# HEALTH CARE PLAN FOR DIABETES MANAGEMENT

***Due ON or BEFORE the FIRST day of School***

**STUDENT**_____ Birthdate _____

School /Year_____ Grade/Teacher/House/Counselor_____

Mother's Work Phone: _____ Hours:_____ Home Phone: _____

Father's Work Phone: _____ Hours:_____ Home Phone: _____

Age at diagnosis _____ What type of diabetes? Type 1 Insulin-Dependent or Type 2 Other:_____

Diabetes Health Care Provider_____ Phone (_____)_____FAX(_____)_____

---

**Check *ALL* that apply. Write "NA" if not applicable.**

## FOOD PLAN AT SCHOOL:

_____Will bring morning snack of _____ carbohydrates/grams to be eaten at _____ a.m.

_____Will bring afternoon snack of _____ carbohydrates/grams to be eaten at _____ p.m.

_____Will eat snack _____BEFORE or _____ AFTER Physical Education / Gym.

_____Will eat _____carbohydrates/grams (15 grams / serving) at lunch.

_____ Parent will provide cold lunch/snacks listing foods with assigned carbs/grams.

_____ Student will be able to independently count carbs/grams for foods eaten.

_____ Student will require assistance to choose foods and count carbs/grams intake.

_____ On special occasions, student can eat same snack provided to classmates. Call parent to determine carbs.

_____ On special occasions, student will select alternate snack from supply provided by parent.

Comments: _____

## BLOOD SUGAR TESTING:

**Target range for blood sugar =** _____mg/dl to _____mg/dl

Brand of meter to be used at school:_____

ALL diabetes supplies and food/beverage items will be provided by parent and replenished as needed.

_____ Will ***not*** test at school.

_____ Will be done daily at _____AND when symptoms are present.

_____ Will need hands-on assistance from trained personnel.

_____ Will ***not*** need hands-on assistance to test. ***Trained personnel will provide supervision.***

_____ Will require extra blood testing:

- _____ IF blood sugar (BS) is less than _____mg/dl anytime after lunch; Retest 20-45 minutes prior to bus transport and treat per protocol. Call parent to transport if BS is not greater than _____ mg/dl.
- _____ IF extra insulin has been given in the afternoon after a regular scheduled dose, retest 2 hours after dosing. Treat per protocol.
- _____ IF excessive physical activity is to be performed (e.g. one mile run, etc.), test 15 minutes prior to activity. Treat per protocol.
- _____ IF the following: _____

_____ Weekly BS results should be sent home with student (per parent request).

***Teacher's Note:*** **Take the following on off-site activities: • Cell phone • Testing Supplies • Sugar source • Care Plan**

## INSULIN ADMINISTRATION:

_____ Will ***not*** need insulin during school hours.

_____ Will need insulin during school hours. ***(Please complete Authorization to Administer Insulin)***

_____ Will be using an insulin pump and is self-sufficient in its use.

_____ Will be using an insulin pump and will need assistance.

## TREATMENT OF LOW BLOOD SUGARS:

*Beverages / food will be provided by parent and replenished as needed.*

***Teacher's Note:*** **If student is experiencing symptoms of a low blood sugar, do NOT allow him/her to go unescorted to the Health Room. If necessary, call for the Health Room Assistant to come to the student.**

**Symptoms:**
- Complaints of feeling "LOW"
- Drowsiness
- Blurred vision
- Slurred speech
- Paleness
- Personality change
- Weakness
- Shakiness
- Sweating
- Hunger
- Inability to concentrate
- Crying
- Dizziness
- Headache

► **If blood sugar is less than _____ AND/OR student is having symptoms of LOW blood sugar,** give 15 grams of fast-acting carbohydrate such as:

- Fruit juice: 4 oz or ½ glass
- Regular soda: 4-6 oz. (⅓ to ½ can)
- Glucose tablets: 3-4 (chew and swallow)
- Lifesavers: 5-7 pieces (chew and swallow)
- **OR** _____

► **If blood sugar is less than _____ ,** give 30 grams of fast- acting carbohydrate such as:

- Fruit juice: 8 oz or 1 glass
- Regular soda: 8-12 oz (1/2 to 1 can)
- Glucose tablets: 6-8 (chew and swallow)
- Lifesavers: 10-14 pieces (chew and swallow)

► **In both cases:**

- Health Room Assistant will call parent and School District Nurse to report health status.
- Retest in 15 minutes, if still low, give another 15 grams of fast-acting carbohydrate. If student is feeling better, may go back to class.
- If more than one hour before the next meal or snack, give extra 15 grams of carbohydrate.
- If lunch or snack time is within the hour, student may eat usual lunch or snack.

► **If student is not able to eat or drink without the risk of choking, if experiencing a seizure, and/or is unconscious:**

- (*) CALL ***9-1-1.*** The City of Brookfield/Elm Grove Police and Fire Department will follow Waukesha County EMS Guidelines/Standards of Care (Dextrose IV bolus; if IV line can not be established IM Glucagon will be given.
- If School District Nurse is present on the site, parent-provided Glucagon injection will be given as authorized by Health Care Provider with prescriptive rights. NOTE: Student may vomit after receiving Glucagon.

► **For student using an insulin pump: If unable to eat or drink without the risk of choking, if experiencing a seizure, and/or is unconscious:**

- Disconnect or remove insulin infusion set attached to student, typically found on abdomen or buttock.
- (*) See steps above.

## TREATMENT OF HIGH BLOOD SUGARS:

***Teacher's Note:*** **Allow student to use a water bottle in class and use the restroom as needed.**

**Symptoms:**
- Inability to concentrate
- Blurred vision
- Frequent urination
- Increased hunger & thirst
- Stomachache
- Drowsiness
- Confusion/irritability
- Dehydration

► **If blood sugar is greater than _____ mg/dl, the student will drink extra water or sugar-free fluids.**

_____ Will not test urine for ketones at school.

_____ Will test urine for ketones at school. (Call parent and School District Nurse if results are moderate or large)

_____ Administer extra insulin dose as prescribed on **Authorization to Administration Insulin**. Recheck blood sugar in 2 hours after correction dose is given.

► **For student using an insulin pump:**
If blood sugar is greater than _____ for two tests in a row, call parent and School District Nurse.

## *HEALTH CARE PROVIDER'S AUTHORIZATION:*

I have reviewed and included my recommendations for this Health Care Plan for Diabetes Management. I understand that designated school personnel, with training and supervision by the School District Nurse, will perform specialized health care services. This consent shall remain in effect through the end of the current school year unless changed in writing by myself and the parent/guardian.

_____/_____ _____/_____

Health Care Provider's Name (Please Print) Phone Health Care Provider's Signature Date

## *PARENTAL CONSENT:*

I request that specialized health care services for Diabetes Management be provided for my son/daughter. I understand that designated school personnel, with training and supervision by the School District Nurse, will perform these services. I give permission to share this information with appropriate school personnel and for personnel to contact the Health Care Provider when necessary.
I will: 1) provide the necessary supplies and equipment and 2) notify the Health Services staff in writing if there is a change in my child's Health Care Plan for Diabetes Management.

Parent / Guardian Signature _____ Date_____

**Please protect this information. It may be shared with those who need to know while in the learning environment.**
**Teachers: Place this letter in your sub folder and shred it at the end of the semester or school year.**