

Diabetic Care Plan

This plan should be completed by the student's personal diabetes healthcare team, including the parents/guardians, and reviewed annually. It is the responsibility of the student's parents to inform the school of their child's diagnosis and supply the school with this care plan. The diabetic care plan should be reviewed with relevant school staff and copies should be kept in a place that can be accessed easily by the school nurse, health coordinator, and other authorized personnel.

Medication and the tasks outlined in this plan may be administered by non-medical personnel. The school will be held harmless for adverse drug reactions and side effects of properly administered medication.

Date of plan: _____ This plan is valid for the current school year: _____ - _____

Student information

Student's name: _____ Date of birth: _____

Date of diabetes diagnosis: _____ Type 1 Type 2 Other: _____

Grade: _____

School Nurse or Health Coordinator: _____ Phone: _____

Contact information

Parent/guardian 1: _____

Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email address: _____

Parent/guardian 2: _____

Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email address: _____

Student's physician/health care provider: _____

Address: _____

Telephone: _____ Emergency number: _____

Email address: _____

Other emergency contacts:

Name: _____ Relationship: _____

Telephone: Home: _____ Work: _____ Cell: _____

Checking blood glucose

Brand/model of blood glucose meter: _____

Target range of blood glucose:

Before meals: 90–130 mg/dL Other: _____

Check blood glucose level:

- Before breakfast After breakfast _____ Hours after breakfast 2 hours after a correction dose
 Before lunch After lunch _____ Hours after lunch Before dismissal
 Mid-morning Before PE After PE Other: _____
 As needed for signs/symptoms of low or high blood glucose As needed for signs/symptoms of illness

Preferred site of testing: Side of fingertip Other: _____

Note: The side of the fingertip should always be used to check blood glucose level if hypoglycemia is suspected.

Student's self-care blood glucose checking skills:

- Independently checks own blood glucose
 May check blood glucose with supervision
 Requires a school nurse or trained diabetes personnel to check blood glucose
 Uses a smartphone or other monitoring technology to track blood glucose values

Continuous glucose monitor (CGM): Yes No Brand/model: _____

Alarms set for: Severe Low: _____ Low: _____ High: _____

Predictive alarm: Low: _____ High: _____ Rate of change: Low: _____ High: _____

Threshold suspend setting: _____

Additional information for student with CGM

- Confirm CGM results with a blood glucose meter check before taking action on the sensor blood glucose level. If the student has signs or symptoms of hypoglycemia, check fingertip blood glucose level regardless of the CGM.
- Insulin injections should be given at least three inches away from the CGM insertion site.
- Do not disconnect from the CGM for sports activities.
- If the adhesive is peeling, reinforce it with approved medical tape.
- If the CGM becomes dislodged, return everything to the parents/guardians. Do not throw any part away.
- Refer to the manufacturer's instructions on how to use the student's device.

Student's Self-care CGM Skills	Independent?	
The student troubleshoots alarms and malfunctions.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The student knows what to do and is able to deal with a HIGH alarm.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The student knows what to do and is able to deal with a LOW alarm.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The student can calibrate the CGM.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The student knows what to do when the CGM indicates a rapid trending rise or fall in the blood glucose level.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

The student should be escorted to the nurse if the CGM alarm goes off: Yes No

Other instructions for the school health team: _____

Hypoglycemia (Low Blood Sugar) Treatment

Student's usual symptoms of hypoglycemia (list below): _____

If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than _____ mg/dL, give a quick-acting glucose product equal to _____ grams of carbohydrate.

Recheck blood glucose in 15 minutes and repeat treatment if blood glucose level is less than _____ mg/dL.

Additional treatment: _____

If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movement):

- Position the student on his or her side to prevent choking.
- Give glucagon: 1mg ½ mg Other (dose) _____
 - Route: Subcutaneous (SC) Intramuscular (IM)
 - Site for glucagon injection: Buttocks Arm Thigh Other: _____
- Call 911 (Emergency Medical Services) and the student's parents/guardians.
- Contact the student's health care provider.

Hyperglycemia (High Blood Sugar) Treatment

Student's usual symptoms of hyperlycemia (list below): _____

- Check Urine Blood for ketones every _____ hours when blood glucose levels are above _____ mg/dL.
- For blood glucose greater than _____ mg/dL AND at least _____ hours since last insulin dose, give correction dose of insulin (see correction dose orders).
- Notify parents/guardians if blood glucose is over _____ mg/dL.
- For insulin pump users: see **Additional Information for Student with Insulin Pump**.
- Allow unrestricted access to the bathroom.
- Give extra water and/or non-sugar-containing drinks (not fruit juices): _____ ounces per hour.

Additional treatment for ketones: _____

- Follow physical activity and sports orders. (See **Physical Activity and Sports**)

If the student has symptoms of a hyperglycemia emergency, call 911 (Emergency Medical Services) and contact the student's parents/guardians and health care provider. Symptoms of a hyperglycemia emergency include: dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy, or depressed level of consciousness.

Insulin therapy

Insulin delivery device: Syringe Insulin pen Insulin pump

Type of insulin therapy at school: Adjustable (basal-bolus) insulin Fixed insulin therapy No insulin

Insulin therapy (continued)

Adjustable (Basal-bolus) Insulin Therapy

- **Carbohydrate Coverage/Correction Dose:** Name of insulin: _____
- **Carbohydrate Coverage:**
 - Insulin-to-carbohydrate ratio:** _____ **Lunch:** 1 unit of insulin per _____ grams of carbohydrate
 - Breakfast:** 1 unit of insulin per _____ grams of carbohydrate **Snack:** 1 unit of insulin per _____ grams of carbohydrate

Carbohydrate Dose Calculation Example
$\frac{\text{Total Grams of Carbohydrate to Be Eaten}}{\text{Insulin-to-Carbohydrate Ratio}} = \text{Units of Insulin}$

Correction Dose: Blood glucose correction factor (insulin sensitivity factor) = _____ Target blood glucose = _____ mg/dL

Correction Dose Calculation Example
$\frac{\text{Current Blood Glucose} - \text{Target Blood Glucose}}{\text{Correction Factor}} = \text{Units of Insulin}$

Correction dose scale (use instead of calculation above to determine insulin correction 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

See the worksheet examples in **Advanced Insulin Management: Using Insulin-to-Carb Ratios and Correction Factors** for instructions on how to compute the insulin dose using a student's insulin-to-carb ratio and insulin correction factor.

When to give insulin:

Breakfast

- Carbohydrate coverage only
- Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.
- Other: _____

Lunch

- Carbohydrate coverage only
- Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.
- Other: _____

Snack

- No coverage for snack
- Carbohydrate coverage only
- Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.
- Correction dose only: For blood glucose greater than _____ mg/dL AND at least _____ hours since last insulin dose.
- Other: _____

Insulin therapy (continued)

Fixed Insulin Therapy Name of insulin: _____

- _____ Units of insulin given pre-breakfast daily
 _____ Units of insulin given pre-lunch daily
 _____ Units of insulin given pre-snack daily
 Other: _____

Parents/Guardians Authorization to Adjust Insulin Dose

- Yes No Parents/guardians authorization should be obtained before administering a correction dose.
 Yes No Parents/guardians are authorized to increase or decrease correction dose scale within the following range: +/- _____ units of insulin.
 Yes No Parents/guardians are authorized to increase or decrease insulin-to-carbohydrate ratio within the following range: _____ units per prescribed grams of carbohydrate, +/- _____ grams of carbohydrate.
 Yes No Parents/guardians are authorized to increase or decrease fixed insulin dose within the following range: +/- _____ units of insulin.

Student's self-care insulin administration skills:

- Independently calculates and gives own injections.
 May calculate/give own injections with supervision.
 Requires school nurse or trained diabetes personnel to calculate dose and student can give own injection with supervision.
 Requires school nurse or trained diabetes personnel to calculate dose and give the injection.

Additional information for student with insulin pump

Brand/model of pump: _____ **Type of insulin in pump:** _____

Basal rates during school: Time: _____ Basal rate: _____ Time: _____ Basal rate: _____
Time: _____ Basal rate: _____ Time: _____ Basal rate: _____
Time: _____ Basal rate: _____

Other pump instructions: _____

Type of infusion set: _____

Appropriate infusion site(s): _____

- For blood glucose greater than _____ mg/dL that has not decreased within _____ hours after correction, consider pump failure or infusion site failure. Notify parents/guardians.
 For infusion site failure: Insert new infusion set and/or replace reservoir, or give insulin by syringe or pen.
 For suspected pump failure: Suspend or remove pump and give insulin by syringe or pen.

Physical Activity

- May disconnect from pump for sports activities: Yes, for _____ hours No
Set a temporary basal rate: Yes, _____% temporary basal for _____ hours No
Suspend pump use: Yes, for _____ hours No

Additional information for student with insulin pump(continued)

Student's Self-care Pump Skills	Independent?	
Counts carbohydrates	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculates correct amount of insulin for carbohydrates consumed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Administers correction bolus	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculates and sets basal profiles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculates and sets temporary basal rate	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Changes batteries	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Disconnects pump	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reconnects pump to infusion set	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prepares reservoir, pod, and/or tubing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Inserts infusion set	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Troubleshoots alarms and malfunctions	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other diabetes medications

Name: _____ Dose: _____ Route: _____ Times given: _____
 Name: _____ Dose: _____ Route: _____ Times given: _____

Meal plan

Meal/Snack	Time	Carbohydrate Content (grams)
Breakfast		_____ to _____
Mid-morning snack		_____ to _____
Lunch		_____ to _____
Mid-afternoon snack		_____ to _____

Other times to give snacks and content/amount: _____

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event): _____

Special event/party food permitted: Parents'/Guardians' discretion Student discretion

Student's self-care nutrition skills:

- Independently counts carbohydrates
- May count carbohydrates with supervision
- Requires school nurse/health coordinator to count carbohydrates

Physical activity and sports

A quick-acting source of glucose such as glucose tabs and/or sugar-containing juice must be available at the site of physical education activities and sports.

Student should eat 15 grams 30 grams of carbohydrate other: _____

before every 30 minutes during every 60 minutes during after vigorous physical activity other: _____

If most recent blood glucose is less than _____ mg/dL, student can participate in physical activity when blood glucose is corrected and above _____ mg/dL.

Avoid physical activity when blood glucose is greater than _____ mg/dL or if urine/blood ketones are moderate to large.

(See **Administer Insulin** for additional information for students on insulin pumps.)

Disaster plan

To prepare for an unplanned disaster or emergency (72 hours), obtain emergency supply kit from parents/guardians.

Continue to follow orders contained in this DMMP.

Additional insulin orders as follows (e.g., dinner and nighttime): _____

Other: _____

Signatures

This Diabetic Care Plan has been approved by:

Student's Physician/HealthCare Provider

Date

I, (parent/guardian) _____ acknowledge that medication and the tasks outlined in this Diabetic Care plan may be administered by non-medical personnel. I give permission for school and its designated employee (school nurse/health coordinator) to perform and carry out the diabetes care tasks as outlined in (student) _____ Diabetic Care Plan. The school, (school) _____, and its employees will be held harmless for adverse drug reactions and side effects of properly administered medication. I also consent to the release of the information contained in this Diabetic Care Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or school health coordinator to contact my child's physician/healthcare provider.

Acknowledged and received by:

Student's Parent/Guardian

Date

Student's Parent/Guardian

Date

School Representative (Principal, Nurse or Health Coordinator)

Date