Hamilton Heights School Corporation
Diabetes Management and Treatment Plan for School

Name:____Grade:_______________Date of Birth:___________

Physical Condition: Diabetes Type 1 Diabetes Type 2 Date of Diagnosis:_________________

CONTACT INFORMATION

Mother/Guardian Name:____
Address:____
Telephone: Home_____________________ Work______________________Cell______________________

Father/Guardian Name:____
Address:____
Telephone: Home_____________________ Work______________________Cell______________________

Student's Doctor/Licensed Health Care Practitioner

Name:____
Address:____
Telephone: ____FAX_________________________________

Other Emergency Contacts:

Name:____
Relationship:____
Telephone: Home_____________________ Work______________________Cell_______________________

Name:____
Relationship:____
Telephone: Home_____________________ Work______________________Cell_______________________

Notify parent/guardian or emergency contact in the following situations:

____

____

ALLERGIES:____
Food, Medication, etc.

Does student wear diabetic identification bracelet or necklace? Yes_____ No______

STUDENT'S ASSESSMENT FOR LEVEL OF SELF CARE

Task			
Testing blood sugar	☐ Can do alone	☐ Needs supervision	☐ Adult to do
Treating mild low blood sugars	☐ Can do alone	☐ Needs supervision	☐ Adult to do
Independently count carbohydrates	☐ Can do alone	☐ Needs supervision	☐ Adult to do
Drawing up insulin	☐ Can do alone	☐ Needs supervision	☐ Adult to do
Administering insulin (syringe, pen, or pump)	☐ Can do alone	☐ Needs supervision	☐ Adult to do
Checking ketones	☐ Can do alone	☐ Needs supervision	☐ Adult to do
Calculate carbohydrates consumed	☐ Can do alone	☐ Needs supervision	☐ Adult to do
Calculate correction doses	☐ Can do alone	☐ Needs supervision	☐ Adult to do
Recognize signs/symptoms of site infection	☐ Can do alone	☐ Needs supervision	☐ Adult to do
Calculate and set basal profiles	☐ Can do alone	☐ Needs supervision	☐ Adult to do
Calculate and set a temporary basal rate	☐ Can do alone	☐ Needs supervision	☐ Adult to do
Disconnect pump if needed	☐ Can do alone	☐ Needs supervision	☐ Adult to do
Reconnect pump at infusion set	☐ Can do alone	☐ Needs supervision	☐ Adult to do
Prepare reservoir and tubing	☐ Can do alone	☐ Needs supervision	☐ Adult to do
Insert new infusion set	☐ Can do alone	☐ Needs supervision	☐ Adult to do
Troubleshoot alarms and malfunctions	☐ Can do alone	☐ Needs supervision	☐ Adult to do
Re-program basal profiles if needed	☐ Can do alone	☐ Needs supervision	☐ Adult to do

BLOOD GLUCOSE MONTIORING

Target Range for blood glucose is: ______________________________

Target Blood glucose ***range for testing***: ______________________________

Usual times to check blood glucose: ______________________________

Times to do extra blood glucose checks (check all that apply):

☐ Before exercise

☐ After exercise

☐ When student exhibits symptoms of hyperglycemia

☐ When student exhibits symptoms of hypoglycemia

☐ Other (please explain) ______________________________

Exceptions: ______________________________

Type of blood glucose meter student uses: ______________________________

Does student take oral diabetes medications? ☐ YES ☐ NO

Type of medication: ____________________ Timing: ____________________

Other medications: ____________________ Timing: ____________________

INSULIN THERAPY:

TYPE OF INSULIN: ____

BASAL RATES:

_____ units from _____ to _____
_____ units from _____ to _____
_____ units from _____ to _____
_____ units from _____ to _____
_____ units from _____ to _____

CORRECTION DOSES:

__________ units of _______________ if blood glucose is __________ to __________ mg/dl
__________ units of _______________ if blood glucose is __________ to __________ mg/dl
__________ units of _______________ if blood glucose is __________ to __________ mg/dl
__________ units of _______________ if blood glucose is __________ to __________ mg/dl
__________ units of _______________ if blood glucose is __________ to __________ mg/dl

INSULIN TO CARBOHYDRATE (CHO) RATIO:

_____ unit for ________ grams of carbohydrates from _____ to _____
_____ unit for ________ grams of carbohydrates from _____ to _____
_____ unit for ________ grams of carbohydrates from _____ to _____
_____ unit for ________ grams of carbohydrates from _____ to _____

SENSITIVITY FACTOR:

1 unit for every _____ points from _____ to _____
1 unit for every _____ points from _____ to _____
1 unit for every _____ points from _____ to _____

CORRECTION DOSE FORMULA IS:

(Blood sugar – __________) / __________

MEALS AND SNACKS EATEN AT SCHOOL

Meal/Snack	*Time*	*Food content/amount*
Breakfast	________________________________	________________________________
Mid-morning snack	________________________________	________________________________
Lunch	________________________________	________________________________
Mid-afternoon snack	________________________________	________________________________
Dinner	________________________________	________________________________

Snack needed before exercise? ☐ YES ☐ NO
Snack needed after exercise? ☐ YES ☐ NO

If yes, please indicate type/amount: ____

Other times to give snacks (include content and amount): ____

Foods to avoid, if any: ____

EXERCISE AND SPORTS ACTIVITES

Student may participate in regular PE classes ☐ YES ☐ NO
Student may participate in after school sports ☐ YES ☐ NO

Restrictions on activity, if any: ____

A fast-acting carbohydrate, such as ______________________ should be available at the site of the exercise or sport.

Student should not exercise if blood glucose level is below ________ mg/dl OR above ________ mg/dl OR if moderate to large urine ketones or blood ketones of ________ mmol/L are present.

TREATMENT OF LOW BLOOD SUGAR (HYPOGLYCEMIA)

Usual Signs and Symptoms of Low Blood Glucose include: (Please circle all that apply)

A. Trembling/Shakiness B. Hunger C. Sweatiness
D. Pale E. Weak F. Dizzy
G. Headache/stomachache H. Irritable/crying I. Personality changes
J. Confusion K. Restless L. Combative
M. Other ____

Treatment for conscious student with Low Blood Sugar who is able to swallow:

Check blood glucose if possible. If blood glucose is less than ________ mg/dl or child is symptomatic, then:

1. Administer 15 grams of carbohydrates
2. Recheck the student in 15-20 minutes
3. If blood glucose is less than ________ mg/dl or student is still symptomatic, administer additional 15 grams of carbohydrates
4. If blood glucose is more than ________ mg/dl, child is symptom free, and it is more than 1 hour until the next meal or snack – follow with 3 graham crackers, 6 crackers, 8 oz. of white milk, or ____

Notify parents/guardians if low blood glucose treatment is given or if ______________________.

Comments/ Special Instructions: ____

Treatment of student with low blood sugar who is unconscious or unable to swallow:

1. DO NOT leave the child unattended
2. DO NOT attempt to give anything by mouth
3. Trained individual should administer Glucagon injection ☐ YES ☐ NO
   Dosage ______________
4. Turn student on side
5. **CALL 911**
6. Notify parents/guardians

Comments / Special Instructions ____

TREATMENT OF HIGH BLOOD SUGAR (HYPERGLYCEMIA)

Usual Signs and Symptoms of High Blood Glucose include: (Please circle all that apply)

A. Increased Thirst
B. Frequent Urination
C. Stomachache
D. Vomiting
E. Other ____

If student is symptomatic OR blood glucose is over ____________ mg/dl, check for blood or urine for ketones.

If urine ketones are negative or trace OR blood ketones are below 0.6 mmol/L:

1. Call the school nurse
2. No additional insulin is required
3. Student may participate in all activities
4. Give sugar free liquids (i.e. water) _____________ounces per hour.
5. Student may require extra bathroom privileges
6. Nurse must notify parents so they can continue to monitor at home

If urine ketones are small OR blood ketones are 0.6 – 1.5 mmol/L:

1. Call the school nurse
2. No additional insulin is required
3. Student may participate in all activities
4. Give sugar free liquids (i.e. water) _____________ounces per hour
5. Student may require extra bathroom privileges
6. Nurse must notify parents so they can continue to monitor at home

If urine ketones are moderate or large OR blood ketones are above 1.5 mmol/L

1. Call the school nurse
2. Additional insulin may be required
3. Give a correction dose ____
4. Student should not return to class or participate in exercise related activities
5. Give sugar free liquids (i.e. water) _____________ounces per hour
6. Student may require extra bathroom privileges
7. Nurse must notify parents so they can continue to monitor at home

Comments/ Special Instruction: ____

SUPPLIES TO BE LEFT AT SCHOOL AND PROVIDED BY THE PARENT

_______ Blood glucose meter, blood glucose test strips, batteries for meter
_______ Lancet device, lancets
_______ Urine or blood ketone strips
_______ Insulin vials and syringes
_______ Insulin pump and supplies
_______ Insulin pen, pen needles, insulin cartridges
_______ Fast-acting source of glucose
_______ Carbohydrate containing snacks
_______ Glucagon emergency kit
_______ Other (please list) ____

SIGNATURES

The Diabetes Management and Treatment Plan has been approved by:

____

Student's Physician/Health Care Provider   Date

I give permission to the school nurse, trained diabetes personnel, and other designated staff members of Hamilton Heights School Corporation to perform and carry out the diabetes care tasks as outlined by ____'s Diabetes Management and Treatment Plan. Should the student's Physician or Health Care Provider make changes to the Diabetes Management and Treatment Plan during the school year, I agree to provide the information to the student's School Nurse in writing. I also consent to the release of the information contained in the Diabetes Medical Management Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

Acknowledged and received by:

____

Student's Parent/Guardian   Date

____

Student's Parent/Guardian   Date

Reviewed by:

____

School Nurse   Date