M.S.D. Student Health Services

LAF Fax: 260-569-6837 MNE Fax: 260-569-6838 NHS Fax 260-569-6839
SCE Fax: 260-569-6841 SES Fax: 260-569-6842 SHS Fax: 260-569-6843

School Year

STUDENT HEALTH SERVICES
PLAN OF CARE - DIABETES

Student Name: _____ D.O.B:_____ Grade:_____

Year of Diagnosis: _____

Parent/Guardian Name:_____Home phone #: _____ Work # _____ Cell #:_____

Emergency Phone Contact #1 _____
_____ Name Relationship Phone

Emergency Phone Contact #2 _____
_____ Name Relationship Phone

Physician student sees for diabetes: _____ Phone_____

Family Physician: _____ Phone_____

ALLERGIES _____
_____Food, medication, etc.

Student wears a diabetic identification bracelet or necklace. ☐ Yes ☐ No

****

Insulin Pump: ☐ Yes ☐ No Insulin / Carbohydrate Ratio: _____
Is student competent regarding pump? ☐ Yes ☐ No

Blood Glucose Target Range _____

Type of Insulin / Dosage / Time
Pre Breakfast _____ Lunch _____ Supper _____ Bedtime _____

Current Insulin Treatment:

Student will inject insulin at school. ☐ Yes ☐ No
Student can determine correct dose of insulin and draw or bolus correct dosage. ☐ Yes ☐ No
Students needs assistance with injection. ☐ Yes ☐ No

Meals / Snacks Times

Breakfast _____ Snack _____ Lunch _____ PM Snack _____ Dinner _____ Bedtime Snack _____

Student will generally bring one of the following for a snack:

_____ _____ _____
_____ _____ _____

Exercise / Sport Activity

Snack before ☐ Yes ☐ No **Snack after** ☐ Yes ☐ No

Student may participate in regular PE classes ☐ Yes ☐ No
Student may participate in 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 _____.

BLOOD GLUCOSE MONITORING

Name of Monitor / Meter _____

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 _____

Supper _____ Before AM snack _____

Bedtime _____ Before PM snack _____

Exhibits symptoms of high blood sugar. ☐ Yes ☐ No

Exhibits symptoms of low blood sugar. ☐ Yes ☐ No

TREATMENT OF HIGH BLOOD SUGARS

1. If blood glucose is over _____, check urine for Ketones. (Parents provide strips)
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 _____.
   - Child is vomiting with blood glucose higher than 400.

Comments / Special Instructions: _____

_____

Notify parent if _____

TREATMENT OF LOW BLOOD SUGARS (Hypoglycemia)

Symptoms student has experienced when having a low blood glucose level include: _____

_____

Signs and Symptoms of Low Blood Sugar:

A. Trembling	B. Sweaty	C. Pale
D. Weak	E. Dizzy	F. Headache
G. Incoherent (as if drunk)	H. Irritable	I. Confused
J. Restless	K. Combative	L. Hungry

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

1. Administer immediately sugar source such as:
   - 3 glucose tablets
   - ½ cup fruit juice
   - 6 oz. Regular soda
   - one fruit roll up
   - 8 life savers
   - ½ candy bar
   - 2 tablespoons cake frosting from tubes
   - glucose gel placed between cheek and side of gum
2. If symptoms do not improve in 15-20 minutes, repeat treatment.
3. Notify parent of low blood glucose treatment given if _____.

Comments / Special Instructions: _____

_____

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

1. Administer Glucagon injection ***(parents supply injection)***. ☐ Yes ☐ No
2. Contact **911**.
3. Notify parent of low blood glucose.
4. ***DO NOT*** give liquids to drink while unresponsive.
5. Test blood glucose every 10 minutes.

Comments / Special Instructions: _____

_____

Physician's printed name	Physician's signature	Phone #	Date

Printed name of parent / guardian	Signature	Date