ROCKFORD PUBLIC SCHOOLS
Diabetes Care Plan

Date ___________
Student name ___________________________________ Date of birth _____________
School ____________________ Grade _______ Teacher ___________________________
Parent(s)/Guardian(s) ______________________________
Phone: Home __________________ Work ____________________ Other____________________
Additional emergency contact information ____________________________
Diabetes Care Provider: Helen DeVos Children's Hospital, Pediatric Endocrinology
Dr. ____ Emergency phone: 1-866-940-7073 Fax 616-391-6240
Diabetes Nurse Educator: Helen DeVos Children's Hospital, Diabetes education Non-emergency phone 616-391-3933 Fax: 616-391-6240
Hospital of choice ____

Routine Management
Target blood Sugar Range _______to ____________before meals
Parent(s)/Guardian(s) and student are responsible for maintaining supplies, snacks, testing kit, medications and equipment.

REQUIRED BLOOD SUGAR/KETONE TESTING AT SCHOOL

- ☐ Trained personnel must perform blood sugar and ketone tests
- ☐ Trained personnel must supervise blood sugar and ketone tests
- ☐ Student can perform testing independently
- ☐ Treat as directed if blood sugars are below ☐ 70 ☐ 80 ☐ 70-80 with symptoms
- ☐ Test ☐ Urine ☐ Blood ketones when blood sugar is over 240 mg/dl or not feeling well
- ☐ Call parent if ketones present

TIMES TO DO BLOOD SUGAR

- ☐ Before lunch
- ☐ Before Physical Education
- ☐ After Physical Education
- ☐ As needed for signs/symptoms 0f low or high blood sugar

MEDICATIONS TO BE GIVEN DURING SCHOOL HOURS

- ☐ Parents are to inform school in writing of any medication dose change
- ☐ Oral diabetes medication(s): Type/dose ______________________________ Time to be administered __________
- ☐ **INSULIN**

To Be Administered Immediately: ☐ **Before Breakfast** ☐ **Before Lunch** ☐ **Other** _______
Insulin using (check type) ☐ Humalog ☐ Novolog ☐ Regular

☐ **Sliding scale:**
______ unit(s) if lunch blood sugar is between ______and ______
______ unit(s) if lunch blood sugar is between ______and ______
______ unit(s) if lunch blood sugar is between ______and ______
______ unit(s) if lunch blood sugar is between ______and ______

☐ Insulin ratios: ______Unit for every ______grams of carbohydrate eaten, plus ______ unit(s) for every ______mg/dL point's above______mg/dL

- ☐ Other insulin type, dose and when to administer _______
- ☐ Student can draw up and inject own insulin ☐ Student cannot draw up own insulin but can give own injection
- ☐ Trained adult will draw up and administer injection ☐ Student can draw up but needs adult to inject insulin
- ☐ Student on pump ☐ Assist/Supervise ☐ Independent ☐ Student needs assistance checking insulin dosage

☐ Glucagon (subcutaneous injection) dosage; dosage = ______mg. (refer to "How to use glucagon for a child with severly low blood sugar")

DIET
Lunch time ______ Scheduled Physical Education time ______ Recess time(s) ______
Snack time(s)______ a.m. ______p.m. Location that snacks are kept______ Location eaten ______

- ☐ Child needs assistance with prescribed meal plan (see attached). ☐ Give exercise snack to be given before Phy. Ed
- ☐ Do not give insulin for carbohydrates taken to treat a low blood sugar or for an exercise snack

FIELD TRIP INFORMATION

1. Notify parent and school nurse in advance so proper training can be accomplished
2. Adult staff must be trained and responsible for student's needs on field trip
3. Extra snacks, glucose monitoring kit, copy of health plan, glucose gel or other emergency supplies must accompany student
4. Adults accompanying student on a field trip will be notified on a need to know basis

PEOPLE TRAINED FOR BLOOD TESTING, RESPONSE AND MEDICATION ADMINISTRATION
Date __________ Name ______________________________ Date ___________ Name __________________________________

PERMISSION SIGNATURES
As parent/guardian of the above named student, I give permission for use of this health plan in my student's school and for the school nurse to contact the above providers regarding the above condition. Orders are valid through the end of the current school year.

Date _____________ Parent's signature____

Date _____________ Time _________ School nurse's signature Andrea St. Charles RN, BSN

Date _____________ Time _________ Physician's signature ____