Diabetes Health Care Plan for Insulin Administration via Syringe or Pen

School: 
Start Date: 
End Date: 
Name: 
Grade/ Homeroom: 
Teacher: 

Transportation: 
L. Bus  
J. Car  
Van  
- Type 1  
L. Type 2  

Parent/ Guardian Contact: Call in order of preference

<table>
<thead>
<tr>
<th>Name</th>
<th>Telephone Number</th>
<th>Relationship</th>
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<tbody>
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Prescriber Name: Phone: Fax: 

Blood Glucose Monitoring: 
Meter Location: 
Student permitted to carry meter: Yes  No 

Testing Time: 
Before Breakfast/Lunch  
1-2 hours after lunch  
Before/after snack  
Before/after exercise  

Snacks:
- Please allow a ______ gram snack at ________ before/after exercise 
Snacks are provided by parent/guardian and are located in ________

Treatment for Hypoglycemia/Low Blood Sugar

If student is showing signs of low blood sugar or if blood sugar is below ______mg/dl

- Treat with 10-15 grams of quick-acting glucose:
  - 4oz 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: Give Glucagon Yes No

  - Amount of Glucagon to be administered: ______mg(s) IM, SC, and call 911 and parents

- 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 ______mg/dl  Notify parent/guardian if ketones are moderate to large
  - Notify parent/guardian for blood sugar over ______mg/dl

- 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
Insulin

Insulin is administered via: □ Vial/Syringe □ Insulin Pen

Can student draw up correct dose, determine correct amount and give own injections?

□ Yes  □ No  □ Needs supervision (describe)

Insulin Administration:

□ Not taking insulin at school

Insulin Type: ____________________ Student permitted to carry insulin & supplies: □ Yes  □ No

Flexible Insulin Dose mealtime dose:

Insulin to Carbohydrate Ratio _____ units/s per _____ # grams

Give _____ units per _____ grams
Give _____ units per _____ grams
Give _____ units per _____ grams
Give _____ units per _____ grams

ADD: Insulin to carbohydrate ratio dose and Correction/Adjustment scale dose

Correction/Adjustment Scale _____ units/s per _____ over _____ mg/dl

If blood glucose is _____ to _____ mg/dl Give _____ units
If blood glucose is _____ to _____ mg/dl Give _____ units
If blood glucose is _____ to _____ mg/dl Give _____ units
If blood glucose is _____ to _____ mg/dl Give _____ units

Other:

Give mealtime dose:  ” before meals  ” immediately after meals

□ Parental authorization should be obtained before administering a correction dose for high blood glucose level (excluding mealtime) □ Yes  □ No

□ Parents are authorized to adjust the insulin dosage +/- by _____ units for the following reasons:
□ Increase/Decrease Carbohydrate  □ Increase/Decrease Activity  □ Parties  □ Other

<table>
<thead>
<tr>
<th>Student self-care task</th>
<th>Independent</th>
<th>School Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Glucose Monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carbohydrate Counting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selection of snacks and meals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insulin Dose calculation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insulin injection Administration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment for mild hypoglycemia</td>
<td></td>
<td></td>
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<tr>
<td>Test Urine/Blood for Ketones</td>
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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 __________________________

Reviewed by Dr. Carly Wilbur

April 2019

University Hospitals

Diabetes Page 9