

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

Student's Name: _____

Summer 2021



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

DOB: _____ Grade (2020-2021) _____

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

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.

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:

<input type="checkbox"/>	Change in personality/behavior	<input type="checkbox"/>	Headache	<input type="checkbox"/>	Inattention/Confusion
<input type="checkbox"/>	Pallor	<input type="checkbox"/>	Rapid Heartbeat	<input type="checkbox"/>	Slurred Speech
<input type="checkbox"/>	Weak/Shaky/Tremulous	<input type="checkbox"/>	Nausea/Loss of Appetite	<input type="checkbox"/>	Loss of Consciousness
<input type="checkbox"/>	Tired/Drowsy/Fatigued	<input type="checkbox"/>	Clammy/Sweating	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Dizzy/Staggering Walk	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	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:

<input type="checkbox"/>	Increased or Extreme Thirst	<input type="checkbox"/>	Warm, Dry, or Flushed Skin	<input type="checkbox"/>	Blurred Vision
<input type="checkbox"/>	Increased Urination	<input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/>	Weakness/Muscle Aches
<input type="checkbox"/>	Increased Appetite	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	Fruity Breath Odor
<input type="checkbox"/>	Tired/Drowsy	<input type="checkbox"/>	Rapid, Shallow Breathing	<input type="checkbox"/>	Other

Treatment of **HIGH** blood glucose:

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

Treatment for Ketones:

Parent/Guardian (call first)

Parent/Guardian (call second)

Name _____

Name _____

Phone _____

Phone _____

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

Name: _____

Name: _____

Phone: _____

Phone: _____

Parent Signature: _____ **Date:** _____