Riverside Local School District

Diabetes Health Care Plan for Insulin Administration via Syringe or Pen

School:________________________________

Start Date: _______________________ End Date: _________________________

Name_________________________ Grade/ Homeroom ________________ Teacher__________________________

Student Photo

Parent/ Guardian Contact: Call in order of preference

Name *Telephone Number* *Relationship*

1.____
2.____
3. ____

Prescriber Name ___________________Phone_________________Fax___________________________

Blood Glucose Monitoring: Meter Location _________________________ Student permitted to carry meter ☐ Yes ☐ No

Testing Time ☐ Before Breakfast/Lunch ☐ 1-2 hours after lunch ☐ Before/after snack ☐ Before/after exercise ☐ Before recess
☐ Before riding bus/walking home ☐ **Always** check when student is feeling high, low and during illness
☐ Other__________________________

Snacks

☐ Please allow a ______gram snack at_________ ☐ before/after exercise

Snacks are provided by parent /guardian and located in ________________________________

Treatment for Hypoglycemia/Low Blood Sugar

If student is showing signs of low blood sugar or if blood sugar is below ________mg/dl

☐ **Treat with 10-15 grams of quick-acting glucose:**

☐ 4oz juice or ☐ ____ glucose tablets or ☐ Glucose Gel or ☐ Other ________________

☐ Retest blood sugar every 15 minutes, repeat treatment until blood sugar level is above target _______mg/dl

☐ If no meal or snack within the hour give a 15 gram snack

☐ If student unconscious or having a seizure: Give Glucagon ☐ Yes ☐ No

☐ Amount of Glucagon to be administered: ________mg(s) IM, SC, and call 911 and parents

☐ **Notify parent/guardian for blood sugar below _________mg/dl**

Treatment for Hyperglycemia /High Blood Sugar

If student showing signs of high blood sugar or if blood sugar is above ________mg/dl

☐ Allow free access to water and bathroom

☐ Check ketones for blood sugar over ______ mg/dl ☐ Notify parent/guardian if ketones are **moderate to large**

☐ **Notify parent/guardian for blood sugar over** ________mg/dl

☐ See insulin correction scale (next page)

☐ **Call 911 and parent/guardian for *hyperglycemia emergency*. Symptoms may include nausea &vomiting, heavy breathing, severe abdominal pain, chest pain, increased sleepiness or lethargy, or loss of consciousness.**

Document all blood sugars and treatment

Doctor and Parent signature required on Page 3

Riverside Local School District

Diabetes Health Care Plan for Insulin Administration via Syringe or Pen

School:________________________________

Start Date: ________________________ End Date: __________________________

Student Name:

Orders for Insulin Administration

Insulin is administered via: ☐**Vial/Syringe** ☐**Insulin Pen**

Can student draw up correct dose, determine correct amount and give own injections?

☐**Yes** ☐**No** ☐**Needs supervision (describe)**____

Insulin Administration: ☐ **Not taking insulin at school**

Insulin Type: _____________ Student permitted to carry insulin & supplies: ☐ **Yes** ☐**No**

Calculation of Insulin Dose: A+B=C

A. Insulin to Carbohydrate Ratio 1 unit of Insulin per _____grams of Carbohydrate

Give____ units per _______grams
Give____ units per _______grams **OR** **Total Grams of Carbohydrates to be eaten** = ____ **Units of Insulin (A)**
Give____ units per _______grams **Carbohydrate ratio**
Give____ units per _______grams

B. Correction Scale_____ units of insulin for every _____ over ______mg/dl (blood glucose)

If blood glucose is __________to _______mg/dl Give____ units
If blood glucose is __________to _______mg/dl Give____ units
If blood glucose is __________to _______mg/dl Give____ units
If blood glucose is __________to _______mg/dl Give____ units

C. Mealtime Insulin dose = A+B

Give mealtime dose: ☐ before meals ☐ immediately after meals ☐ if blood sugar is less than 100mg/dl give after meals

☐ Parental authorization should be obtained before administering a correction dose for high blood glucose level (excluding mealtime) ☐**Yes** ☐ **No**

☐Parents are authorized to adjust insulin dosage +/- by _____ units for the following reasons:

☐Increase/Decrease Carbohydrate ☐Increase/Decrease Activity ☐Parties ☐Other____________________________

☐Oral Diabetes Medication include medication name, dose, time and any side effects:
____
____

Activities/Skills	**Independent**	
Blood Glucose Monitoring	Yes	No
Carbohydrate Counting	Yes	No
Selection of snacks and meals	Yes	No
Treatment for mild hypoglycemia	Yes	No
Test urine/blood for ketones	Yes	No
Insulin dose calculation	Yes	No
Insulin injection administration	Yes	No

Doctor and Parent signature required on Page 3

Student Name:____

<u>*School Transportation:*</u>

Please provide instruction if student requires emergency medication while using school transportation and/or special considerations and safety precautions (regarding school activities, sports, trips, etc.).

____

____

____

Authorization for the Release of Information:

I hereby give permission for __________________________ (school) to exchange specific, confidential medical information with __________________________ (Diabetes healthcare provider) on my child ___________________, to develop more effective ways of providing for the healthcare needs of my child at school

Prescriber Signature_____________________________________ Date______________

Parent Signature____ Date______________

<u>NOTE: All Diabetic Action Plans need updated EACH school year by your doctor and</u>

<u>Signed by parent AND physician.</u>