Form 504.1.5 – Diabetes Care Plan

Diabetes Care Plan

Diabetes Care Plan For: _____

School: _____ Effective Dates: _____

Date of Birth: _____ Grade: _____ Homeroom Teacher: _____

Place photo of student here.

Contact Information

Parents/Guardians	Home Phone	Work Phone	Cell Phone	Address
Students Doctor	**Home Phone**	**Work Phone**	**Cell Phone**	**Address**
Other Contacts	**Home Phone**	**Work Phone**	**Cell Phone**	**Address**

School to contact parent/guardian in the following situations:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Form 504.1.5 – Diabetes Care Plan cont'd

Hypoglycemia (Low Blood Sugar)

Usual symptoms of hypoglycemia:_____

_____

Treatment for hypoglycemia:_____

_____

Location of hypoglycemia kit:_____

_____

Glucagon treatment for severe hypoglycemia ☐ **Yes** ☐ **No**

Location of Glucagon kit: _____

_____

Call 911 or emergency medical service if the student is incoherent, unconscious, is unable to swallow or has had a seizure.

Glucagon should not be given during a seizure **(convulsion).**

School personnel trained to administer glucagon and dates of training:

Name	Date

Form 504.1.5 – Diabetes Care Plan cont'd

I. Hyperglycemia

Usual symptoms of hyperglycemia: _____

_____

Treatment for hyperglycemia: _____

_____

_____

Test urine for ketones when blood glucose greater than _____ mmol/L

Test urine for ketones when student is feeling sick: ☐ Yes ☐ No

Procedure for ketone testing: _____

_____

_____

_____

Diabetes Supplies

Supplies	Location
Blood glucose monitoring equipment	
Insulin administration supplies	
Hypoglycemia treatment kit	
Glucagon emergency kit	
Ketone testing supplies	
Snack foods	

Blood Glucose Monitoring

Type of blood glucose meter student uses: _____

_____

Target range for blood glucose: _____mmol/L to _____mmol/L

Usual times to test blood glucose:

☐ Before Breakfast ☐ Before Supper

☐ Before Lunch ☐ Before bedtime or before bedtime snack

☐ 2 hours after meals ☐ During the night (Time: _____)

Times to do extra test (Check all that apply)

☐ Before Exercise ☐ After Exercise

☐ When student exhibits hyperglycemia

☐ When student exhibits hypoglycemia

☐ Other (explain) _____

Form 504.1.5 – Diabetes Care Plan cont'd

Can student perform own blood glucose test? ☐ Yes ☐ No

Exceptions: _____

_____

School personnel trained to monitor blood glucose levels and dates of training:

☐ Not applicable

Name	Date

Insulin

Times, type and dosages to be given during school:

Time	Type	Dosage

School personnel trained to assist with insulin injections and dates of training:

☐ Not applicable

Name	Date

Can student give own injections? ☐ Yes ☐ No

Can student determine correct amount of insulin? ☐ Yes ☐ No

Can student draw/dial correct amount of insulin? ☐ Yes ☐ No

Form 504.1.5 – Diabetes Care Plan cont'd

For Students With Insulin Pumps:

Type of pump: _____

Basal Rates: _____

Meal Boluses: _____

Insulin/Carbohydrate ratios: _____

Correction Factor: _____

Is student competent regarding pump? ☐ Yes ☐ No

Can student deal with pump malfunction? ☐ Yes ☐ No

Contact person if pump malfunction is suspected: _____

_____

Comments:_____

_____

_____

Form 504.1.5 – Diabetes Care Plan cont'd

Meals and Snack Foods

Meal	Time	Food Content/Amount
Breakfast		
AM Snack		
Lunch		
PM Snack		
Dinner		
Bedtime Snack		

Snack before exercise? ☐ Yes ☐ No Type of Snack:_____

Snack after exercise? ☐ Yes ☐ No Type of Snack:_____

Other Times To Give Snacks: _____ Type of Snack:_____

A source of glucose, such as _____ should be readily available at all times.

Foods to Avoid:_____

_____

_____

Instructions for when food is provided to the class: _____

_____

_____

_____

Form 504.1.5 – Diabetes Care Plan cont'd

II. Exercise and Sports

A snack such as _____ should be readily available at the site of the exercise or sport.

Restrictions on activity in any: _____

_____

Student should not exercise if blood sugar is below _____ mmol/L, or greater than _____ _____ mmol/L, and showing ketones in urine.

Signatures

Reviewed By: _____ Acknowledged By: _____
Diabetes care team member *Parent/Guardian*

Received By: _____ Received By: _____
School health team member *School Personnel or Administrator*

For more information, contact the diabetes care team @ 403-382-6675, Diabetes and Lipids Education Program, Chinook Health Region

OR

School Health Nurse @ 403-385-6666
Community Health Lethbridge, Chinook Health Region