Diabetes Health Care Plan for Insulin Administration via Syringe or Pen

School: ___________________________  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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<tbody>
<tr>
<td>1.</td>
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<td>3.</td>
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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 recess
□ 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

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<table>
<thead>
<tr>
<th>Signs of Low Blood Sugar</th>
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<tbody>
<tr>
<td>personality change, feels funny, irritability, inattentiveness, tingling sensations headache, hunger, clammy skin, dizziness, drowsiness, slurred speech, seeing double, pale face, shallow fast breathing, fainting</td>
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</tbody>
</table>
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

OR

_______ + _______ = _________ Units of Insulin (A)
Carbohydrates To Eat Carbohydrate Ratio Carbohydrate Bolus

B. Correction Factor: ____ unit/s of insulin for every ____ over ____ mg/dl Target BG

If BG/SG is ____ to ____ mg/dl Give ____ units
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OR

____ - _______ = _______ + _______ = _______ Units of Insulin (B)
Current BG/SG Target BG Amount to Correct Correction Factor

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 _______________

<table>
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<th>Student self-care task</th>
<th>Independent</th>
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<tbody>
<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>
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<tr>
<td>Treatment for mild hypoglycemia</td>
<td>Yes</td>
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<tr>
<td>Test Urine/Blood for Ketones</td>
<td>Yes</td>
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</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

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