

Diabetes Health Care Plan for Insulin Administration via Syringe or Pen



School: _____

Start Date: _____ End Date: _____

Name _____ Grade/ Homeroom _____ Teacher _____

Parent/ Guardian Contact: Call in order of preference

Name

Telephone Number

Relationship

1. _____

2. _____

3. _____

Student
Photo

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

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

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 _____

Reviewed by Dr. Carly Wilbur April 2019

Parent Signature _____ Date _____

