Evansville Vanderburgh School Corporation
Bringing Learning to Life

Date:_____

DIABETES CARE PLAN

Last Name: _____ First Name:_____ MI:_____ DOB:_____

School:_____ Grade:_____ Year of Diagnosis:_____

Parent/Guardian Name:_____ Phone (H):_____
Phone (W):_____
Address:_____

Parent/Guardian Name:_____ Phone (H):_____
Phone (W):_____
Address:_____

Emergency Contact #1:_____ Relationship:_____ Phone:_____

Emergency Contact #2:_____ Relationship:_____ Phone:_____

Physician seen for Diabetes:_____ Phone:_____
Address:_____ Fax:_____

Primary Care Physician:_____ Phone:_____

ALLERGIES: (Food, Medication, etc)_____
STUDENT WEARS A DIABETIC IDENTIFICATION BRACELET OR NECKLACE: Yes:☐ No:☐

BLOOD GLUCOSE TARGET RANGE:_____

BLOOD GLUCOSE MONITORING: **MONITOR/METER NAME:**_____

Student is able to perform self blood glucose testing: **Yes:**☐ **No:**☐
Student needs assistance to test: **Yes:**☐ **No:**☐
Student monitors blood glucose **BEFORE:**
Breakfast:☐ **Before Exercise:**☐
Lunch:☐ **After Exercise:**☐
Dinner:☐ **Before AM Snack:**☐
Bedtime:☐ **Before PM Snack:**☐

CURRENT INSULIN TREATMENT:

Student will inject insulin at school: **Yes:**☐ **No:**☐
Student will self-prepare and inject: **Yes:**☐ **No:**☐
Student needs assistance with injection: **Yes:**☐ **No:**☐

TYPES OF INSULIN: _____

BREAKFAST: Carb exchange ratio:_____
Corrective dose used: **Yes:**☐ **No:**☐
BS - _____ **divided by** _____
***Sliding Scale used:** **Yes:**☐ **No**☐

LUNCH: Carb exchange ratio:_____
Corrective dose used: **Yes:**☐ **No:**☐
BS - _____ **divided by** _____
***Sliding Scale used:** **Yes:**☐ **No:**☐

***IF** sliding scale used, define scale below:

_____

INSULIN PUMP: **Yes:**_____ **No:**_____
*Brand / Model:*_____

GLUCAGON ORDERED: **Yes:**☐ **No:**☐
■ See **TREATMENT OF HIGH** area, Pg. 2

ROUNDING RULES:
_____
_____

MEAL / SNACK TIMES: Breakfast_____ AM Snack_____ Lunch_____ PM Snack_____

(*Student will generally bring the following for snack*: _____)

EXERCISE / SPORT ACTIVITY: May participate in regular PE classes**: Yes:**☐ **No:**☐ After-school sports: **Yes:**☐ **No**:☐

■ Student carries _____ for treatment of Low Blood Glucose. ■A snack will be eaten if blood glucose is under _____

■ Exercise should be delayed if blood glucose is higher than _____ or lower than _____.

TREATMENT OF HIGH BLOOD SUGAR

1. **If blood glucose is over _____ , check urine for Ketones.**
2. **Give sugar-free liquids (such as water): _____ ounces per hour if Ketones are present.**
3. **Contact parent:**
   - ☐ If Ketones are positive and blood glucose is over _____.
   - ☐ If child is vomiting with blood glucose over _____.
   - ☐ OTHER: _____

COMMENTS/SPECIAL INSTRUCTIONS:_____

_____

TREATMENT OF LOW BLOOD SUGAR

Symptoms student has experienced when having a low blood glucose:

_____ _____ _____ _____ _____ _____

Common signs and symptoms of Low Blood Sugar:

- ■ *Trembling* ■ *Shakiness* ■ *Sweatiness* ■ *Paleness*
- ■ *Weakness* ■ *Weakness* ■ *Dizziness* ■ *Headache*
- ■ *Incoherent* ■ *Irritable* ■ *Confusion* ■ *Restlessness*
- ■ *Combativeness*

Treatment for <u>conscious</u> student with Low Blood Sugar who is able to swallow:

1. Administer **IMMEDIATELY** sugar source: _____

   Sugar examples: ■ 3 glucose tablets ■ ½ cup fruit juice ■ 6oz regular soda
   ■ 1 fruit rollup ■ 8 life savers ■ mini bag of skittles
   ■ ½ candy bar ■ 2 tablespoons cake frosting from tube
2. If symptoms do not improve in 15 – 20 minutes, repeat treatment
3. Notify parent if**:**_____

COMMENTS / SPECIAL INSTRUCTIONS:_____

_____

Treatment for <u>unconscious</u> student with Low Blood Sugar who is unable to swallow:

1. Administer Glucagon Injection: Yes:☐ No:☐ (☐1/2 vial ☐1 vial)
2. Test blood glucose every 10 minutes
3. Notify parent of low blood glucose
4. Contact **911** if child remains unresponsive 15 minutes after Glucagon
5. **DO NOT** give liquids to drink while unresponsive

COMMENTS / SPECIAL INSTRUCTIONS:_____

_____

Physician Signature:_____ **Date:**_____