

PLAN OF CARE - DIABETES

Name: _____ Grade: _____ Age: _____
Last Name First MI

School: _____ Year of Diagnosis: _____

Parent/Guardian Name: _____ Phone (H) _____

Address: _____ Phone (W) _____

Parent/Guardian Name: _____ Phone (H) _____

Address: _____ Phone (W) _____

Emergency Phone Contact #1: _____
Name Relationship Phone

Emergency Phone Contact #2: _____
Name Relationship Phone

Physician Student Sees for Diabetes: _____ Phone: _____

Other Physician: _____ Phone: _____

ALLERGIES: (Food, Medication, etc) _____

Student wears a diabetic identification bracelet or necklace: YES _____ NO _____

Insulin Pump: YES _____ NO _____ Blood Glucose Target Range: _____

Current Insulin Treatment:

Student will inject insulin at school: YES _____ NO _____
 Student will self-prepare and inject: YES _____ NO _____
 Student needs assistance with injection: YES _____ NO _____

Types of Insulin Dose and Time:

Pre-Breakfast _____ Lunch _____ Supper _____
 Bedtime _____

Meals/Snacks Times:

Breakfast _____ Snack _____ Lunch _____ PM snack _____
 Dinner _____ Bedtime snack _____

Student will generally bring one of the following for snack:

Exercise/Sport Activity:

Student may participate in regular PE classes YES _____ NO _____
 Student may participate in after-school sports YES _____ NO _____

Student carries _____ for treatment of Low Blood Glucose.

A snack will be eaten if blood glucose is under _____. Exercise should be delayed if blood glucose is higher than _____ or lower than _____.

Blood glucose monitoring:

Name of Monitor/Meter: _____

Student is able to perform self blood glucose testing: YES____ NO____
Student needs assistance to test: YES____ NO____

Student monitors blood glucose BEFORE: _____Breakfast _____Before Exercise
_____Lunch _____After Exercise
_____Supper _____Before AM Snack
_____Bedtime _____Before PM Snack

TREATMENT OF HIGH BLOOD SUGARS

1. If blood glucose is over _____, check urine for Ketones.
2. Give sugar-free liquids (such as water): _____ounces per hour if Ketones are present.
3. Contact parent:
 - * If Ketones are positive and blood glucose is over _____.
 - * If child is vomiting with blood glucose higher than 400.

Comments / Special Instructions: _____

Notify parent if _____

TREATMENT OF LOW BLOOD SUGARS

Symptoms student has experienced when having a low blood glucose: _____

Signs and Symptoms of Low Blood Sugar:

- | | | |
|--------------|-----------------------------|--------------|
| A. Trembling | B. Shakiness | C. Sweaty |
| D. Pale | E. Weak | F. Dizzy |
| G. Headache | H. Incoherent (as if drunk) | I. Irritable |
| J. Confused | K. Restless | L. Combative |

Treatment for conscious student with Low Blood Sugar who is able to swallow:

1. Administer IMMEDIATELY sugar source such as:
 - * 3 glucose tablets * ½ cup fruit juice * 6oz regular soda
 - * 1 fruit roll up * 8 life savers * ½ candy bar
 - * 2 tablespoons cake frosting from tube
 - * glucose gel placed between cheek and side of gum
2. If symptoms do not improve in 15-20 minutes, repeat treatment.
3. Notify parent of low blood glucose treatment given if _____

Comments / Special Instructions: _____

Treatment for student with Low Blood Sugar who is unconscious or unable to swallow:

1. Administer Glucagon Injection YES____ NO____
2. Test blood glucose every 10 minutes
3. Notify parent of low blood glucose
4. Contact **911** if child remains unresponsive 15 minutes after Glucagon
5. **DO NOT** give liquids to drink while unresponsive

Comments / Special Instructions: _____

Physician Signature

Date

Parent Signature

Date