Diabetes Health Care Plan for Insulin Administration via Syringe or Pen

Student Photo

School:_____

Start Date: _____ End Date: _____

Name_____ Grade/ Homeroom ____ Teacher_____

Transportation: L Bus ⊥ Car _Van _ Type 1 L Type 2

Parent/ Guardian Contact: Call in order of preference

	Name	*Telephone Number*	*Relationship*
1.			
2.			
3.			

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 | Before recess Before bus ride | **Always** check when student is feeling high, low and during illness Other_____

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**

Signs of Low Blood Sugar
personality change, feels funny, irritability, inattentiveness, tingling sensations headache, hunger, clammy skin, dizziness, drowsiness, slurred speech, seeing double, pale face, shallow fast breathing, fainting

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

Name:_____

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 _____unit/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_____ unit/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_____

Student self-care task	Independent	School Assistance
Blood Glucose Monitoring		
Carbohydrate Counting		
Selection of snacks and meals		
Insulin Dose calculation		
Insulin injection Administration		
Treatment for mild hypoglycemia		
Test Urine/Blood for Ketones		

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

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University Hospitals