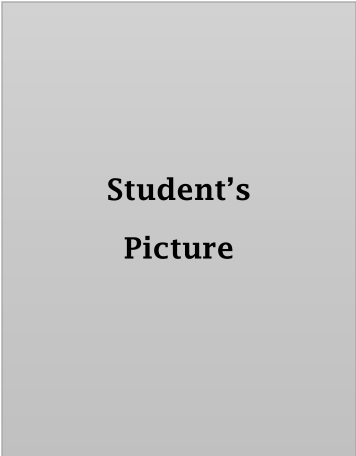

UTICA COMMUNITY SCHOOLS
DIABETES HEALTH CARE PLAN

EFFECTIVE DATE:________________________________

Student's Name____

DOB______________**Grade**________ **Teacher**______________________________

Reviewed by: _______________________________________(health care provider)
Signature Date

Acknowledged by:_____________________________________(parent/guardian)
Signature Date

Acknowledged by: ____(school rep.)
Signature Date

Contact Information

Parent #1 Name____________________________________ **Parent #2 Name**______________________________________

Parent/Guardian #1: Home_______________________ **Work**_________________________ **Cell**________________________________

Parent/Guardian #2: Home_______________________ **Work**_________________________ **Cell**________________________________

Student's Doctor/Health Care Provider____ **Phone**_____________________________

Other Contact__________________________________ **Relationship** ______________________ **Phone**______________________________

Notify parent/guardian in the following situation: ____

Location of Supplies

Monitoring Equipment_________________________________ **Ketone Test Strips**____________________________________

Insulin Supplies____ **Glucagon Kit**____

Sharps Disposal: School Office

Snack Foods____

Glucose Testing

Target range for Blood Glucose: ____ **to** ____ **Target Blood Glucose:** __________________________

Usual Glucose Testing Times – Use dropdown to select Blood Glucose (BG) or Continuous Glucose Monitor (CGM):

____a.m. ____a.m. ____p.m. ____p.m.

Check Extra Glucose Testing Times— Use dropdown to select Blood Glucose (BG) or Continuous Glucose Monitor (CGM):

Before gym

Before recess

After gym

After recess

_X_ With Symptoms of High blood sugar

_X_ With Symptoms of Low Blood Sugar

Can student perform own glucose testing? Yes No Supervised? Yes No

****Students with Diabetes may test anywhere in building: classroom, cafeteria, office, etc.****

Continuous Glucose Monitoring (CGM)

___If CGM glucose reading is less than _______ or student exhibits symptoms that do not match reading, check an actual blood glucose with student's glucometer

___If CGM glucose reading is greater than _______ or student exhibits symptoms that do not match reading, check an actual blood glucose with student's glucometer

_X_ Student may have cell phone with alarm limits audibly set for continuous glucose monitoring with CGM technology

Adapted from National Diabetes Education Program's 2017: Helping the Student with Diabetes Succeed: A Guide for School Personnel

Insulin

Brand of Insulin ____________________ **Sensitivity/Correction Factor (CF)_____** **Insulin-to-Carb Ratio (I:C)** _____

Insulin Delivery: ____ Vial and Syringe ___Pen ___Pump:________________________________(Brand Name of Pump)

Times for insulin delivery: ____ Morning Snack ____ Lunch ____ Afternoon Snack

Can student determine dose of insulin Yes Yes, with supervision No

required? Can student administer insulin Yes Yes, with supervision No

independently? Can student replace pump Yes No, call parent for replacement of pump site

I understand that a designee of the building administrator will be administering insulin ____________________________

(Parent Signature)

Meals and Snacks

Breakfast (Time and Amount of Carbohydrates): __________________________ ____

Morning Snack (Time and Amount of Carbohydrates): ______________________ ____

Lunch (Time and Amount of Carbohydrates): ___________________________ ____

Afternoon Snack (Time and Amount of Carbohydrates): _______________________ ____

Instructions for Class Functions (i.e. Class Parties): ____

Exercise and Sports

A snack such as ____ **should be available at the site of activity at all times.**

Student should not exercise if glucose level is below ________ **or above** _________ **with moderate to large ketones.**

Restrictions on activity: _X_ Student may return to the activity if glucose level comes back up to _____________

Snack before gym? _____ If needed _____ Routinely before gym/exercise

Hypoglycemia (Low Blood Glucose)

Student's usual symptoms of hypoglycemia:____

Treatment of hypoglycemia: Give ______ grams of fast-acting carbohydrates, recheck glucose level in 15 minutes, and repeat until above _______

____ If more than one hour before next meal, once glucose level up to desired amount, give a longer-acting carb snack (i.e. Carbohydrate and protein snack)

****Students may have snacks as needed anywhere on school grounds to treat a low blood sugar.****

****Glucagon should be given if student is unconscious, falls asleep and can't awaken, unable to swallow or has a seizure. Call 911, administer Glucagon, and place student on side following injection. Contact parents.****

Hyperglycemia (High Blood Glucose)

Student's usual symptoms of hyperglycemia: ____

Treatment of hyperglycemia: ____ Drink water _____ Staff or student to contact parent for glucose greater than 300

_____ Student may exercise to help bring down blood sugars as long as ketones are not moderate or large

_X_ Check ketones for glucose level greater than______

Insulin administration: ______ Via pump, if glucose is greater than _____ and at least 2 hours since last dose per DMMP.

______ Per parent direction, if glucose is greater than _____ and at least 2 hours since last dose per DMMP.

****Student's may have unlimited water and bathroom access due to high blood sugars. ****

****Parents will be called to pick up students with moderate to large ketones for closer observation at home with guidance from the child's Endocrinologist. ****

Transportation

UCS Transportation Medical & Emergency Form Completed? Yes No Sugar source in backpack? Yes No