School District of Iola-Scandinavia-Confidential

Health Services: Diabetic Health Care Plan

Students Name:	Date of Birth:
Grade:	School Year:
Bus student: (Circle one) YES NO	

Blood Sugar Testing (Check ALL that apply.)

___Will **NOT** need assistance from an adult ____Will need assistance from an adult

___Will be done by student when symptoms are present such as: ____

___Will be done by student every day at: ____

___Testing supplies will be kept at school in: ____

___Will a continuous glucose monitoring device be utilized at school? YES______ NO ______

Please describe____

Insulin Needs (Check ALL that apply.)

___Will NOT need insulin at school **Blood Glucose Target Range: _______________________________**

___Will need insulin at school. If so what type of insulin: ______________________Does it need refrigeration? Yes No

___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 daily morning snack of ____ carbohydrates to be eaten at ____a.m.

___Will bring daily afternoon snack of ____carbohydrates to be eaten at ____p.m. _

___On special occasions, student can eat same snack provided to classmates

___On special occasions, student will select alternate snack from supply provided by his/her family

Low Blood Sugar Symptoms (Check ALL that apply)

___Blurred Vision ___Fatigue ___Irritability ___Trembling ___Dizziness ___Headache

___Weakness ___Hunger ___Sweating ___Personality change ___Fast Heartbeat

___Other:____

Low Blood Sugar Treatment (Teachers: Students with symptoms must be escorted to the office)

If student experiencing symptoms, TEST BLOOD SUGAR

If blood sugar below _____ give quick sugar of ____

Re-test blood sugar in 10-15 minutes. Repeat treatment as needed. Parents to provide drinks/and or food

Student may return to class if blood sugar is > than ____

Severe Low Blood Sugar Treatment <u>WITHOUT</u> Insulin Pump: In addition to the interventions listed above- For severe hypoglycemia with loss of consciousness or inability to swallow- Call 911, STAY WITH STUDENT, and administer prescribed Glucagon and child’s parent will be notified.

Severe Low Blood Sugar Treatment for Insulin Pump Therapy: In addition to the interventions listed above- For severe hypoglycemia with loss of consciousness or inability to swallow-Disconnect tubing from the insulin pump, Call 911, STAY WITH STUDENT, and administer prescribed Glucagon and child’s parent will be notified.

Glucagon Administration-(student unconscious or unable to eat or drink)
Administer Glucagon _______ mg I.M. (Buttock, Thigh, or Arm) ***Must have a Medication Authorization Form signed***
Have student in side lying position, if not done already call 911, monitor student, document the time medication was given, dosage of medication given and location in which it was received. If student stops breathing administer rescue breaths and if pulse stops begin CPR, and contact parent/guardian

High Blood Sugar Symptoms (Teachers: Allow use of a water bottle in class and use of restroom as needed) Check ALL that apply)
___Blurred Vision ___Frequent urination ___Nausea/Vomiting ___Drowsiness ___Fatigue
___Heavy Breathing ___Stomach ache ___Extreme thirst ___Hunger
___Other:____

High Blood Sugar Treatment (With or without insulin pump)
Test Blood Sugar, if over _____mg/dl student should drink large amounts of water. Retest the blood sugar in ____ minutes/hours and if symptoms persist and blood sugar remains high call parent for further instruction
Comments:____
____

Ketone testing: (Check one) ___Testing at school ___No ketone testing at school-(not applicable)

Test Urine Ketones if blood sugar is over _____mg/dl or if child is experiencing symptoms of high blood sugar
Contact parent/guardian when ketones are: ____

****If your child requires blood glucose monitoring or medication at school you must have a medication authorization form signed by you and your child's doctor on file for THIS school year****

<u>If medication is needed, a supply must be kept at school for your child to participate in field trips/extracurricular activities</u>

Parent/Emergency Contact Information:

Mother	Father	Other
Name:	Name:	Name:
Home Phone:	Home Phone:	Home Phone:
Cell Phone:	Cell Phone:	Cell Phone:
Work Phone:	Work Phone:	Work Phone:
Email address:	Email address:	Email address:

Authorization is hereby granted to release this information to appropriate school personnel and classroom teacher to ensure safe management of your child's condition. If there are any questions or changes in this plan, please inform the School Nurse <u>and/or</u> office staff as soon as possible.

Parent/or legal guardian Signature: ______________________________Date: _______________________

School Nurse Signature: ______________________________________ Date: _______________________