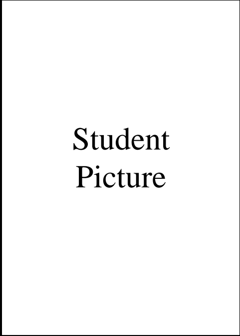
Diabetes Care Plan — Durango School District 9R



Student Name:	Birth Date:
Teacher:	Grade:
Parent/Guardian:	Cell Phone:
Home Phone:	
Other Contact:	Phone:

District Nurse:	Phone:
Physician:	Phone:
Diabetes Educator:	Phone:
Hospital of Choice:	504 Plan on File: ☐Yes ☐No

Student has: ☐Type 1 Diabetes ☐Type 2 Diabetes Date of Diagnosis: _____
Target Blood Glucose Range _____ To _____
Call Parent if Blood Glucose values are below _____ or above _____

Required blood glucose checking at school

- ☐ Trained personnel must perform blood glucose checks
- ☐ Trained personnel must supervise blood glucose checks
- ☐ Student can perform checking independently
- ☐ Student can carry supplies and check where needed

Schedule

Lunch time _____
Scheduled P.E. time _____
Recess time _____
Snack time(s) _____ a.m., _____ p.m.
Location where snacks are kept _____
Location where snacks are eaten _____

Times to check blood glucose

- ☐ Before meals
- ☐ After meals
- ☐ Before snack
- ☐ Before P.E.
- ☐ After P.E.
- ☐ Before getting on bus/going home
- ☐ As needed for signs/symptoms of low/high blood glucose
- ☐ Other list _____

Medications to be given

☐ Oral diabetes medication(s), Type _____	Dose _____	Times to be given _____
☐ Insulin, Type _____	Times to be given _____	
☐ Insulin, Type _____	Times to be given _____	

Dose Insulin according to the following

Insulin to Carbohydrate Ratio: _____ units insulin for every _____grams of carbohydrate eaten

Blood Glucose Correction and Insulin Dosage using Rapid Acting Insulin

Blood Glucose Range	Units Insulin
mg/dl	Units
mg/dl	Units
mg/dl	Units
mg/dl	Units
mg/dl	Units
mg/dl	Units
mg/dl	Units

- ☐ Student independently administers insulin
- ☐ Student self injects with supervision by trained school personnel
- ☐ Student self injects with verification of dosage by trained school personnel
- ☐ Injection should be done by trained school personnel

- ☐ Parent/Guardian authorized to increase or decrease sliding scale +/- 2 units of insulin
- ☐ Parent/Guardian authorized to increase or decrease insulin to carbohydrate count within the following range: 1 unit per +/- 5 grams of carbohydrates

Field Trips and Special Events

- ➢ Staff must notify parent and school nurse in advance so proper training and preparations can be accomplished.
- ➢ Adult staff must be trained and responsible for student's needs on field trip/event.
- ➢ Extra snacks, blood glucose meter, copy of health plan, emergency glucose, and emergency supplies must accompany student.
- ➢ Adults accompanying student on field trip/event will be notified of student's health accommodations on a need to know basis.

Parent Initials________

Student Name _____

➜ Low Blood Glucose – Below _____ mg/dl

Causes:

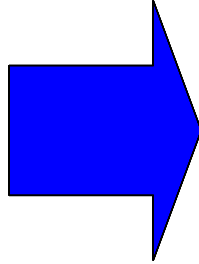
- **Too much insulin**
- **Too much exercise**
- **Too few carbohydrates consumed**
- **High excitement**

Mild Low Blood Glucose

If You See This:

Student is Alert

- Headache
- Sweating, pale
- Shakiness, dizziness
- Tired, falling asleep
- Inability to concentrate
- Poor coordination
- Irritable
- Eyes dilated, glassy



Do This:

- Check blood glucose
- If less than _____ mg/dl, give 15-20gr. carbohydrates:
  - 4-6oz. fruit juice
  - 4-6oz. sugared soda
  - 8-12 Sweetarts® or Smarties® candy
  - 3 peppermints

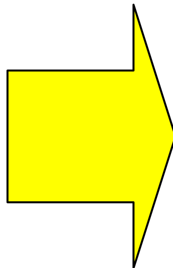
  DO NOT GIVE INSULIN FOR THESE CARBS!
- After 15 minutes, check blood glucose again
- Repeat if necessary until blood glucose is >_____ mg/dl
- Follow with a protein/carbohydrate snack (15-20gr. carbs.), peanut butter & crackers or cheese & crackers
- Remain with student until recovered
- Notify parent/guardian

Moderate Low Blood Glucose

If You See This:

Student is Not Alert

- Severe confusion
- Disorientation
- Not able or unwilling to swallow
- May be combative
- Slurred speech



Do This:

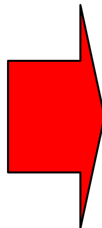
- Check blood glucose
- Keeping head elevated, rub one of the following between cheek and gum:
  - 1 tube Cake Mate®
  - 1 tube instant glucose gel
- After 15 minutes check blood glucose again
- Re-treat if necessary, until blood glucose is >_____ mg/dl
- Follow with a protein/carbohydrate snack (15-20gr. carbs), peanut butter & crackers or cheese & crackers
- Notify parent/guardian
- Remain with student until recovered

Severe Low Blood Glucose

If You See This:

Student is Unconscious

- Unable to swallow
- Seizure
- **GIVE NOTHING BY MOUTH!**



Do This:

- Place student on side (may vomit)
- Inject Glucagon if authorized, prescribed dose _____ mg intramuscular
- Call 911
- Notify parents/guardian & district nurse
- Remain with student until help arrives

Parent Initials_______

Student Name _____

↑ High Blood Glucose – Above _____ mg/dl

Causes

- Illness
- Underestimated carbohydrates or insulin intake
- Excessive exercise without proper insulin
- Bad insulin
- Increased stress

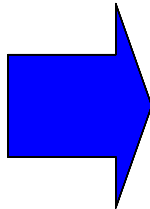
If You See Signs of High Blood Glucose

- Excessive thirst
- Frequent urination
- Hunger
- Nausea, vomiting
- Hyperactivity
- Headache
- Irritable
- Tired
- Abdominal pain
- Fatigue

Check Blood Glucose

If Blood Glucose is:

_____ to _____ mg/dl

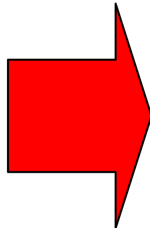


Do This:

- Give correction insulin dose according to scale below
- Encourage increase in fluid intake (6-16oz. water per hour)
- Restrict physical activity until blood glucose is in normal range
- Recheck blood glucose in 2 hours, give another insulin dose if necessary
- Call parent if blood glucose is not in normal range after 2 hours

If Blood Glucose is:

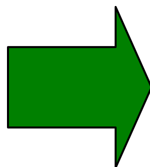
>_____ mg/dl



Do This:

- **Give correction insulin dose according to scale below**
- **Contact parent/guardian**
- Encourage increase in fluid intake (6-16oz. water per hour)
- **No physical activity** until blood glucose is in normal range
- Check ketones, if moderate to large or >0.6 mmol, **call parent immediately!** Student should be sent home for parent to monitor
- Recheck blood glucose in 2 hours, give another insulin dose if needed, call parent if not in normal range

Vomiting, ill, stomachache or lethargic



- Check blood glucose, give correction insulin dose according to scale below if needed
- Check ketones
- **Contact parent, student should be sent home for parent to monitor**

Blood Glucose Range	Units of Insulin
mg/dl	units
mg/dl	units
mg/dl	units
mg/dl	units
mg/dl	units
mg/dl	units
mg/dl	units

Parent Initials___________

Student Name _____

Supplies Needed at School			
Supplies	**Needed**	**Provided**	**Not Needed**
Blood glucose meter and glucose strips	☐	☐	☐
Lancets with lancing device	☐	☐	☐
Blood ketone strips and meter (if using the Precision meter)	☐	☐	☐
Urine ketone strips	☐	☐	☐
Insulin syringes	☐	☐	☐
Antibacterial skin cleaner or alcohol wipes	☐	☐	☐
Bottle of rapid acting insulin, Type: _____	☐	☐	☐
Glucose tabs, Cake Mate® gel, juice, or other source of fast glucose	☐	☐	☐
Protein/Carbohydrate snack	☐	☐	☐
Glucagon Emergency Kit®	☐	☐	☐
Sharps container	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

Signatures

As parent/guardian of the above named student, I give my permission to the school nurse and other designated staff to perform and carry out the diabetes tasks as outlined in this Individual Care Plan and for my child's healthcare provider to share information with the school nurse for the implementation of this plan. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the School Nurse whenever there is any change in the student's health status or care. Parent/guardian and student are responsible for maintaining necessary supplies, snacks, blood glucose meter, medications, and other equipment.

_______________________________________ _________________

Parent/Guardian Signature **Date**

We agree to implement this Individual Care Plan. We reserve the right to withdraw this Care Plan should it become a safety risk or ineffective to the health of the student. At such time the parent will be contacted and the plan will be re-evaluated.

____________________________ ________ ____________________________ ________

School Nurse Signature **Date** **School Health Provider Signature** **Date**

Revised 2/2012