EAST TROY
COMMUNITY SCHOOL DISTRICT
Committed to the Growth & Success of Each Student, Each Year

DIABETIC CARE PLAN

SCHOOL INFORMATION

- ◯ Little Prairie Primary School
  2109 Townline Rd, East Troy
  P: 262-642-6730, F: 262-642-2724
- ◯ Prairie View Elementary School
  2131 Townline Rd, East Troy
  P: 262-642-6720, F: 262-642-6788
- ◯ East Troy Middle School
  3143 Graydon Ave, East Troy
  P: 262-642-6740, F: 262-642-6743
- ◯ East Troy High School
  3128 Graydon Ave, East Troy
  P: 262-642-6760, F: 262-642-6776

STUDENT INFORMATION

Student's Name:____________________ Date of Birth:__________ Gr:_____ Sex: ◯ M ◯ F

Parent's Name:____________________ Home #:__________ Cell #:__________

DIABETIC CARE PLAN

BLOOD SUGAR TESTING (Check ALL that apply)

- ☐ will not test at school.
- ☐ will be done by student every day at: ________ ◯ AM ◯ PM
- ☐ will be done by student when symptoms are present: ____________________
- ☐ will need assistance from an adult. Physician's Authorization must be signed.
- ☐ will not need assistance from an adult.
- ☐ testing supplies will be kept at school in: ____________________

INSULIN NEEDS (Check ALL that apply)

- ☐ will not need insulin at school.
- ☐ will need insulin at school. Complete Authorization for Prescription Medication.
- ☐ will be using an insulin pump and is self-sufficient in its use.
- ☐ will be using an insulin pump and will need assistance.

FOOD PLAN (Check ALL that apply)

- ☐ will bring a morning snack of ________ carbohydrates to be eaten at ________ ◯ AM ◯ PM
- ☐ will bring a afternoon snack of ________ carbohydrates to be eaten at ________ ◯ AM ◯ PM
- ☐ will eat ________ carbohydrates servings of ________ grams of carbohydrates at lunch.
- ☐ on special occasions, student can eat same snack provided to classmates.
- ☐ on special occasions, student will select alternate snack from supply provided by parent.

MEAL AND INSULIN NEEDS

BREAKFAST Insulin/Carbs	SNACK Insulin/Carbs	LUNCH Insulin/Carbs	SNACK Insulin/Carbs	SNACK Insulin/Carbs	SUPPER Insulin/Carbs	SNACK Insulin/Carbs
Time:	Time:	Time:	Time:	Time:	Time:	Time:

Insulin Type:____________________

Blood Glucose Target Range:____________________

Comments:____________________

Date Completed:____________________

Sliding Scale			
Blood Sugar		Insulin Dose	
	mg/dl		units
	mg/dl		units
	mg/dl		units
	mg/dl		units

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LOW BLOOD SUGAR SYMPTOMS

Blurred Vision	Fatique	Irritability	Trembling	Dizziness	Headache
Personality Change	Weakness	Fast Heartbeat	Hunger	Sweating	

Comments:____

LOW BLOOD SUGAR TREATMENT
(Teachers: Student with symptoms MUST be escorted to the Health Room). If student is experiencing symptoms, TEST BLOOD SUGAR.

For blood sugar <____________________ give 15 gms fast acting carbohydrate__________________________________

For blood sugar <____________________ give 30 gms fast acting carbohydrate__________________________________

If lunch or snack time - allow child to eat normal amounts of carbohydrate.
If not lunch or snack time - repeat blood sugar in 15-20 minutes. Repeat treatment as needed. (Parent will provide appropriate drinks and/or food).

Retest blood sugar in_____________ minutes. If under,_________________ repeat above treatment. If student is feeling better, he/she can

____

LOW BLOOD SUGAR TREATMENT FOR INSULIN PUMP THERAPY: In addition to the interventions listed above, if student who is using an insulin pump becomes unconscious due to a severe low blood sugar, trained staff will disconnect tubing from insulin pump. Call 911 and the child's parent. **For severe hypoglycemia with loss of consciousness or seizure, call 911, administer Glucagon 0.5 mg (<44 lbs), 1 mg (>44 lbs), then shut pump off & call parents.**

HIGH BLOOD SUGAR SYMPTOMS (Teachers: Allow use of a water bottle in class and use of the restroom as needed.)

Blurred Vision	Freq Urination	Nausea/Vomitting	Drowsiness	Stomachness	Extreme Thirst	Hunger	Heavy Labored Breathing

Comments:____

Test blood surgar if over____________________ student should drink large amounts of water.

Test urine ketones if blood sugar is over______________________ or if child is experiencing symptoms of high blood sugar.

HIGH BLOOD SUGAR TREATMENT FOR INSULIN PUMP THERAPY

In addition to the interventions listed above, if student is using an insulin pump and blood sugar is over 240 or___________ for two readings in a row, call parent.

Blood Glucose Target Range:__________________________

On Insulin Pump Therapy - High blood sugar before meals and 2 hours after:

Assess for pump/tubing/site problems.

Blood sugar is >____________________ give extra insulin by using the S/S or ISF.

Repeat blood sugar within_____________ hours if previous blood sugar >_______________

If report blood sugar >_________________ give insulin by syringe using the S/S or ISF.

Contact parents/guardians and/or health care provider if blood sugar >______________ and vomiting, difficulty breathing or lethargy (or other ketoacidosis)

Repeat blood sugar every_____________ hour(s). Give insulin using the S/S or ISF until the blood sugar is <_________________

Insulin Sensitivity Factor (ISF)

(correction factor)

1 unit of insulin will bring the blood sugar level down by:_________________

See student's table/formula

Sliding Scale			
Blood Sugar		Insulin Dose	
	mg/dl		units
	mg/dl		units
	mg/dl		units
	mg/dl		units

Comments:

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EMERGENCY DIABETIC CARE PLAN

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STUDENT INFORMATION

Student's Name:______________________ Date of Birth:__________ Gr:______ Sex: ◯ M ◯ F

Parent's Name:______________________ Home #:__________ Cell #:__________

EMERGENCY DIABETIC CARE PLAN

I have UNSULIN-DEPENDENT DIABETES which means I must take insulin every day along with balancing my diet and exercise. It is important for you to understand some things about diabetes while I am in your care. Several times a day, I check my blood sugar levels by using a special meter the I keep:

☐ with me ☐ in the office ☐ other: ______________________

LOW BLOOD SUGAR REACTIONS

Occasionally, my blood sugar may be too low (insulin reaction). This can be very dangerous. A low blood sugar reaction can be a result of receiving too much insulin, skipping a meal or snack, or an unusual amount of exercise. If you think my blood sugar is low, I may check my blood sugar in the classroom. If I go elsewhere to check my blood sugar, **someone must accompany me**. Some symptoms of low blood sugar may be:

- Shakiness
- Change in personality
- Confusion
- Sweatiness
- Feeling “low” or “hungry” or “tired”
- Looking pale or flushed in the face

If my blood sugar is low (<60mg/dl), I need fast-acting sugar quickly. You can give me______________________

I should start to feel better in 10-15 minutes. If my blood sugar remains low, call my parents and do the following:______________________

If my blood sugar drops too low, I may become unconscious or have a seizure. If this happens:

Call 911. **Give Glucagon** by injection. The following are trained to do this:**
*______________________
*______________________
*______________________

Glucagon is not life threatening even if it is given when not needed.

Call my parents.

Date Authorized:______________________

REVIEW SIGNATURES

I have reviewed and approved the Individualized Health Care Plan for Diabetes Management. I understand that specialized health care services will be performed by designated school personnel under the training and supervision provided by the School District Nurse or designee. This consent shall remain in effect through the end of the current school year unless discontinued or changed in writing. The plan or appropriate parts of the plan will be share with relevant school staff.

Physician's Signature:______________________ Date:__________

Parent/Guardian's Signature:______________________ Date:__________

District Nurse's Signature:______________________ Date:__________

Building Administrator's Signature:______________________ Date:__________

Other Staff's Signature:______________________ Date:__________

Other Staff's Signature:______________________ Date:__________

Other Staff's Signature:______________________ Date:__________

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