



Optional Student Photo

DIABETES CARE PLAN- Daily Insulin Injections Side 1
TO BE COMPLETED BY HEALTHCARE PROVIDER

EFFECTIVE DATE:	END DATE:
STUDENT'S NAME:	Date of Birth:

ALLERGIES:

DIABETES HEALTHCARE PROVIDER INFORMATION Name: _____
 Phone #: _____ Fax #: _____

SCHOOL: _____ / Grade _____ School Fax: _____

Monitor Blood Glucose – test ... (reference Hypo/Hyperglycemia treatment protocol for BG < 70 and BG ≥ 250)

If student has symptoms of high or low blood glucose

Breakfast Before After Exercise /PE/gym/recess: Before After

Lunch: Before After Before leaving school

Snack: Before After Other: _____

Where to test: Classroom Health office Other: _____

Without moving student if has low blood glucose symptoms

Continuous Glucose Monitoring: Type of CGM: _____

Student may use reading from CGM for: Insulin dosing End of day check Before activity check

Perform a finger stick: Blood glucose is rapidly changing when dosing insulin To confirm hypoglycemia

Hyperglycemia Calibrations Other: _____

Routine Daily Insulin Injection:

Insulin Delivery: Syringe/vial Pen Smart Pen

Insulin Type: rapid acting (Insulin Lispro/Insulin Aspart/FIASP) other: _____

Step 1. BLOOD GLUCOSE CORRECTION

USE THE FOLLOWING PARAMETERS TO CALCULATE CORRECTION DOSE Use correction scale

Target blood glucose: _____ mg/dL **Insulin sensitivity factor:** _____

(Current Blood Glucose – Target Blood Glucose) = _____ Units of Insulin

Insulin Sensitivity Factor

When to give correctional insulin:

Before breakfast Before lunch Other: _____

All BG/SG results to be entered into the Smart Pen to determine dosing.

Do not give correction dose more than once every 3 hours.

Glucose range	Insulin Units
mg/dL	
mg/dL	
mg/dL	
mg/dL	
mg/dL	
mg/dL	
mg/dL	

Step 2. CARBOHYDRATE COVERAGE

Bolus Meal Insulin: Before eating or After eating

If BG <70 before a meal, treat with carbohydrate per algorithm for blood glucose results. USE

THE FOLLOWING PARAMETERS TO CALCULATE CARBOHYDRATE COVERAGE DOSE

BREAKFAST 1 unit of insulin per _____ grams of carbohydrate

LUNCH 1 unit of insulin per _____ grams of carbohydrate **AM**

SNACK 1 unit of insulin per _____ grams of carbohydrate **PM**

SNACK 1 unit of insulin per _____ grams of carbohydrate

Total Grams of Carbohydrates to Be Eaten = _____ Units of Insulin

Insulin-to-Carbohydrate Ratio

When to give carbohydrate coverage insulin:

Breakfast Lunch Snack Special Occasions Other: _____

DIABETES CARE PLAN- Daily Insulin Injections Side 2

Optional
Student
Photo

TO BE COMPLETED BY HEALTHCARE PROVIDER

STUDENT NAME: _____ Date of Birth _____

Step 3. MEALTIME TOTAL INSULIN DOSE

Blood Glucose Correction + Carbohydrate Coverage= Insulin Dose

Round doses to the nearest: Half unit Whole unit

MEDICATION	Frequency	DOSE	ROUTE	NOTES
<input type="checkbox"/> Tresiba/Lantus	Once daily at	_____ units	Subcutaneous	Injection to be witnessed or performed by the nurse or trained person.
<input type="checkbox"/>				
<input type="checkbox"/> PRN Glucagon	PRN Severe Hypoglycemia	<input type="checkbox"/> 1 mg <input type="checkbox"/> 0.5 mg	IM or SC Injection	Administration site includes buttocks, arm, or thigh by the nurse or trained person.

Exercise and Sports

A quick-acting source of glucose such as glucose tabs or sugar-containing juice should be available at the site of physical activity or sports.

Do not exercise with moderate to large ketones per hyperglycemia protocols.

Student should monitor blood glucose hourly.

Student should eat _____ **grams of carbohydrates:**

Before Every 30 minutes during Every 60 minutes during After vigorous activity

If pre-exercise blood glucose is less than _____ **mg/dL**, student can participate in physical activity once blood glucose is corrected and above _____ **mg/dL**.

If pre-exercise blood glucose is less than _____ **mg/dL**, student can participate in physical activity once they consume a ___ gram snack with protein.

If student is to exercise right after lunch, student should subtract ___ gm from their carbohydrate count.

Parent/Guardian Authority to Adjust Insulin Dose

Dose adjustment allowed up to 20% higher or lower Yes No

HCP Assessment of Student's Diabetes Management Skills:

Skill	Independent	Needs Supervision*	Cannot do
Check blood glucose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Count carbohydrates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calculate insulin dose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Troubleshoot CGM alarms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*The RN or other trained staff is expected to observe for accuracy & completion of the skill.

- **For blood glucose \geq 250 mg/dL, repeat blood glucose check in 2 hours. If blood glucose remains \geq 250 mg/dL, check urine ketones and refer to Hyperglycemia Treatment Protocol.**
- **Check ketones with signs of illness including abdominal pain, upset stomach and vomiting.**
- **For blood glucose less than 70 mg/dL, refer to the Hypoglycemia Treatment Protocol.**

Other health concerns:

Notes:

MEDICAL PROVIDER WITH PRESCRIPTIVE AUTHORITY IN ALASKA (PRINTED)	TELEPHONE NUMBER
MEDICAL PROVIDER SIGNATURE AND CREDENTIALS	DATE

STUDENT'S NAME:

Student's usual **LOW** blood glucose symptoms:

- _ Shaky or jittery
- _ Sweaty
- _ Hungry
- _ Pale
- _ Headache
- _ Blurry vision
- _ Sleepy
- _ Dizzy
- _ Uncoordinated
- _ Irritable, nervous
- _ Argumentative
- _ Combative
- _ Changed personality
- _ Changed behavior
- _ Unable to concentrate
- _ Weak, lethargic

ALGORITHMS FOR BLOOD GLUCOSE RESULTS

CHECK BLOOD GLUCOSE

Student's usual **HIGH** blood glucose symptoms:

- Hyperglycemia**
 - _ Increased thirst, dry mouth
 - _ Frequent or increased urination
 - _ Change in appetite, nausea
 - _ Blurry vision
 - _ Fatigue
 - _ Other
- Emergency levels**
 - _ Extreme thirst
 - _ Nausea, vomiting
 - _ Severe abdominal pain
 - _ Fruity breath
 - _ Heavy breathing, shortness of breath
 - _ Increasing sleepiness, lethargy

BELOW 70

1. Give 15 gm fast-acting carbohydrate
2. Observe for 15 minutes then retest blood glucose.
 - a. If less than 70, repeat 15 gm carbohydrate and retest in 15 min.
 - b. If over 70 and not eating a meal within an hour, give carbohydrate and protein snack without insulin coverage.
3. Notify school nurse and parent if no improvement.
4. Student should not exercise.

CALL 911 if student becomes unconscious, seizures or is unable to swallow

- o Turn student on side to ensure open airway
- o Give glucagon as ordered. Keep student in recovery position on side.
- o If on insulin pump, either place it in 'suspend' or stop mode, disconnect it at the pigtail or clip, or cut tubing. If pump was removed, send it with EMS to the hospital.
- o Notify school nurse, parent and HCP
- o Wait 15 minutes; if no response, repeat glucagon.
 - o If responsive, offer juice. Wait 15 minutes and give protein & carbohydrate snack.

70 - 90

1. If prior to exercise or immediately following strenuous activity and **NO** meal/snack is planned within 30 minutes, give 15 gm carbohydrate and protein snack.
2. If **NOT** exercise-related and student is symptomatic, observe and recheck in 15 minutes.
3. If **NOT** exercise-related and is **NOT** symptomatic, return to class.

15 GM FAST-ACTING CARBOHYDRATE =

- ½ c. juice
- 3-4 glucose tablets
- Tube of glucose gel
- ½ c. regular (not diet) soda
- 6-7 small sugar candies (to chew)
- 1 c. skim milk

Do not give chocolate

EXERCISE AND SPORTS

- ✓ Assure has quick access to water for hydration, fast-acting carbohydrates, snacks and monitoring equipment.
- ✓ Student should not exercise if blood glucose level is below 70 mg/dl or if has moderate to large ketones.

Never send a child with suspected low blood glucose anywhere alone.

91-125

Student may eat before exercising or recess.

126-300

No action needed.

STUDENT TREATED BY INJECTION

1. Use correction scale or formula at lunch or every 2-3 hours
2. Check ketones if symptoms or if blood glucose > 250 twice in a row:
 - a. If ketones are absent or small, encourage exercise and water
 - b. If ketones moderate or large:
 - No exercise; give water
 - Add units of insulin per orders
3. Notify school nurse and parent
4. **Provide free, unrestricted access to water and the restroom.**

ABOVE 250

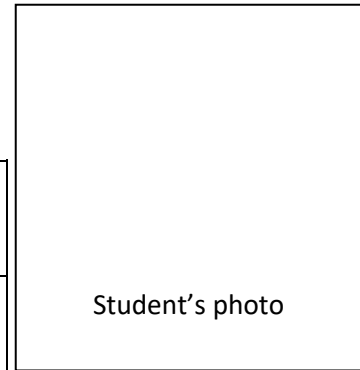
STUDENT TREATED BY PUMP

1. If 2-3 hours since last bolus, treat with correction bolus via pump. Re-check in 2-3 hrs. Trouble shoot pump function.
 - Check for redness at site, tubing for kinks or air bubble, insulin supply
2. If blood glucose still \geq 250 mg/dl and not explained, check ketones:
 - a. If ketones are absent or small, encourage exercise and water
 - b. If ketones moderate or large:
 - Give insulin correction dose per orders via syringe.
 - No exercise; encourage water
3. Change infusion set or continue insulin injections every 2-3 hours via syringe.
4. Notify school nurse and parent
5. **Provide free, unrestricted access to water and the restroom.**

CALL 911 if the student vomits, becomes lethargic and/or has labored breathing. Notify school nurse, parent and HCP.

INDIVIDUALIZED HEALTHCARE PLAN - DIABETES

SCHOOL AND PARENT PART



STUDENT'S NAME:			PLAN EFFECTIVE DATE:		
<i>Diabetes information</i> Date of Diagnosis: <input type="checkbox"/> Diabetes Type 1 <input type="checkbox"/> Diabetes Type 2 <input type="checkbox"/> Other					
SCHOOL INFORMATION					
Grade: _____		Teacher: _____		504 plan on file: <input type="checkbox"/> Yes <input type="checkbox"/> No	
CONTACT INFORMATION:					
Parent/Guardian 1:		Name _____ Call first <input type="checkbox"/>			
Phone numbers:	Home _____	Work _____	Cell _____	Other _____	
Parent/Guardian 2:		Name _____ Call first <input type="checkbox"/>			
Phone numbers:	Home _____	Work _____	Cell _____	Other _____	
Other/emergency:		Name: _____		Relationship: _____	
Phone numbers:	Home _____	Work _____	Cell _____	Other _____	
Additional Times to Contact Parent...			Student treated by pump:		
Student treated by injection <input type="checkbox"/> Blood Glucose test out of target range <input type="checkbox"/> Routine Daily Insulin injections <input type="checkbox"/> Correction dose			<input type="checkbox"/> Blood Glucose test out of target range <input type="checkbox"/> Carbohydrate bolus <input type="checkbox"/> Correction bolus <input type="checkbox"/> Infusion set comes out/needs to be replaced		
STUDENT DIABETES SELF-MANAGEMENT PLAN					
Student will manage diabetes independently <input type="checkbox"/> Student has signed Agreement for Student Independently Managing Diabetes		Trained staff will supervise student self-care <input type="checkbox"/> Verify blood glucose test <input type="checkbox"/> Check carbohydrate count <input type="checkbox"/> Confirm dose <input type="checkbox"/> Supervise insulin self-injection <input type="checkbox"/> Monitor bolus administration <input type="checkbox"/> Trouble shoot pump alarms, malfunction <input type="checkbox"/> Watch infusion set change		Trained staff will provide care <input type="checkbox"/> Test blood glucose <input type="checkbox"/> Count carbohydrates <input type="checkbox"/> Calculate insulin dose and inject as above <input type="checkbox"/> Provide insulin injection <input type="checkbox"/> Administer bolus <input type="checkbox"/> Trouble shoot pump alarms, malfunction <input type="checkbox"/> Change infusion set	
Comment: _____					
FOOD PLAN		Time	Notes	Monitor/Remind Student	Food at a classroom/school party: <input type="checkbox"/> Student will eat treat <input type="checkbox"/> Replace the treat with a parent-supplied alternative <input type="checkbox"/> Put in baggie to take home with teacher note <input type="checkbox"/> Student should not eat treat <input type="checkbox"/> Modify the treat as follows:
				Yes No	
Breakfast					
Morning snack					
Lunch					
Afternoon snack					
Extra snack		Before exercise			
		After exercise			
BUS TRANSPORTATION PLAN					
Bus transportation: <input type="checkbox"/> To school <input type="checkbox"/> Home				<input type="checkbox"/> Student may test blood glucose and self-manage diabetes while on the bus.	
<input type="checkbox"/> Test blood 10-20 minutes before boarding school bus home. Student must have blood glucose > 70 mg/dl to board bus ; if ≤ 70, provide care based on algorithm and call to have student picked up. <input type="checkbox"/> Blood test not required.					
FIELD TRIPS					
<input checked="" type="checkbox"/> School nurse to be notified two weeks before the field trip to assure qualified personnel are available. <input type="checkbox"/> All diabetes supplies are taken and care is provided according to this Plan (copy to accompany trip). <input type="checkbox"/> Lunch and snack times should not change.					
SCHEDULED AFTER- OR BEFORE-SCHOOL ACTIVITIES					
List of clubs, sports, etc. that student anticipates: _____					

If parent wants trained staff coverage for an activity, parent will notify school nurse two weeks before it begins

STUDENT'S NAME:

PLAN EFFECTIVE DATE:

Means student uses this item **AND** parent will provide.

SUPPLY LIST

Blood Glucose Test Kit

- Meter
- Test strips
- Lancing device and lancet

- Sharps container
- Anti-bacterial cleaner/alcohol swabs

- cotton balls
- spot band-aids

Glucose meter brand/model: _____

Insulin

Treatment by Injection

- Insulin pen
- Pre-filled syringes (labeled per dose)
- Insulin vials and syringes

Treatment by Pump

- Pump syringe
- Pump tubing/needle
- Batteries
- Tape
- Sof-serter
- Insulin vial and syringes

Infusion set type: _____

Pump type

- Medtronic MiniMed www.minimed.com (800) 826-2099
- Animas www.animas.com (877) 767-7373
- Omnipod www.myomnipod.com (800) 591-3455

Low Blood Glucose (5-day supply)

- Fast-acting carbohydrate drink (apple juice, orange juice, regular soda pop – NOT diet), ≥ 6 containers
- Pre-packaged snacks (e.g., crackers with cheese or peanut butter, nite bite), ≥ 5 servings
- Supply of fast-acting glucose at least equal to 15 gm per day for 5 days (e.g., ≥ 75 gm total)

Glucagon Kit

High Blood Glucose

- Urine ketone test strips/bottle
 - Urine cup
 - Water bottle
- (Timing device may be wall clock or watch)

3-day Disaster Kit

- Complete daily insulin dose schedule (separate page)
- Blood glucose test kit (testing strips, lancing device, lancets, meter batteries)
- Vial of insulin and 6 syringes; insulin pens and supplies
- Insulin pump and pump supplies
- Hypoglycemia treatment supplies, ≥ 3 episodes
- Other medications, including glucagon kit
- Urine ketone strips/plastic cup
- Antiseptic wipes or hand sanitizer
- 3-day food supply with meal plan
- Other:

Other

SUPPLY LOCATIONS

	With student	In classroom	In health office	Other		With student	In classroom	In health office	Other
Daily breakfast, snacks and lunch					Blood glucose test kit Extra kit				
Extra snacks					Pump supplies				
Low blood glucose supplies					Insulin Daily use Extra/emergency				
High blood glucose supplies					Disaster Disaster food				
Other									

SIGNATURES

As parent/guardian of the above-named student, I give permission for the school nurse and/or other trained staff of

_____ to perform and carry out the diabetes care tasks as outlined in this Individualized Healthcare Plan.
(school)

- I have reviewed this plan and agree with the indicated instructions. I understand that the school is not responsible for equipment loss or damage, or expenses associated with these treatments and procedures.
- I understand that the information contained in this plan will be shared with other school staff on a need-to-know basis.
- I give permission to the school nurse to contact my child's physician/health care provider and discuss my child's care related to this plan.
- I will notify the school nurse whenever there is any change in my child's health status or care.
- My child and I are responsible for maintaining the necessary supplies, snacks, blood glucose meter, medications and other equipment.

Student's parent/guardian _____ Date _____

Student's parent/guardian _____ Date _____

Approved by School Nurse

School nurse _____

Date _____

AGREEMENT FOR STUDENTS INDEPENDENTLY MANAGING THEIR DIABETES

Student: _____ Grade: _____

Student

- I agree to dispose of any sharps either by keeping them in my kit and taking them home, or placing them in the sharps container provided at school.
- I will notify the health office if my blood sugar is below _____ mg/dl or above _____ mg/dl.
- I will not allow any other person to use my diabetes supplies.
- I plan to keep my diabetes supplies:
 - With me
 - In the school health office
 - In an accessible and secure location (_____)
- I will seek help in managing my diabetes from _____ if I need it.
- I understand that the freedom to manage my diabetes independently is a privilege and I agree to abide by this contract.

Student's signature: _____ Date: _____

Parent/Guardian

- I agree that my child can self-manage his/her diabetes and can recognize when he/she needs to seek help from a staff member.
- I will provide back-up supplies to the health office for emergencies.
- I understand that this contract is in effect for the current school year unless revoked by my son/daughter's physician or my son/daughter fails to meet the above safety guidelines.

Parent's signature: _____ Date: _____

School nurse

- I will assure that school staff members that need to know about this student's condition and that he/she must to carry their diabetes supplies with them have been notified.

School Nurse's signature: _____ Date: _____