



HARRISBURG SCHOOL DISTRICT 41-2

**Diabetic Care Plan**

Student Name: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_ M  F   
 School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_ Rides Bus:  Yes  No  
 Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 \_\_\_\_\_ Phone: \_\_\_\_\_  
 Emergency Contact: 1) \_\_\_\_\_ Phone: \_\_\_\_\_  
 2) \_\_\_\_\_ Phone: \_\_\_\_\_  
 Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Endocrinologist's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Target range for blood glucose:**  70-130 mg/dL  70-180 mg/dL  other \_\_\_\_\_

Blood Glucose Monitoring	Perferred Site Testing	Student's Self-Care Blood Glucose Checking Skills
<input type="checkbox"/> Before Breakfast <input type="checkbox"/> Before PE <input type="checkbox"/> Mid- Morning <input type="checkbox"/> After PE <input type="checkbox"/> Before Lunch <input type="checkbox"/> Before Dismissal <input type="checkbox"/> ____Hours after Lunch <input type="checkbox"/> 2 hours after correction dose <input type="checkbox"/> As needed for sign/symptoms of low or high blood glucose <input type="checkbox"/> As needed for signs/symptoms of illness <input type="checkbox"/> Other _____	<input type="checkbox"/> Fingertip <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh <input type="checkbox"/> Other _____  *Brand/Model of Blood Glucose Meter: _____ <i>Note: The fingertip should always be used to check blood glucose level if hypoglycemia is suspected.</i>	<input type="checkbox"/> Independently checks own blood glucose <input type="checkbox"/> May check blood glucose with supervision <input type="checkbox"/> Requires school nurse to check blood glucose

Hypoglycemia Treatment	Hyperglycemia Treatment
<ul style="list-style-type: none"> <li>Symptoms of hypoglycemia: _____</li> <li>If exhibiting symptoms of hypoglycemia, OR blood glucose level is less than _____mg/dL, give a quick-acting glucose product equal to _____grams of carbohydrate.</li> <li>Re-check blood glucose in 10-15 minutes and repeat treatment if glucose level is less than _____mg/dL.</li> <li><b>If student is unable to eat or drink, is unconscious or unresponsive or having seizure activity give:</b>                Glucagon: <input type="checkbox"/> 1mg <input type="checkbox"/> 1/2mg Route: <input type="checkbox"/> SC <input type="checkbox"/> IM                Site: <input type="checkbox"/> arm <input type="checkbox"/> thigh <input type="checkbox"/> other _____                Call 911 and student's parent/guardian             </li> </ul>	<ul style="list-style-type: none"> <li>Symptoms of hyperglycemia: _____</li> <li>Check for ketones every _____hour when blood glucose levels are above _____mg/dL.</li> <li>Blood glucose level greater than _____mg/dL and at least _____hours since last insulin dose, give correction dose of insulin.</li> <li>Give extra water and/or non- sugar containing drinks: _____ounces per hour.</li> <li><b>If student has symptoms of hyperglycemia emergency</b> (dry mouth, extreme thirst, nausea/vomiting, heavy breathing, chest pain, lethargy, decreased level of consciousness) <b>Call 911 and student's parents/guardian.</b></li> </ul>

# INSULIN THERAPY

*Diabetic Management Plan to be completed by Physician*

## Adjustable Insulin Therapy:

**\* Carbohydrate Coverage/Correction Dose:**

Name of insulin: \_\_\_\_\_

**\* Carbohydrate Coverage:**

**Insulin-to-Carbohydrate Ratio:**

- Breakfast: 1 unit of insulin per \_\_\_\_\_ grams of carbohydrate
- Lunch: 1 unit of insulin per \_\_\_\_\_ grams of carbohydrate
- Snack: 1 unit of insulin per \_\_\_\_\_ grams of carbohydrate

**Carbohydrate Dose Calculation Example:**  
 $\frac{\text{Grams of Carbohydrate}}{\text{Insulin-to-Carbohydrate Ratio}} = \text{units of insulin}$

**\* Correction Dose Calculation:**

- Blood Glucose Correction Factor/Insulin Sensitivity Factor \_\_\_\_\_
- Total Blood Glucose = \_\_\_\_\_ mg/dL

**Correction Dose Calculation Example:**  
 $\frac{\text{Actual Blood Glucose} - \text{Target Blood Glucose}}{\text{Blood Glucose Correction Factor/Insulin Sensitivity Factor}} = \text{units of insulin}$

▪ **Correction Dose Scale:**

(Instead of Correction Dose Calculation to determine correction dose)

Blood Glucose \_\_\_\_\_ to \_\_\_\_\_ mg/dL give \_\_\_\_\_ units  
 Blood Glucose \_\_\_\_\_ to \_\_\_\_\_ mg/dL give \_\_\_\_\_ units  
 Blood Glucose \_\_\_\_\_ to \_\_\_\_\_ mg/dL give \_\_\_\_\_ units  
 Blood Glucose \_\_\_\_\_ to \_\_\_\_\_ mg/dL give \_\_\_\_\_ units

## When to Give Insulin

**Breakfast:**

- Carbohydrate Coverage Only
- Carbohydrate plus Correction Dose when blood glucose is greater than \_\_\_\_\_ mg/dL and \_\_\_\_\_ hours since last insulin dose.
- Other \_\_\_\_\_

**Lunch:**

- Carbohydrate Coverage Only
- Carbohydrate plus Correction Dose when blood glucose is greater than \_\_\_\_\_ mg/dL and \_\_\_\_\_ hours since last insulin dose.
- Other \_\_\_\_\_

**Snack:**

- No coverage for snack
- Carbohydrate Coverage Only
- Carbohydrate plus Correction Dose when blood glucose is greater than \_\_\_\_\_ mg/dL and \_\_\_\_\_ hours since last insulin dose.
- Other \_\_\_\_\_

## Fixed Insulin Therapy:

Name of Insulin: \_\_\_\_\_

- \_\_\_\_\_ Units of insulin given pre-breakfast daily
- \_\_\_\_\_ Units of insulin given pre-lunch daily
- \_\_\_\_\_ Units of insulin given pre-snack daily
- Other \_\_\_\_\_

## Student's Self-Care Insulin Administration Skill:

- Independently calculates and give injections  Yes  No
- May calculate/give own injections with supervision  Yes  No
- Requires school nurse to calculate/give injections  Yes  No

### Parental Authorization to Adjust Insulin Dose:

- Parent/guardian are authorized to increase or decrease correction dose scale within the following range: +/- \_\_\_\_\_ units of insulin.
- Parent/guardian are authorized to increase or decrease insulin-to-carbohydrate ratio within the following range: \_\_\_\_\_ units per prescribed grams of carbohydrate, +/- \_\_\_\_\_ grams of carbohydrate.
- Parent/guardian are authorized to increase or decrease fixed insulin dose within the following range: +/- \_\_\_\_\_ units of insulin.

### INSULIN PUMP

*Diabetic Management Plan to be completed by Physician*

Brand/Model of pump: \_\_\_\_\_

Type of insulin in pump: \_\_\_\_\_

Basal Rate during school: \_\_\_\_\_

Type of infusion set: \_\_\_\_\_

- For blood glucose greater than \_\_\_\_\_ mg/dL that has not decreased within \_\_\_\_\_ hours after correction, consider pump failure or infusion site failure. Notify parent/guardian.
- For infusion site failure: insert new infusion set and/or replace reservoir.
- For suspected pump failure: suspend or remove pump and give insulin by syringe/pen.

#### **Physical Activity:**

- May disconnect from pump for sports activities:  Yes  No
- Set a temporary basal rate: \_\_\_\_\_% temporary basal for \_\_\_\_\_ hours  Yes  No
- Suspend pump use:  Yes  No

#### **Student's Self-Care pump skills:**

- Count Carbohydrate's  Yes  No
- Bolus correct amount for carbohydrates consumed  Yes  No
- Calculate and administer corrective bolus  Yes  No
- Calculate and set basal profiles  Yes  No
- Calculate and set temporary basal rate  Yes  No
- Disconnect pump  Yes  No
- Reconnect pump to infusion set  Yes  No
- Prepare reservoir and tubing  Yes  No
- Insert infusion set  Yes  No

### PHYSICAL ACTIVITY AND SPORTS

*Diabetic Management Plan to be completed by Physician*

- A quick-acting source of glucose such as  glucose tabs and/or  juice must be available at the site of physical activity or sporting event.
- Student should eat:  15 grams of carbohydrates  30 grams of carbohydrates  other \_\_\_\_\_  
 before  every 30 minutes during  after vigorous physical activity  other \_\_\_\_\_
- If most recent blood glucose is less than \_\_\_\_\_ mg/dL, student can participate in physical activity when blood glucose is corrected and about \_\_\_\_\_ mg/dL.
- Avoid physical activity when blood glucose is greater than \_\_\_\_\_ mg/dL and if urine ketones are present.

**MEAL and SNACKS (while at school)**  
*Diabetic Management Plan to be completed by Physician*

Meal/Snack	Time	Carbohydrate Content (grams)
Breakfast		
Mid-Morning Snack		
Lunch		
Mid-Afternoon Snack		

**Student's Self-Care Nutrition Skills:**

- Independently counts carbohydrates  Yes  No
- May count carbohydrates with supervision  Yes  No
- Requires school nurse to count carbohydrates  Yes  No
- Special event/party food permitted:  Yes with parent/guardian discretion  No
- Instructions for when food is provided to the class (example: birthday parties, class parties):  
 \_\_\_\_\_

This Diabetes Management Plan has been completed and approved by:

\_\_\_\_\_  
 Physician's Printed Name

\_\_\_\_\_  
 Physician's Signature

\_\_\_\_\_  
 Date

**\*In Harrisburg, EMS will be activated by a call to 911 at which time we will state that we need transport to the hospital by Rural Metro. Harrisburg Volunteer Fire Department is typically first on the scene to further assist.**

**\*A Medication and Treatment Authorization Form** must be completed and kept on file in the school health office. New Health Care Plans are completed yearly. Any updates throughout the school year should be submitted to the School Nurse.

By signing below I understand that I am giving my permission to share this information with school staff/trained personnel as needed with strict confidentiality maintained by all. I also give my permission for the school nurse/aide to contact the Primary Care Physician or Endocrinologist if further information or clarification is needed.

*\* This information will be come part of your child's confidential permanent record. If for any reason you do not wish to have part(s) of this form completed you are under no obligation to do so. Please understand that we are not responsible for injury or illness that may be a result of these omissions*

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

School Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_