

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 _____

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

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

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

$\frac{\text{Carbohydrates To Eat}}{\text{Carbohydrate Ratio}} = \text{Units of Insulin (A)}$

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

OR

$\frac{\text{Current BG/SG} - \text{Target BG}}{\text{Amount to Correct}} \div \text{Correction Factor} = \text{Units of Insulin (B)}$
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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	School Assistance
Blood Glucose Monitoring		
Carbohydrate Counting		
Selection of snacks and meals		
Insulin Dose calculation		
Insulin injection Administration		
Treatment for mild hypoglycemia		
Test Urine/Blood for Ketones		

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 _____



Rev. 10/2019 Reviewed by
 Drs Carly Wilbur & Jamie Wood