Diabetes Health Care Plan for Insulin Administration via Syringe or Pen

School:_____

Start Date: _____ End Date: _____

Name_____ Grade/ Homeroom _____ Teacher_____

Parent/ Guardian Contact: Call in order of preference

	Name	*Telephone Number*	*Relationship*
1.			
2.			
3.			

Student Photo

Prescriber Name _____Phone_____Fax_____

Blood Glucose Monitoring: Meter Location _____ Student permitted to carry meter ☐ Yes ☐ No

Testing Time ☐ Before Breakfast/Lunch ☐ 1-2 hours after lunch ☐ Before/after snack ☐ Before/after exercise ☐ Before recess ☐ Before riding bus/walking home ☐ **Always** check when student is feeling high, low and during illness ☐ Other_____

Snacks

☐ Please allow a _____gram snack at_____ ☐ before/after exercise

Snacks are provided by parent /guardian and located in _____

Treatment for Hypoglycemia/Low Blood Sugar

If student is showing signs of low blood sugar or if blood sugar is below _____mg/dl

☐ **Treat with 10-15 grams of quick-acting glucose:**

☐ 4oz juice or ☐ ____ glucose tablets or ☐ Glucose Gel or ☐ Other _____

☐ Retest blood sugar every 15 minutes, repeat treatment until blood sugar level is above target _____mg/dl

☐ If no meal or snack within the hour give a 15 gram snack

☐ If student unconscious or having a seizure: Give Glucagon ☐ Yes ☐ No

☐ Amount of Glucagon to be administered: _____mg(s) IM, SC, and call 911 and parents

☐ **Notify parent/guardian for blood sugar below _____mg/dl**

Treatment for Hyperglycemia /High Blood Sugar

If student showing signs of high blood sugar or if blood sugar is above _____mg/dl

☐ Allow free access to water and bathroom

☐ Check ketones for blood sugar over _____ mg/dl ☐ Notify parent/guardian if ketones are **moderate to large**

☐ **Notify parent/guardian for blood sugar over** _____mg/dl

☐ See insulin correction scale (next page)

☐ **Call 911 and parent/guardian for *hyperglycemia emergency*. Symptoms may include nausea &vomiting, heavy breathing, severe abdominal pain, chest pain, increased sleepiness or lethargy, or loss of consciousness.**

Document all blood sugars and treatment

Name:

Orders for Insulin Administration

Insulin is administered via: ☐**Vial/Syringe** ☐**Insulin Pen**

Can student draw up correct dose, determine correct amount and give own injections?

☐**Yes** ☐**No** ☐**Needs supervision (describe)**_____

Insulin Administration: ☐ **Not taking insulin at school**

Insulin Type: _____ Student permitted to carry insulin & supplies: ☐ **Yes** ☐**No**

Calculation of Insulin Dose: A+B=C

A. Insulin to Carbohydrate Ratio 1 unit of Insulin per _____grams of Carbohydrate

Give____ units per _____grams
Give____ units per _____grams **OR** $\frac{\text{Total Grams of Carbohydrates to be eaten}}{\text{Carbohydrate ratio}}$ = ____ **Units of Insulin (A)**
Give____ units per _____grams
Give____ units per _____grams

B. Correction Scale_____ units of insulin for every _____ over _____mg/dl (blood glucose)

If blood glucose is _____to _____mg/dl Give____ units
If blood glucose is _____to _____mg/dl Give____ units
If blood glucose is _____to _____mg/dl Give____ units
If blood glucose is _____to _____mg/dl Give____ units

C. Mealtime Insulin dose = A+B

Give mealtime dose: ☐ before meals ☐ immediately after meals ☐ if blood sugar is less than 100mg/dl give after meals

☐ Parental authorization should be obtained before administering a correction dose for high blood glucose level (excluding mealtime) ☐**Yes** ☐ **No**

☐Parents are authorized to adjust insulin dosage +/- by _____ units for the following reasons:

☐Increase/Decrease Carbohydrate ☐Increase/Decrease Activity ☐Parties ☐Other_____

☐Oral Diabetes Medication include medication name, dose, time and any side effects:

_____

_____

Activities/Skills	**Independent**	
Blood Glucose Monitoring	Yes	No
Carbohydrate Counting	Yes	No
Selection of snacks and meals	Yes	No
Treatment for mild hypoglycemia	Yes	No
Test urine/blood for ketones	Yes	No
Insulin dose calculation	Yes	No
Insulin injection administration	Yes	No

Authorization for the Release of Information:

I hereby give permission for _____ (school) to exchange specific, confidential medical information with _____ (Diabetes healthcare provider) on my child _____, to develop more effective ways of providing for the healthcare needs of my child at school

Prescriber Signature_____Date_____

Parent Signature_____Date_____