ISD 709 Duluth Public Schools

Duluth Public Schools
Health Services
Diabetes Care Plan

To be completed by parents/guardians/health care team and reviewed with necessary staff.

Place Childs Picture Here

*****Teachers: Never send a symptomatic student unaccompanied to the Health Office *****

Students Name: _____ **Birthdate:**_____ **Grade:**_____

Parent(s)/Guardian(s):_____ Home:_____ Cell:_____ Work:_____

Diagnosis: __*Type 1 Diabetes* __*Type 2 Diabetes* Date of Diagnosis: _____

Physician:_____Phone:_____Diabetic Nurse Educator:_____Phone:_____

Emergency Contact:_____ Home:_____ Cell:_____ Work:_____

Blood Glucose Monitoring: **Target Range**:_____-_____mg/dL

For BG Testing Student Will Need: ***__Supervision/Verification __Assistance __Independent***

Check BG: ***__ before lunch __ before exercise __after exercise __with signs/symptoms of hyper/hypoglycemia***

Other/Comments: _____

Insulin Delivery Device: __ *Syringe* __*Insulin Pen* __*Insulin Pump Type of Pump:*_____

Student Receives: ___ Novolog ____Humalog ___ Apidra ____Other:_____

For Insulin Injection Student Will Need: __*Supervision/Verification* __*Assistance* __*Independent*

Insulin/Carbohydrate Ratio: 1 unit per _____ grams of carbs **Correction Factor:**_____

Location of Supplies: _____ Location of Snack: _____

Can student effectively troubleshoot problems (ketosis, pump malfunction, ext.)? ___ Yes ___No

Other/Comments: _____

Hypoglycemia/Hyperglycemia:

If BG is below ____ mg/dL, give____ grams of fast-acting carbohydrate.

Retest after 10-15 minutes to assure BG is back up to_____ mg/dL.

If BG is above ____ mg/dL: ____Increase Water ____Given Insulin _____ Other

Please Check Yes or Not Applicable (N/A):

If BG is above _____ check ketones; if positive call parents immediately. **____ Yes ____ N/A**

Treatment for Ketones: _____

Student will have Glucagon available at school: *Dose:*_____ *Route:* ***__SQ __ IM*** **____ Yes ____ N/A**

Administer Glucagon if student is unable to swallow, unconscious or having a seizure. **____ Yes ____ N/A**

Other/Comments: _____

Exercise and Sports:

Snack before activity: __ Yes __ No Amount_____ Restrictions: _____

Transportation: __ Walk __ Bus __Other Length of bus ride _____

Field Trips: *Teacher will notify school nurse at least one week prior to allow time to plan with parents.*

***I authorize the above information to be shared with appropriate school staff and school transportation personal if applicable.**

Parent/Guardian Authorization: _____ **Date**_____

School Nurse Signature: _____ **Date** _____

Physician's Signature: _____ **Date** _____

Plan reviewed/updated:

Parent/Guardian Signature:_____Date:_____School Nurse Signature:_____Date:_____

Revised 4/20/2016