Peyton Manning
Children's Hospital

St. Vincent

Diabetes Care Plan

Student's Name:_____DOB:_____Grade:_____

Diabetes: Type 1 ____ Type 2____ Date of Diagnosis: _____

Student wears a diabetic identification bracelet or necklace: ___Yes ___No

Parent/Guardian:_____ Phone Number_____

Parent/Guardian:_____ Phone Number_____

Treating Physician:_____ Phone Number_____

Address: _____ Emergency Number:_____

****

Blood Glucose Target Range: _____mg/dl

Check blood glucose level:

__( )Hours after breakfast __2 hours after a correction dose

__Before lunch __After lunch __( )hours after lunch __Before dismissal

__Mid-morning __Before PE __After PE __As needed for signs/symptoms of illness

__ Suspected hyper/hypoglycemia

****

Student's Level of Diabetes Self Care

Student's Blood glucose checking skills: __ Independent __with supervision

__Requires School Nurse/trained diabetes personnel __Uses smartphone or other monitoring technology (CGM)

Student's self-care nutrition skills: __Independently counts carbohydrates __May count carbohydrates with supervision

__Requires School nurse/trained diabetes personnel to count carbohydrates

Student's self-care insulin administration:

__Independently calculates and gives own injections

__May calculate/give own injections with supervision

__Requires school nurse/trained diabetes personnel to calculate and student can give own injection with supervision

__Requires school nurse/ trained diabetes personnel to calculate dose and give the medication

Exercise/Physical activity:

Student may participate in regular physical education classes: __Yes __No

Student should not participate if blood glucose level is below _____mg/dl or above _____mg/dl.

Snack before exercise? __Yes __No __As needed Snack after exercise? __Yes __No __As needed __

Instructions for when food is provided to the class (e.g. class party, food sampling): _____

_____

Field Trip: *Staff will inform parent/guardian of all field trips.*

****

Insulin Therapy

Insulin delivery device: ___ Syringe ___ Insulin pen ___ Insulin pump

Type of insulin therapy at school: ___ Adjustable (basal-bolus) insulin ___ Fixed insulin therapy ___No insulin

***Carbohydrate Coverage/Correction Dose:** Name of Insulin: _____

***Carbohydrate Coverage: Insulin-to-carbohydrate ratio:** Lunch: 1 unit of insulin per _____grams of carbohydrate

Snack: 1 unit of insulin per _____grams of carbohydrate

Carbohydrate Dose Calculation Example

$$\frac{\textit{Total Grams of Carbohydrate to be Eaten}}{\textit{Insulin-to-Carbohydrate Ratio}} = \_\_\textit{Units of Insulin}$$

***Correction Dose:** Blood glucose correction factor (insulin sensitivity factor)=_____ Target blood glucose=_____mg/dl

Correction Dose Calculation Example

$$\frac{\textit{Current Blood Glucose} - \textit{Target Blood Glucose}}{\textit{Correction Factor}} = \_\_\textit{Units of Insulin}$$

****

Correction Dose Scale

Parental authorization should be obtained before administering a correction dose for high blood glucose levels.

_____Yes _____No

_____units if blood glucose is less than _____ mg/dl
_____units if blood glucose is _____ to _____ mg/dl
_____units if blood glucose is _____ to _____ mg/dl
_____units if blood glucose is _____ to _____ mg/dl
_____units if blood glucose is _____ to _____ mg/dl
_____units if blood glucose is over _____ mg/dl

Lunch: _____ Carbohydrate coverage only

_____Carbohydrate coverage 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 coverage plus correction dose when blood glucose is greater than _____mg/dl and_____hours since last insulin dose.

_____Correction dose only: For blood glucose greater than _____mg/dl AND at least _____hours since last insulin dose.

Other:_____

****

Hypoglycemia treatment (low blood sugar)

= _____ mg/dl or lower and/or physical symptoms

NEVER** send a student with actual or suspected low blood glucose anywhere alone

Student's usual symptoms of hypoglycemia:_____
_____
_____

If exhibiting symptoms of hypoglycemia, OR if blood glucose level is_____mg/dl or below, give 15 grams of fast-acting carbohydrate. _____
If blood glucose level is _____mg/dl or below, give 30 grams of fast-acting carbohydrate. _____

*Recheck blood glucose in 15 minutes and repeat treatment if blood glucose level is less than _____mg/dl.

Additional treatment:_____
_____

If student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions:
*Position the student on his or her side to prevent choking.
*Give _____mg **Glucagon** by injection.
*Call 911 and the student's parents/guardian immediately
*Stay with the student

****

Hyperglycemia treatment (high blood sugar)

= _____ mg/dl or higher

Student's usual symptoms of hyperglycemia:_____
_____
_____

*Give extra water and/or non-sugar containing drinks (not fruit juices): _____ounces per hour.
*Allow unrestricted access to the bathroom.
*Check urine for ketones every _____ hours when blood glucose levels are above _____mg/dl. _____
*For blood glucose greater than _____mg/dl AND at least _____ hours since last insulin dose, give correction dose of insulin.
(Please see individual student orders)
*Notify parents/guardians if blood glucose is over _____mg/dl.

Additional treatment: _____
_____
_____

For a hyperglycemia emergency, call 911 and contact the student's parents/guardians. *Hyperglycemia emergency may include: dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increased sleepiness or lethargy or depressed level of consciousness.*

****

Other diabetes medications

Name:_____ Dose:_____Route:_____ Times given:_____
Name:_____ Dose:_____Route:_____ Times given:_____

****

Supplies to be kept at School

_____ Water Bottles
_____ Blood glucose meter, test strips, extra batteries for meter
_____ Lancet device, lancets
_____ Urine ketone strips
_____ Insulin pump supplies
_____ Insulin pen, pen needles, extra insulin cartridges
_____ Fast-acting source of glucose
_____ Long-acting carbohydrate/protein
_____ Glucagon emergency kit
_____ CGM supplies, adhesive
Other:_____

****

****Please attach current Physician orders.**

Parent/Guardian Signature _____Date_____

I, the parent of _____, authorize the release and exchange of medical information between any of my child's health care providers and St. Vincent. I understand that this is for continuity of care purposes and may occur as needed without any prior notification or additional authorization throughout my child's care in the school system.

Parent/Guardian Signature _____ Date _____

Updated 4-2017