

# M.S.D. Student Health Services

MNE Fax: 260-569-6838

SES Fax: 260-569-6842

SCE Fax: 260-569-6841

NHS Fax 260-569-6839

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 \_\_\_\_\_

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 #
Printed Name of Parent/Guardian	Signature	Date