MENOMONEE FALLS SCHOOLS
Engage | Learn | Improve

DISTRICT ADMINISTRATION OFFICE
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DIABETIC CARE PLAN

School Year: _____

Student's Name: _____ School: _____

Date of Birth: _____ Gender: _____ Grade: _____

Parent/Guardian's Name: _____

Mailing Address: _____

Home Phone: _____ Work Number: _____

Cell Phone: _____

Physician: _____Physician's Number: _____ Fax: _____

BLOOD GLUCOSE MONITORING

Usual time(s) to be tested at school _____
Other times the student my need to do testing _____

The student will or will not (circle one) need help performing test. Please help with the following:
_____

Test range for blood glucose: _____ md/dl to _____ mg/dl
Call parent/guardian if glucose is below _____ or above _____

Should monitoring be done in the Health room? Yes or No *(circle one)*
*All students with diabetes are able to test their blood glucose level at anytime during school if not feeling well.

INSULIN

Time, type and dosage of insulin injection(s) at school:		
Time	**Type**	**Dosage**

Is the student able to determine correct amount of insulin? Yes or No *(circle one)*
Is the student able to draw correct amount of insulin? Yes or No *(circle one)*
Is the student able to give own injection? Yes or No *(circle one)*
Will insulin injections be done in the Health Room? Yes or No *(circle one)*

FOR STUDENTS WITH INSULIN PUMPS

Type of pump _____

Insulin type _____
Basal rate _____
Insulin/carbohydrate ratio _____
Correction factor _____
Is student competent regarding pump? Yes or No *(circle one)*
If no, explain what type of help is needed _____
_____
_____
Insulin bolus will be done in the Health Room? Yes or No *(circle one)*

INSULIN DOSING

Lunch time dose:
Give insulin _____ before lunch (eat within 5 minutes)
Give insulin _____ after lunch (give within 10 minutes of finishing lunch)

Type of insulin _____
_____Unit(s) for _____carb servings or _____ grams of carb.

Correction Dosing (add+/-)
Blood sugar from _____ to _____ = units
Blood sugar from _____ to _____ = units
Blood sugar from _____ to _____ = units
Blood sugar from _____ to _____ = units
Blood sugar from _____ to _____ = units
Blood sugar from _____ to _____ = units
Blood sugar from _____ to _____ = units
Blood sugar from _____ to _____ = units

Is student able to calculate carbohydrates and insulin dose independently? Yes or No *(circle one)*
If no, explain what type of help is needed:
_____
_____

FOOD AT SCHOOL

The student is on a **Flexible** or **Fixed** meal plan *(circle one)*

Snack & Meal Plan		
	Time	# of Carbs
Morning snack		
Lunch		
Afternoon snack		

In addition to the above meal plan the student may require an extra snack.
_____ Before Gym _____ After Gym _____ Other: _____

FIELD TRIPS

Notify parent of all field trips in advance. The following items will be taken along on the field trip:

_____ Student Health Care Plan
_____ Insulin
_____ Meter and test strips
_____ Sharps container
_____ Fast acting sugar source
_____ Glucagon
_____ Other _____

Designated, trained school personnel will be assigned to student for monitoring at all times.

EMERGENCY ACTION PLAN

Hypoglycemia/Low Blood Glucose Treatment

Usual symptoms may include:

Hunger	Sleepiness	Sweating
Confusion	Dizziness	Crying

Headache
Feels "low"
Trembling or Shaking
Inablility to concentrate
Personality change
Poor coordination
Pale appearance
Fast heart rate
Slurred speech
Other: _____

If the student is experiencing any of these symptoms:
Check blood glucose level. If the level is less than _____, give the student one of the following:
_____4 oz juice _____ 4-6 oz regular soda _____3-4 glucose tabs _____ other _____
If the student is not feeling better in 10 to 15 minutes:
_____ repeat one of the above or
_____

Do not leave student alone or allow him/her to leave the classroom without an adult to accompany them. If student is not responding to treatment, call parent ASAP.

If the student is not able to eat or drink, experiencing a seizure and/or unconscious:

1. Trained staff will give Glucagon injection. Dosage _____Turn student on side and keep airway clear.
2. Call 911
3. Call parent
4. Other _____

Hyperglycemia/High Blood Glucose Treatment
Symptoms may include:
Dehydration
Dry skin
Increased thirst
Sleepiness
Hungry
Inability to concentrate
Confusion
Irritability
Blurred vision
Frequent urination
Other:_____

If the student is experiencing any of these symptoms:

1. Check blood glucose level
2. Encourage drinking water
3. Extra insulin dosages Yes or No *(circle one)*

Criteria for extra insulin correction dose: It has been more than 2 hrs since last shot was given and it is not meal time. Blood glucose is over _____ mg/dl.

Type of insulin _____
Blood sugar from _____ to _____ = units
Blood sugar from _____ to _____ = units
Blood sugar from _____ to _____ = units
Blood sugar from _____ to _____ = units
Blood sugar from _____ to _____ = units
Check blood glucose _____ hours after correction dose given.

4. Notify parents
5. Other: _____

This information may be shared with all appropriate staff

_____ _____
Student's Signature Date

_____ _____
Parent/Guardian's Signature Date

_____ _____
Health Care Provider's Signature Date

CARE PLAN REVIEWED WITH SCHOOL PERSONNEL

School Representative Signature(s)	Date
