

Kansas Diabetes Health Care Plan

Physician to Complete _____

Date of Plan: _____

Student's Name: _____

Date of Birth: _____

Blood Glucose Monitoring

Target range for blood glucose is 70-150 70-180 other _____

Times to check blood glucose (circle all that apply)

Circle specific time of day: 8a 9a 10a 11a before lunch after lunch 1p 2p 3p 4p Other _____

before exercise after exercise when student exhibits symptoms of hypoglycemia or hyperglycemia

Check urine with ketone strip if blood sugar is greater than 280 mg/dL.

Notify Physician if urine ketones are: present moderate amt. large amt do not notify

ORDERS FOR MEDICATION

Oral Diabetes Medications Not Applicable

Type of medication: _____ Dosage _____ Frequency _____

Sub-q Insulin and Dosage: Not Applicable

Type _____ Dosage _____ Frequency _____

Insulin Pen _____ Please circle type: Luxura, Humalog Disposable, Novolog Jr., Novolog Flexpen

Sliding Scale Insulin and Dosage: Not Applicable

Type of Insulin _____

If BS is ____ to ____ mg/dl give ____ units of insulin If BS is ____ to ____ mg/dl give ____ units of insulin

If BS is ____ to ____ mg/dl give ____ units of insulin If BS is ____ to ____ mg/dl give ____ units of insulin

Insulin Pumps Not Applicable Follow pump orders as prescribed by specialist/endocrinologist

Type of pump: _____ Type of Insulin in pump _____

Type of infusion set: _____ Algorithm available? yes no

Insulin to carbohydrate ratio: _____ Sensitivity: _____ Bolus Range: _____

Basal rates: ____ to ____ ____ to ____

____ to ____ ____ to ____

Correction for Hypoglycemia

If student is unconscious or having a seizure, presume the student is having low blood glucose and

Call 911 immediately; administer glucagon; and notify parents.

____ Glucagon ½ mg; 1mg; ____mg; (circle desired dose) sub-q/IM should be given immediately.

____ Glucose gel 1 tube inside cheek and massage from outside while waiting or during administration of glucagon.

____ Glucagon/glucose gel could be used if student has documented low blood sugar; is vomiting; unable to swallow.

Student should be turned on side and maintained in this "recovery" position until fully awake.

Insulin Correction Dosage for Hyperglycemia

Type of Insulin _____

If BS is ____ to ____ mg/dl give ____ units of insulin sq

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Other Instructions: _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

Print Physician Name _____ Physician Contact Phone Number _____

Kansas Diabetes Health Care Plan

Parent/Guardian/Student to Complete

Student's Name: _____

Date of Plan: _____
Date of Birth: _____ Grade: _____

Physical Condition: " Diabetes Type 1 " Diabetes Type 2

Contact Information

Mother/Guardian: _____ Daytime phone: _____ Cell _____
Father/Guardian: _____ Daytime phone: _____ Cell _____

Other Emergency Contacts:

Name: _____ Relationship: _____
Daytime phone _____ Cell _____

| STUDENT SELF-MANAGEMENT | YES | NO | NEEDS ASSISTANCE |
|---|-----|----|------------------|
| Has student done his/her own blood glucose checks? | | | |
| Has student been giving own insulin? <input type="checkbox"/> sub-q injection <input type="checkbox"/> pump | | | |
| Able to perform blood glucose checks? Meter student uses: _____ | | | |
| Able to calculate Carbohydrates (Carbs)? | | | |
| Prepare reservoir and tubing for pump? | | | |
| Troubleshoots alarms and pump problems? | | | |

Carbs allowed: Breakfast _____ Mid-morning snack _____ Lunch _____ Mid-afternoon snack _____
Type of pump: _____ Type of Insulin in pump _____ Type of infusion set: _____
Algorithm available? yes no Insulin to carbohydrate ratio: _____ Sensitivity: _____
Bolus Range: _____ Basal rates: (_____ to _____) (_____ to _____) (_____ to _____) (_____ to _____)
Snack before exercise? yes no # of Carbs _____ Snack after exercise? yes no # of Carbs _____
Foods to avoid, if any: _____
Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event): _____

Exercise/Sports and Field Trips

When he/she participates, a fast-acting carbohydrate such as _____ should be immediately available.

Restrictions on activity

Student should not exercise if blood glucose level is below _____ mg/dl or above _____ mg/dl .
If moderate to large urine ketones are present -- can student participate in exercise. yes no
Notify parent if urine ketones are present. yes no
Parent/guardian will be notified if student refuses medication, appropriate testing and/or intervention for abnormal blood sugar.

Supplies to be Kept at School

- " Insulin or oral medications
- " Urine ketone strips
- " Blood glucose meter and testing supplies
- " Glucagon emergency kit
- " Fast-acting source of glucose
- " Insulin pump and supplies
- " Insulin pen, pen needles, insulin cartridges
- " Carbohydrate containing snack
- " Reservoir, infusion sets, etc.
- " Other (list)

TO BE COMPLETED BY THE PARENT/GUARDIAN: I give permission to the school nurse, trained diabetes personnel, and other designated staff members of _____ school to perform and carry out the diabetes care tasks as ordered by the physician. I also consent to the release of the information to staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I permit my child to manage his/her diabetic care and self-administer medication as approved by the school nurse and ordered by the physician.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

**SELF MANAGEMENT CONSENTS:
TO BE COMPLETED BY SCHOOL NURSE**

The student demonstrated appropriate use, knowledge and skills of testing tools, equipment and medications to manage his/her diabetic care as ordered by physician.

SCHOOL NURSE SIGNATURE _____
DATE: _____

TO BE COMPLETED BY STUDENT

I have been instructed in the proper use of monitoring tools, equipment and medication. I will manage my diabetes and administer medications as prescribed by my physician.

STUDENT SIGNATURE _____
DATE: _____