Lubbock Christian School

Diabetes Management & Treatment Plan

Must be signed by parent and physician and updated yearly

STUDENT NAME _____ DOB_____ **EFFECTIVE DATE**_____

TEACHER_____ GRADE _____

A. To Be Completed by Physician

BLOOD GLUCOSE MONITORING

Target range for blood glucose and school _____ mg/dl to _____ mg/dl.

Times for testing (check all that apply):

___ no glucose testing at school ___ for suspected hypoglycemia ___for suspected hyperglycemia
___ before am snack ___ before lunch ___ two hours after lunch
___ before exercise ___ after exercise ___ other_____

Guidelines for Responding to Blood Glucose Test Results

- **If blood glucose is BELOW _____ (hypoglycemia or low blood sugar):**
    1. Give child 15 grams carbohydrate i.e. 6 ounces regular soda OR 4 ounces of juice OR 6 pieces hard candy OR 3-4 glucose tabs
    2. Allow child to rest for 10-15 minutes then retest glucose
    3. If glucose is above _____, allow student to proceed with scheduled class or meal
    4. If symptoms persist or blood glucose remains below _____, repeat steps 1 and 2
    5. If symptoms continue, notify parent and keep child with nurse
- ***If blood glucose if BELOW _____ and the child is unconscious or seizing:***
    1. Call 911
    2. Rub a small amount of glucose gel or cake frosting on gums and oral mucosa
    3. If available, inject Glucagon _____ mg SQ
    4. Notify parent
- ***If blood glucose is FROM _____ to _____:*** Follow usual meal plan and activities, unless otherwise directed by insulin correction scale for insulin administration.
- ***If blood glucose if OVER _____:***
    1. If within 30 minutes prior to lunch, nurse or unlicensed assistant to be called, if student unable to administer correction dose of insulin per student's sliding scale orders
    2. Student checks urine ketones.

        If Ketones are negative or small

        - Encourage water until ketones are negative

        If Ketones are moderate or large

        - Student should remain in clinic for monitoring
        - Notify parent for pick up
        - Give 1-2 glasses of water every hour
        - If student remains at school, retest glucose and ketones every 2-3 hours or until ketones are negative
    3. Student should not participate in PE or other forms of exercise if blood sugar is above 250 and ketones are present.
    4. If student develops nausea/vomiting, rapid breathing, and/or fruity odor to breathe, call 911, the nurse and the parent/guardian.

Insulin/Medication Administration

Brand Name and Type: _____ Admin. at home only ____ Admin. at home and school____

Administration Times: (check all that apply)

____ AM (breakfast) ____AM Snack ____Lunch ____PM Snack ____Other:_____

Insulin Administered Via: ____Syringe and Vial ____Insulin Pump (attach pump guidelines)
____Insulin Pen ____Other:_____

Insulin Dose Determined By: (check all the apply)

Food/Bolus Dose:

____Standard Lunchtime Dose:_____

____Insulin to Carb Ratio:_____# units Insulin per _____ grams carbs

____Correction Calculation (complete only those that apply):

Give _____ units for every _____mg/dl above _____mg/dl

Decrease correction by ____% units if PE or increased activity is anticipated after correction dose, or last dose was given less than 2 hours before

OR

____Written insulin sliding scale as follows: (complete the following or attach sliding scale)

_____ blood glucose from _____ to _____ = unit(s)

_____ blood glucose from _____ to _____ = unit(s)

_____ blood glucose from _____ to _____ = unit(s)

_____ blood glucose from _____ to _____ = unit(s)

_____ blood glucose from _____ to _____ = unit(s)

____ Add carbohydrate calculation insulin dose and correction calculation for total bolus

Meal Plan

Meals and Snacks Eaten at School: (check all that apply with specific time) A source of glucose should always be readily available

	Time	**Food Content/Amount**	
____Breakfast	_____	_____	Mandatory___ Student's Discretion___
____ AM Snack	_____	_____	Mandatory___ Student's Discretion___
____ Lunch	_____	_____	Mandatory___ Student's Discretion___
____ PM Snack	_____	_____	Mandatory___ Student's Discretion___

Other times to give snacks and amount:_____

Foods to Avoid, if any:_____

Exercise and Sports (check all that apply)

____Snack such as _____ should be readily available at the site of exercise or sport

____ No exercise if most recent blood glucose is < 70 (or _____mg/dl)

____ Eat ____ grams carbs for vigorous exercise: ____ before ____ every 30 minutes ____ after

____ No exercise when blood glucose is > _____ mg/dl or ketones are present

Restrictions on activity, if any: _____

FOR DIABETIC SELF-CARE ONLY

Does this student have physician permission to provide self-care? Yes_____ No _____

Has this student has been provided with instruction/supervision in recognizing signs and symptoms of hypoglycemia and is capable of doing self-glucose monitoring and his/her own insulin injections/insulin pump care, including using universal precautions and proper disposal of sharps? Yes____ No_____

____ Student requires the supervision of a designated adult

____ Student requires the assistance of a designated adult

I authorize the Diabetes Management and Treatment Plan as specified above for this student:

Physician Printed Name:_____ **Signature:** _____

Date: _____ **Office Phone:** _____ **FAX:** _____

B. To Be Completed by Parent:

I request that the above Diabetes Management and Treatment Plan be implemented for my child. Delivery of this form to the school nurse constitutes my participation in developing this plan and is my consent to implement this plan. I will notify the school immediately if the health status of my child changes, if I change physicians or emergency contact information, or if the procedure is cancelled or changes in any way. Information concerning my child's diabetes health management may be shared with/obtained from the physician indicated above.

Printed Name: _____ **Signature:** _____

Relationship to child: _____ Date: _____ Phone: _____