Western School Corporation
PLAN OF CARE – DIABETES

Name: _____Grade_____ Age_____
Last Name First MI
School Building: _____

Parent/Guardian Name: _____Phone (H)_____

Address: _____Phone (W)_____

Emergency Phone Contact #1: _____ _____ _____
Name Relationship Phone
Emergency Phone Contact #2: _____ _____ _____
Name Relationship Phone
Physician Student Sees for Diabetes: _____

Other Physician: _____

ALLERGIES: _____
Food, Medication, etc

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

Insulin Pump Yes _____ No _____

Blood Glucose Target Range _____

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 _____

Type of Insulin - Dose and Time
Pre Breakfast _____ Lunch _____ Supper _____ Bedtime _____

Meals/Snacks - Times
AM Snack _____ PM Snack _____ Bedtime Snack _____

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

Exercise/Sport Activity
Student may participate in regular PE class Yes _____ No _____
Student may participate in after school sports Yes _____ No _____
Student carries _____ for treatment of low blood glucose.
A snack should 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: Breakfast _____ Before Exercise _____

Lunch _____ After Exercise _____

Supper _____ Before AM Snack _____

Bedtime _____ Before PM Snack _____

TREATMENT OF HIGH BLOOD SUGARS

1. If blood glucose is over _____, check urine for Ketones.
2. Give sugar free liquids _____Ounces per hour if Ketones are present.
3. Contact parent if:
   a. If Ketones are positive and blood glucose is over _____.
   b. If child is vomiting with blood glucose higher than 400.

Comments/Special Instructions: _____

_____

Notify parent if _____

TREATMENT OF LOW BLOOD SUGARS

Symptoms student has experienced when having low blood glucose include _____

_____

Signs and Symptoms of Low Blood Sugar:

A.	Trembling	B.	Shaky	C.	Sweaty
D.	Pale	E.	Weak	F.	Dizzy
G.	Headache	H.	Incoherent	I.	Irritable
J.	Confused	K.	Restless	L.	Combative

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

1. Administer immediately sugar source such as:
   a. 3 glucose tablets b. ½ cup fruit juice c. 6 oz. Regular soda
   d. 1 fruit roll up e. 8 life savors f. ½ candy bar
   g. 2 T. cake frosting h. glucose gel placed between cheek and gum
2. If symptoms do not improve in 15-20 minutes, repeat treatment.
3. Notify parent of low blood glucose treatment given or if _____.

Comments/Special instructions _____

_____

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

1. Administer Glucagon injection Yes _____ No_____
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.

_____ _____

Physician Signature Date

_____ _____

Parent Signature Date