

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

TIMES TO DO BLOOD SUGAR

- | | |
|---|---|
| <input type="checkbox"/> Trained personnel must perform blood sugar and ketone tests | <input type="checkbox"/> Before lunch |
| <input type="checkbox"/> Trained personnel must supervise blood sugar and ketone tests | <input type="checkbox"/> Before Physical Education |
| <input type="checkbox"/> Student can perform testing independently | <input type="checkbox"/> After Physical Education |
| <input type="checkbox"/> Treat as directed if blood sugars are below <input type="checkbox"/> 70 <input type="checkbox"/> 80 <input type="checkbox"/> 70-80 with symptoms | <input type="checkbox"/> As needed for signs/symptoms
Of low or high blood sugar |
| <input type="checkbox"/> Test <input type="checkbox"/> Urine <input type="checkbox"/> Blood ketones when blood sugar is over 240 mg/dl or not feeling well | |
| <input type="checkbox"/> Call parent if ketones present | |

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 severely 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 *Kelly Theaker RN, BSN, CEN*

Date _____ Time _____ Physician's signature _____