Diabetes Health Care Plan for Insulin Administration via Syringe or Pen

School: ____________________________
Start Date: ____________________________ End Date: ____________________________
Name: ____________________________ Grade/ Homeroom: ____________________________ Teacher: ____________________________

Transportation: □ Bus □ Car □ Van □ Type 1 □ Type 2
Parent/ Guardian Contact: Call in order of preference

<table>
<thead>
<tr>
<th>Name</th>
<th>Telephone Number</th>
<th>Relationship</th>
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Prescriber Name ____________________________ Phone ____________________________ Fax ____________________________

Blood Glucose Monitoring: Meter Location ____________________________ Student permitted to carry meter and check in classroom □ Yes □ No
BG= Blood Glucose  SG= Sensor Glucose

Testing Time □ Before Breakfast/Lunch □ 1-2 hours after lunch □ Before/after snack □ Before/after exercise □ Before bus ride/walking home □ Always check when student is feeling high, low and during illness □ Other

Snacks: □ Please allow a ________ gram snack at ________ before/after exercise, if needed.

Snacks are provided by parent/guardian and are located in ____________________________

Treatment for Hypoglycemia/Low Blood Sugar

If student is showing signs of hypoglycemia or if BG/SG is below ________ mg/dl

□ Treat with ________ grams of quick-acting glucose:
  □ ________ oz 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 (severe hypoglycemia): Call 911 and then parents

□ Give Glucagon: Amount of Glucagon to be administered: ________ (0.5 or 1 mg) IM, SC  □ OR □ Baqsimi 3 mg intranasally

□ 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 250 mg/dl, Notify parent/guardian if ketones are moderate to large

□ Notify parent/guardian for blood sugar over ________ mg/dl

□ Student does not have to be sent home for trace/small urine ketones

□ 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

Rev. 10/2019 Reviewed by Drs Carly Wilbur & Jamie Wood

Diabetes Page 17

Signs of Low Blood Sugar
personality change, feels funny, irritability, inattentiveness, tingling sensations headache, hunger, clammy skin, dizziness, drowsiness, slurred speech, seeing double, pale face, shallow fast breathing, fainting
Orders for Insulin Administration

Insulin is administered via: □ Vial/Syringe □ Insulin Pen □ Not taking insulin at school

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

□ Yes □ No □ Needs supervision (describe) ____________________________________________________________________________

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 for ______ grams
Give ______ units for ______ grams
Give ______ units for ______ grams
Give ______ units for ______ grams

OR

\[
\frac{\text{Carbohydrates To Eat}}{\text{Carbohydrate Ratio}} = \text{Units of Insulin (A)}
\]

B. Correction Factor: ______ units of insulin for every ______ over ______ mg/dl

If BG/SG is ______ to ______ mg/dl Give ______ units
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If BG/SG is ______ to ______ mg/dl Give ______ units

OR

\[
\frac{\text{Current BG/SG}}{\text{Target BG}} = \text{Amount to Correct} \pm \text{Correction Factor} = \text{Units of Insulin (B)}
\]

C. Mealtime Insulin dose = A + B

□ Other: ____________________________________________________________________________

Give mealtime dose: □ before meals □ immediately after meals □ If blood glucose is less than 100mg/dl give after eating

□ Parental authorization should be obtained before administering a correction dose for high blood glucose level (excluding meal time)

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

□ Increase/Decrease Carbohydrate □ Increase/Decrease Activity □ Parties □ Other ____________________________________________________________________________

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<tr>
<td>Blood Glucose Monitoring</td>
<td>Yes</td>
</tr>
<tr>
<td>Carbohydrate Counting</td>
<td>Yes</td>
</tr>
<tr>
<td>Selection of snacks and meals</td>
<td>Yes</td>
</tr>
<tr>
<td>Insulin Dose calculation</td>
<td>Yes</td>
</tr>
<tr>
<td>Insulin injection Administration</td>
<td>Yes</td>
</tr>
<tr>
<td>Treatment for mild hypoglycemia</td>
<td>Yes</td>
</tr>
<tr>
<td>Test Urine/Blood for Ketones</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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 ___________________________

Reviewed by Drs Carly Wilbur & Jamie Wood

Rev. 10/2019 Diabetes Page 18
Diabetes Health Care Plan for Insulin Administration via Insulin Pump

School: 
Start Date: ____________________ End Date: ____________________
Name: ____________________ Grade/Homeroom: ___________ Teacher: ____________________

Transportation: □ Bus □ Car □ Van □ Type 1 □ Type 2
Parent/Guardian Contact: Call in order of preference
Name
Telephone Number
Relationship
1. ____________________ ____________________ ___________ 
2. ____________________ ____________________ ___________ 
3. ____________________ ____________________ ___________

Prescriber Name ____________________ Phone ____________________ Fax ____________________

Blood Glucose Monitoring: Meter Location ________________ Student permitted to carry meter and check in classroom □ Yes □ No
BG= Blood Glucose  SG= Sensor Glucose
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, if needed
Snacks are provided by parent/guardian and located in ____________________

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Treatment for Hypoglycemia/Low Blood Sugar

If student is showing signs of hypoglycemia or if BG/SG is below ________ mg/dl

☐ Treat with _______(grams of quick-acting glucose:

☐ ___ oz 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 (severe hypoglycemia): Call 911 and then parents

☐ Give Glucagon: Amount of Glucagon to be administered: _____(0.5 or 1 mg) IM,SC  OR  □ Baqsimi 3 mg intranasally

☐ Notify parent/guardian for blood sugar below ________ mg/dl

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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

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☐ 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.

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Document all blood sugars and treatment

Rev. 10/2019 Reviewed by Drs. Carly Wilbur & Jamie Wood
Orders for Insulin Administered via Pump

Brand/Model of pump ____________________________ Type of insulin in pump ____________________________

Can student manage Insulin Pump Independently: □ Yes □ No □ Needs supervision (describe) ____________________________

Insulin to Carb Ratio: ___ units per ___ grams Correction Scale: ___ units per ___ over ___ mg/dl

Give lunch dose: □ before meals □ immediately after meals □ if BG/SG is less than 100 mg/dl give after meals

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

□ Increase/Decrease Carbohydrate □ Increase/Decrease Activity □ Parties □ Other __________________________________________

Student may: □ Use temporary rate □ Use extended bolus □ Suspend pump for activity/lows

If student is not able to perform above features on own, staff will only be able to suspend pump for severe lows.

□ For BG/SG greater than 250 mg/dl that has not decreased in 2 hours after correction, consider pump failure or infusion site failure and contact parents. Check ketones.

□ For infusion set failure, contact parent/guardian:

□ Student/parent insert new infusion set

□ Administer insulin by pen or syringe using pump recommendation

□ For suspected pump failure suspend pump and contact parent/guardian

□ Administer insulin by syringe or pen using pump recommendation

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<td>Management of Insulin Pump</td>
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<tr>
<td>Management of CGM</td>
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Prescriber Signature ____________________________ Date ____________

Parent Signature ____________________________ Date ____________

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Rev. 10/2019