

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

Student's Name: _____



Summer 2022

**DIABETES CARE PLAN
 For Students Who Receive Insulin By Pump**

DOB: _____ **Grade (2021-2022)** _____
 Date Diagnosed: _____ Last Hospitalization: _____

BLOOD GLUCOSE MONITORING

At school, blood glucose should be checked by: School Staff Student

Where (clinic, classroom, etc.): _____

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.

<input type="checkbox"/>	Mid-morning	<input type="checkbox"/>	Before Recess	<input type="checkbox"/>	Before PE	<input type="checkbox"/>	Mid-Afternoon
<input type="checkbox"/>	Before lunch	<input type="checkbox"/>	After Recess	<input type="checkbox"/>	After PE	<input type="checkbox"/>	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 PUMP

Is student competent regarding pump? Yes No

Basal Rate: _____

Bolus Dosage determined by: School Staff Student Parent

Bolus dose administered by: School Staff Student

Times of scheduled Boluses: _____

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.

<input type="checkbox"/>	Mid-morning	<input type="checkbox"/>	Before Recess	<input type="checkbox"/>	Before PE	<input type="checkbox"/>	Before afternoon sports
<input type="checkbox"/>	Mid-afternoon	<input type="checkbox"/>	After Recess	<input type="checkbox"/>	After PE	<input type="checkbox"/>	Other

LUNCH:

Student selects Tray prepared by lunch provider

Target Amount/Food content of Lunch: _____

CLASS PARTIES:

Instructions/Restrictions when food is provided to the class, e.g. class parties

EMERGENCY INSTRUCTIONS:

1. Check blood glucose
2. If student is unresponsive or unable to swallow, administer _____ mg Glucagon (provided to Clinic by parents for emergency use only) if blood glucose is low (below _____ mg/dl).
3. Call 911 immediately and notify parents.
4. Turn student on his/her side.
5. Other Instructions:

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:

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 _____