**HEALTH CARE PLAN FOR DIABETES MANAGEMENT**
Deerfield Public Schools

**STUDENT**_____ Birthdate _____

School _____ Grade_____ School Year _____

**Parent/Guardian 1**:_____ **Parent/Guardian 2**:_____

Daytime Phone (_____)_____ Daytime Phone (_____)_____

Cell (_____)_____ Cell (_____)_____

Age at diagnosis _____ What type of diabetes? Type 1 or Type 2 Other:_____

Diabetes Health Care Provider_____ Phone (_____)_____

Last Hgb A1C _____ Date _____ Next appointment _____

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**Meal Bolus: This is the amount of insulin that is given for the meal. The student will calculate this as needed.**
**_____units of insulin per _____ grams of carbohydrate.**

**Correction: This is the amount of extra insulin given to bring a high blood sugar back to target.**
**_____ units for every _____ mg/dl above _____mg/dl.**

## FOOD PLAN AT SCHOOL:

(Check **ALL** that apply)

_____Will bring morning snack of _____ carbohydrates to be eaten at _____ a.m.
_____Will bring afternoon snack of _____ carbohydrates to be eaten at _____ p.m.
_____Will eat _____carbohydrate servings (15 grams / serving) at lunch.
_____Will need snack before / after Phy Ed. (Circle choice)
_____Will need guidance selecting food items from school menu
_____Will need trained personnel to check carb intake after lunch
_____ On special occasions, may select alternate snack from supply provided by parent
_____ On special occasions, may eat same snack provided to classmates

Comments: _____

## BLOOD SUGAR TESTING:

**Target range for blood sugar =** _____mg/dl to _____mg/dl
Brand of meter to be used at school:_____
Testing supplies (To be provided by parents): Meter, control solution, test strips, lancet / poker, spare meter battery

(Check **ALL** that apply)

_____ Will ***not*** test at school
_____ Will test daily at lunchtime and when symptoms are present
_____ Will ***not*** need assistance from trained school personnel
_____ Will need assistance from trained school personnel ***(Physician's Authorization MUST be signed)***
_____ Weekly blood sugar results should be sent home with student on Fridays
_____ Will keep testing supplies in Health Room / classroom / locker / backpack (Circle choice)

***Teacher's Note:*** **Take the following items on all off-site activities*:***
- **Cell phone**
- **Supplies**
- **Quick-acting sugar source**
- **Health Care Plan**

## INSULIN ADMINISTRATION:

_____ Will ***not*** need insulin during school hours
_____ Will need insulin during school hours ***(Complete Authorization to Administer Insulin)***

Type(s) / Amount/ times of Insulin used: _____

_____

► **Turn Over to Complete *Page 2*** ◄

## LOW BLOOD SUGARS:

***Teacher's Note:*** **Do NOT send student experiencing symptoms to the Health Room unescorted. Call for assistance if necessary.**

**Symptoms:**
- ▪ Blurred vision
- ▪ Weakness
- ▪ Irritable / Anxious
- ▪ Shakiness
- ▪ Sweating
- ▪ Dizziness
- ▪ Headache
- ▪ Paleness
- ▪ Hunger
- ▪ Drowsiness
- ▪ Other_____

► **If blood sugar is less than _____,** give 15 grams of fast-acting carbohydrate (***provided by parent)*** such as:

- Fruit juice: 4 oz or ½ glass
- Regular soda: 4-6 ozs (⅓ to ½ can)
- **OR** _____
- Glucose tablets: 3-4 (chew and swallow)
- Lifesavers: 5-7 pieces (chew and swallow)

- 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 blood sugar does not elevate, call parent.
- 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 becomes unconscious or has a seizure, *call 9-1-1 and parent.***
Administer glucagon as ordered by MD. Glucagon will be located _____
_____

► **For student using an insulin pump:**
If student becomes unconscious or has a seizure, disconnect tubing from insulin pump. Call 911 and parent.

## HIGH BLOOD SUGARS:

***Teacher's Note:*** **Allow student to use a water bottle in class and use the restroom as needed.**

**Symptoms:**
- ▪ Blurred vision
- ▪ Frequent bathroom usage
- ▪ Increased hunger
- ▪ Stomachache / nausea
- ▪ Drowsiness
- ▪ Sweet, fruity breath
- ▪ Very thirsty
- ▪ ***Vomiting*** (danger sign)
- ▪ Other _____

► **If blood sugar is greater than ____dl, the student will drink extra water or sugar-free fluids (provided by parent).**

_____ Will not test urine ketones

_____ Will test urine ketones using strips provided by parents (Call parent if results are moderate or large)

***NOTE*: Student using insulin pump, if blood sugar is greater than _____ for two tests in a row, call parent.**

***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 a Registered Nurse, may perform these services if able to delegate. I give permission to share this information with appropriate school personnel and for school personnel to contact the physician when necessary. I will: 1) provide the necessary supplies and equipment, 2) notify the Health Services staff if there is a change in my child's health status or attending physician and 3) notify the School District Nurse immediately of any changes in the physician's order.

Parent / Guardian Signature _____ Date_____

***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 a Registered Nurse, may perform specialized health care services if able to delegate. This consent shall remain in effect through the end of the current school year unless discontinued or changed by me or the parent/guardian withdraws the request in writing.

_____/_____ _____/_____