# 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 ___

**<u>Correction for Hypoglycemia</u>**
**If student is unconscious or having a seizure, presume the student is having low blood glucose and**
**<u>Call 911 immediately; administer glucagon; and notify parents.</u>**
____ 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.

**<u>Insulin Correction Dosage for Hyperglycemia</u>**
Type of Insulin _____
If BS is ___ to ____mg/dl give ____units of insulin sq If BS is ___ to ____mg/dl give ____units of insulin sq
If BS is ___ to ____mg/dl give ____units of insulin sq If BS is ___ to ____mg/dl give ____units of insulin sq

Other Instructions: _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

Print Physician Name _____ Physician Contact Phone Number _____

# Kansas Diabetes Health Care Plan

**Parent/Guardian/Student to Complete** **Date of Plan:** _____

Student's Name: _____ 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? ☐sub-q injection ☐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: _____