For Clinic Office Use Only
Date:_____ Reviewed By: _____
Glucagon Experation:_____

DIABETES CARE PLAN
For Students Who Receive Insulin By Injection

Student's Name: _____

DOB: _____
Date Diagnosed: _____ Last Hospitalization: _____
Type and dosage of long-acting insulin taken at home: _____

BLOOD GLUCOSE MONITORING:
At school, blood glucose should be checked by: School Staff Student
Target range for blood glucose is _____mg/dl to _____mg/dl.

Check the times that blood glucose should be checked at school. Once the student's class schedule is available, as needed, we will work with the family to make a daily glucose monitoring schedule.

	Mid-morning		Before Recess		Before PE		Mid-Afternoon
	Before lunch		After Recess		After PE		Before afternoon sports
Other/Comments:							

Student should not exercise if blood glucose is below _____ mg/dl or above _____ mg/dl.

INSULIN REGIMEN for Students using INSULIN INJECTIONS:
Insulin Dosage determined by: School Staff Student Parent
Insulin dose drawn up/injected by: School Staff Student

Times of scheduled insulin injections:_____

Insulin/Carbohydrate Ratio: _____

Correction Factor: _____

Sliding Scale: _____

SCHEDULED SNACKS:
*Snacks must be brought from home. Remind student to eat a snack? Yes☐ No☐
Target Amount/Food Content of Snacks: _____

Check times that snacks are to be eaten at school. Once the student's class schedule is available, as needed, we will work together to make a daily snack schedule.

	Mid-morning		Before Recess		Before PE		Before afternoon sports
	Mid-afternoon		After Recess		After PE		Other

LUNCH:
Student selects Tray prepared by kitchen
Target Amount/Food content of Lunch:_____

CLASS PARTIES:
Instructions/Restrictions when food is provided to the class, e.g. class parties: _____

EMERGENCY INSTRUCTIONS:

If student is unconscious, unable to swallow, or having a seizure, presume student has low blood glucose and:

1. Administer _____mg Glucagon (provided to Infirmary by parents for emergency use only).
2. Call 911 immediately and notify parents.
3. Turn student on his/her side.

Is there a history of an adverse reaction to Glucagon? Yes ☐ No ☐

LOW BLOOD GLUCOSE: Below _____ mg/dl

Usual symptoms of **LOW** blood glucose for this student—check all that apply:

☐	Change in personality/behavior	☐	Headache	☐	Inattention/Confusion
☐	Pallor	☐	Rapid Heartbeat	☐	Slurred Speech
☐	Weak/Shaky/Tremulous	☐	Nausea/Loss of Appetite	☐	Loss of Consciousness
☐	Tired/Drowsy/Fatigued	☐	Clammy/Sweating	☐	Seizures
☐	Dizzy/Staggering Walk	☐	Blurred Vision	☐	Other

Treatment of **LOW** blood glucose: _____

HIGH BLOOD GLUCOSE: Above _____ mg/dl

Usual symptoms of **HIGH** blood glucose for this student—check all that apply:

☐	Increased or Extreme Thirst	☐	Warm, Dry, or Flushed Skin	☐	Blurred Vision
☐	Increased Urination	☐	Nausea/Vomiting	☐	Weakness/Muscle Aches
☐	Increased Appetite	☐	Abdominal Pain	☐	Fruity Breath Odor
☐	Tired/Drowsy	☐	Rapid, Shallow Breathing	☐	Other

Treatment of **HIGH** blood glucose: _____

Circumstances when urine **KETONES** should be tested: _____

Treatment for Ketones: _____

Parent/Guardian (call first)

Name_____

Phone_____

Parent/Guardian (call second)

Name_____

Phone_____

Emergency Contacts (contacted only if unable to reach both parents)

Name:_____

Phone:_____

Name:_____

Phone:_____

Parent Signature:_____**Date:**_____

Please return form to:
282 Mt. Paran Road, NW, Atlanta, Georgia 30327 p.404-252-2591 f. 404-252-7615
Email to Terry Sherali, Director of Student Services, tsherali@schenck.org.