



# 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 1/2 glass
- Glucose tablets: 3-4 (chew and swallow)
- Regular soda: 4-6 oz. (1/3 to 1/2 can)
- 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
- Glucose tablets: 6-8 (chew and swallow)
- Regular soda: 8-12 oz (1/2 to 1 can)
- 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.



**AUTHORIZATION TO ADMINISTER INSULIN**  
 To be completed by Physician or other Health Care Provider with prescriptive rights  
**\*\*Due ON or BEFORE the FIRST Day of School\*\***

STUDENT \_\_\_\_\_ Birthdate \_\_\_\_\_  
 School / Year \_\_\_\_\_ Grade/Teacher/House \_\_\_\_\_  
 Father's Work Phone: \_\_\_\_\_ Work Hours: \_\_\_\_\_  
 Mother's Work Phone: \_\_\_\_\_ Work Hours: \_\_\_\_\_  
 Physician: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_  
 School Nurse Approval / Comments: \_\_\_\_\_

**Type of Insulin**

- \_\_\_\_\_ Humalog Insulin
- \_\_\_\_\_ Novolog Insulin
- \_\_\_\_\_ Other: \_\_\_\_\_

**Administration**

- \_\_\_\_\_ Student is able to self-administer insulin injection.
- \_\_\_\_\_ Student is able to self-administer insulin but will require supervision.
- \_\_\_\_\_ Trained school personnel will administer insulin injection.
- \_\_\_\_\_ Insulin is delivered via insulin pump and student is able to do this independently.
- \_\_\_\_\_ Insulin is delivered via insulin pump and requires supervision by trained school personnel.

**Dosage Preparation**

- \_\_\_\_\_ Student is able to independently determine insulin dose using information below.
- \_\_\_\_\_ Student will need supervision by trained school personnel to determine insulin dose using information below.

**Time of Administration**

- \_\_\_\_\_ Receive/give insulin **before** eating lunch (within 5 minutes).
- \_\_\_\_\_ Receive/give insulin **after** eating lunch (within 10 minutes of finishing).

Insulin Dose based on:  
Sliding Scale

Insulin Dose based on:  
Units for Food Eaten + Units to Correct Blood Sugar = Total Units

**To determine Total Units of Insulin needed, use the following scale:**

<u>Blood Sugar</u>	<u>Insulin Dose</u>
_____ to _____	= _____ units
_____ to _____	= _____ units
_____ to _____	= _____ units
_____ to _____	= _____ units
_____ to _____	= _____ units
_____ to _____	= _____ units
_____ to _____	= _____ units
_____ to _____	= _____ units
_____ to _____	= _____ units
_____ to _____	= _____ units

**OR**

**To determine Total Units of Insulin, use the following steps:**

**Step 1: Units for Food Eaten =**  
 \_\_\_\_\_ Units per \_\_\_\_\_ Carbs OR \_\_\_\_\_ Grams **X** Carbs Eaten

**Step 2: Units to Correct Blood sugar =**  
 \* **The scale below is based on Insulin Sensitivity Factor (ISF):**  
 \_\_\_\_\_ unit(s) of insulin lower blood sugar by \_\_\_\_\_ mg/dl

_____ to _____	= _____ units of insulin
_____ to _____	= _____ units of insulin
_____ to _____	= _____ units of insulin
_____ to _____	= _____ units of insulin
_____ to _____	= _____ units of insulin
_____ to _____	= _____ units of insulin
_____ to _____	= _____ units of insulin
_____ to _____	= _____ units of insulin
_____ to _____	= _____ units of insulin

**Units for Food Eaten + Units to Correct Blood Sugar = Total Units**

**Extra Insulin Dosing:**

- \_\_\_\_\_ Not needed during school hours.
- \_\_\_\_\_ Call parent and School District Nurse to determine need for extra insulin dose.

**NOTE: Do NOT exceed 2 extra doses of insulin in one day.**

- 1) **IF BS is greater than \_\_\_\_\_mg/dl AND it has been more than 2 hours since last insulin dose and at least 2 hours BEFORE next insulin dose:**

<b>Give this amount of insulin: <u>Retest BS in 2 hours.</u></b>		
<b><u>Blood Sugar</u></b>		<b><u>Insulin Dose</u></b>
_____ to _____	=	_____ units
_____ to _____	=	_____ units

- 2) **IF extra food is eaten in addition to a scheduled meal or snack:**

<b>Give this amount of insulin: <u>Retest BS in 2 hours.</u></b>		
_____ Units of Insulin per _____ Carbs OR _____ Grams		
<b>Always round DOWN</b> (e.g. 29 grams = 25 grams) 12 carbs = 10 carbs		

**HEALTH CARE PROVIDER'S AUTHORIZATION:**

I have reviewed and approved the **Authorization to Administer Insulin** and have included my recommendations.  
I understand that delegated school personnel, with training and supervision by a Registered Nurse, will perform/supervise these specialized health care services. This consent shall remain in effect through the end of the current school year unless changed by me or the parent/guardian withdraws the request in writing.

Licensed Prescriber's Name \_\_\_\_\_ Phone \_\_\_\_\_  
(Please print)

Licensed Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_  
(No stamp)

**PARENTAL CONSENT:**

I give permission for my son/daughter to receive insulin as authorized by his/her licensed Health Care Provider. I give permission to share this information with appropriate school personnel and for school personnel to contact the Health Care Provider as necessary. I will deliver pharmacy-labeled insulin (insulin pen & insulin cartridges) to school, maintain a sufficient amount of testing supplies and foods/beverages for use at school and provide a new **Authorization To Administer Insulin** if insulin dosing changes.

\_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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