

Student: _____ DOB: _____ School: _____ Grade: _____

Type _____ Diabetes/Year Diagnosis: _____ This plan is only valid for the current school year: _____

Trained School Diabetes Care Providers: _____, _____

- Test Blood Sugar:** Before Breakfast Before Lunch 2 hours after lunch Before Exercise
 After Exercise Before Snack Before getting on the bus
 As needed for signs/symptoms of low or high blood sugar

INSULIN ADMINISTRATION:

Route: Pen Injection Pump – Type _____

If pump failure, use sliding scale

Insulin Type: Lantus: _____ units daily at _____

Insulin Type: For Sliding Scale insulin dosage and blood sugar correction. ONLY to be used every 2 hours

Humalog Novolog Apidra

Parent/guardian authorized to increase/decrease sliding scale within the following range: +/- 2 units of insulin

If blood sugar is greater than 300 mg/dl, check ketones

Blood Sugar Range _____ mg/dl Administer _____ units

INSULIN/CARBOHYDRATE RATIO:

- Breakfast: 1 unit of insulin per _____ grams of carbohydrate
- Mid-Morning Snack: 1 unit of insulin per _____ grams of carbohydrate
- Lunch: 1 unit of insulin per _____ grams of carbohydrate
- Afternoon Snack: 1 unit of insulin per _____ grams of carbohydrate

Parent/guardian authorized to increase or decrease insulin to carbohydrate ratio within the following range: 1 unit prescribed grams of carbohydrates +/- 5 grams of carbohydrates

STUDENTS SELF CARE:

Totally independent management. Yes No

Self-injects with trained staff supervision. Yes No

Test blood sugar independently. Yes No

Injections to be done by trained staff. Yes No

Test and interprets urine/blood ketones. Yes No

Self treats mild hypoglycemia Yes No

Needs verification of blood sugar by staff Yes No

Monitors own snacks and food Yes No

Administers insulin independently Yes No

Independently counts carbohydrates Yes No

Self-injects with verification of dose Yes No

SIGNATURES:

Parent: _____

Date: _____

Physician: _____

Date: _____

Physician Phone: _____ Fax: _____

School Health Nurse Review: _____ Date: _____

Please return this form to your child's school nurse.

Student: _____ DOB: _____ School: _____ Grade: _____
Type _____ Diabetes/Year Diagnosis: _____ This plan is only valid for the current school year: _____

IF STUDENT IS SENT TO THE HEALTH ROOM, AN ESCORT MUST ACCOMPANY THEM.

HYPOGLYCEMIA: BLOOD SUGAR LESS THAN 80mg/dl

Signs and symptoms of hypoglycemia:

- Dizziness
- Shaking
- Anxiety
- Hunger
- Blurry Vision
- Weakness/fatigue
- Headache
- Behavior Changes
- Pallor
- Loss of consciousness
- Seizure

1. Check blood sugar. If meter is not available and child has any of the above symptoms, proceed to step 2.
2. If blood sugar is less than 80 mg/dl: Treat with 15 grams of fast acting carbohydrate (4 oz juice, 6 oz regular soda, 3-4 glucose tablets, 3-4 pieces of hard candy, 3 tsp of sugar, etc.)
3. **If unable to swallow safely, administer 1 tube of glucose gel to inside of cheek.**
4. Recheck and retreat every 15 minutes until blood sugar is greater than 80 mg/dl.
5. When blood sugar is above 80 mg/dl give a complex carbohydrate (crackers with cheese, granola bar, trail mix etc.) if it is going to be more than an hour until next meal or snack.
6. If unable/unwilling to take fast acting carbohydrate, having seizures, or is unconscious: Administer Glucagon by trained staff, call 911, and contact parent/guardian.

If student has an insulin pump, suspend or remove pump.

HYPERGLYCEMIA: BLOOD SUGAR GREATER THAN 300mg/dl

Signs and symptoms of hyperglycemia

- Increase thirst
- Frequent urination
- Hunger
- Fatigue
- Irritability
- Double Vision
- Nausea/Vomiting
- Abdominal pain

1. Check blood sugar.
2. If blood sugar is over 300 mg/dl and greater than 2 hours since last insulin dose, give insulin per sliding scale or bolus via pump.
3. **Check ketones.** If ketones are present, call parents. **STUDENT SHOULD NOT EXERCISE.**
4. Give 8-16 oz of water per hour.
5. Recheck blood sugar in 2 hours and treat with sliding scale insulin as needed. **See below for pump.*
6. When having symptoms of nausea and vomiting student will be released from school to parent/guardian.

***When student has insulin pump:**

Blood sugar greater than 300 mg/dl with ketones or 2 consecutive unexplained blood sugars greater than 300 mg/dl (with or without ketones), may indicate a malfunction in the pump. Student may require insulin via injection and/or new infusion site. **PARENTS MUST BE NOTIFIED.**

SIGNATURES

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations and may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse.

I authorize the Diabetes Care Team to notify me/leave message via

Voice mail Text Email: Cell Phone: _____

Parent signature: _____ Date: _____ Alternate Phone/Emergency Contact: _____

School Health Nurse Review: _____ Date: _____

Please return this form to your child's school nurse.