parental authorization should be obtained before administering a correction dose for high blood glucose level (excluding meal time)

☐Parents are authorized to adjust the insulin dosage +/- by _____ units for the following reasons:

☐Increase/Decrease Carbohydrate ☐Increase/Decrease Activity ☐Parties ☐Other_____

Student self-care task	**Independent**	
Blood Glucose Monitoring	Yes	No
Carbohydrate Counting	Yes	No
Selection of snacks and meals	Yes	No
Insulin Dose calculation	Yes	No
Insulin injection Administration	Yes	No
Treatment for mild hypoglycemia	Yes	No
Test Urine/Blood for Ketones	Yes	No

Authorization for the Release of Information:

I hereby give permission for _____ (school) to exchange specific, confidential medical information with _____ (Diabetes healthcare provider) on my child_ _____, to develop more effective ways of providing for the healthcare needs of my child at school

Prescriber Signature_____Date_____

Parent Signature_____Date_____

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Reviewed by
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