Sturgis Charter Public School

An International Baccalaureate Diploma School

School Year: _____
Grade: _____

Diabetic Health Care Plan for Pump Users

To be completed at the start of the school year by parent(s)/guardian(s) in conjunction with the school nurse.

Student Name: _____ Date of Birth: _____
Primary Care Physician: _____ Phone: _____
Diabetic Care Physician:_____ Phone: _____
Location: _____ Fax: _____
Diabetic Nurse Educator: _____ Phone: _____

Pump Skills: Please indicate his/her ability related to the following skills:

Skill	Independent	Needs Assistance	Comments
Testing blood glucose			
Set basal profile			
Carbohydrate counting			
Calculate and administer correction bolus			
Selecting insertion site			
Disconnect and reconnect pump at infusion site			
Priming infusion system			
Inserting infusion set			
Troubleshoot alarms and malfunctions			

Blood Glucose Monitoring:
Times to monitor at school, please check all the apply:
□ Before snack □ Before lunch □ Before exercise □ After exercise
□ With signs/symptoms of hypo-/hyperglycemia
□ Other: _____
Please keep in mind snack time is _____ am to _____ am and lunch is _____ am/pm to _____ pm.
Type of glucometer: _____ Target Range: _____ mg/dL to _____ mg/dL

Insulin Administration:
Please note: a physician order in needed for insulin be administered at school.
Type of pump: _____ Insulin used with pump: _____
Infusion set used: _____
Basal rates:
____ am/pm to ____ am/pm _____ units/hour ____ am/pm to ____ am/pm _____ units/hour
____ am/pm to ____ am/pm _____ units/hour ____ am/pm to ____ am/pm _____ units/hour
____ am/pm to ____ am/pm _____ units/hour ____ am/pm to ____ am/pm _____ units/hour

Target blood glucose: _____ mg/dL
Sensitivity factor: 1 unit of insulin lowers blood glucose by _____ mg/dL
Insulin/Carbohydrate ratios:
Breakfast-1 unit to ____ g; Snack-1 unit to ____ g; Lunch-1 unit to ____ g; Other:1 unit to ____ g
Correction bolus formula: ((current blood glucose) – (target blood glucose)) / sensitivity factor = units
The total amount of insulin to be administered at meal and/or snack time will be the meal bolus + or – the correction bolus.
The student's health care team and parents may adjust insulin doses and pump settings as necessary within the limits of the physician's orders.

Treatment:

Hypoglycemia: If he/she is unconscious, unable to swallow, or seizure activity is noted administer glucagon per physician orders and CALL 911. The parent/guardian will also be notified.

1. His/her typical hypoglycemic symptoms include: _____
   _____
2. Check blood sugar. If blood glucose is below _____ mg/dL continue to step 3.
3. Give a fast acting sugar source: ___ glucose tabs, ___ oz. juice, other: _____
4. Review pump settings, activity schedule, and dietary intake.
5. Re-check blood sugar in _____ minutes. Repeat steps 2 and 3 as necessary until blood sugar is _____ mg/dL or higher.
6. Call to notify parent.

Hyperglycemia: If he/she is unconscious CALL 911. Parent/guardian will also be notified.

1. His/her typical symptoms include: _____
   _____
2. Check blood sugar. If blood glucose is _____ mg/dL or above treatment is needed. Continue to step 3.
3. Check ketones. If urine ketones are above _____ or blood ketones are above _____ mmol/L, consult physician orders. If ketones are negative consult physician's orders.
4. Troubleshoot pump. Refer to physician's orders.
5. Re-check blood sugar in _____ hour(s).
6. If blood sugar is still above _____ mg/dL consult physician's orders for further treatment.
7. Call to notify parent.

Modifications: The modifications indicated below may need to be discussed in greater detail before this health care plan is implemented.
Is he/she on a 504 plan? Yes ☐ No ☐
Please indicate if academic modifications will be necessary: _____
_____
Please indicate any restrictions to classroom activity including physical and dietary needs: _____
_____
Field trip modifications if any: _____
_____
Other: _____

Supplies: Seventy-two hours worth of supplies, in case of school lock down, to be provided by parent(s)/guardian(s) and kept at school in the health office:

____ An extra blood glucose meter, batteries, and test strips
____ Fast acting sugar source
____ Lancing device/lancets
____ Blood ketone meter and test strips and/or urine ketone strips
____ Insulin and syringes or insulin pen and pen needles
____ Infusion sets/ Reservoirs
____ Batteries for pump
____ Alcohol prep pads
____ Glucagon Emergency Kit
____ Carbohydrate snacks

Parent(s)/Guardian(s) Signature: _____ Date: _____
School Nurse Signature: _____ Date: _____

Field Trip/Extracurricular Activity
Diabetes Emergency Action Plan

School Year: _____ - _____
Student Name: _____
Grade: _____ Date of Birth: _____

Parent/Guardian Name: _____
Telephone: _____

Emergency Contact Name: _____ Phone: _____

Physician Name: _____ Phone: _____

Hypoglycemia-Low Blood Sugar

Blood sugar less than _____ mg/dL

Mild-Moderate Symptoms

Hungry	Irritable	Sweating
Pale	Drowsy	Change in behavior
Dizzy	Shaking	Slurred speech
Inability to concentrate		Poor coordination
Sudden crying		
Other:		

Severe Symptoms

Severe decrease in cognitive ability
Combative
Loss of consciousness
Seizure activity
Other:

Actions

1. Notify school nurse if student is in or near the building during school hours
2. Check blood sugar and follow the steps below

1. Provide fast-acting glucose source
   Instruct student to take 3-4 glucose tabs if able
   Or Give 4 ounces of juice
   Or other: _____
2. Wait 15 minutes. DO NOT leave the student.
3. Retest blood sugar. If blood sugar is below _____ mg/dL, repeat above steps. If blood sugar is above _____ mg/dL provide snack is no meal within the next hour. If and when blood sugar is above _____ mg/dL, student may return to class/activity.
4. Communicate with school nurse and/or parent/guardian.

If the student is

- Unconscious
- cannot communicate
- cannot swallow
- or cannot follow directions due to altered level of consciousness

CALL 911 IMMEDIATELY.

Contact school nurse or parent/guardian as quickly as possible.

Hyperglycemia-High blood sugar

Blood sugar more than _____ mg/dL

Early signs/symptoms

Dry mouth
Thirsty
Hungry
Use of bathroom more frequently
Blurry vision
Inability to concentrate
Fatigue/sleepiness
Other:

More progressive symptoms

Sweet odor to breath
Dry and warm skin
Flushing of the face
Nausea/vomiting/stomach pain
Confusion
Difficulty breathing
Loss of consciousness
Other:

Actions

1. Notify school nurse if student is in or near the building during school hours
2. Check blood sugar and follow the steps below

1. If blood sugar is above _____ mg/dL contact parent/guardian immediately to pick up student.
2. If blood sugar is above _____ mg/dL student should be reminded to check for ketones.
3. If urine ketones are greater than _____, contact parent/guardian immediately to pick up student.
4. If student is able to self-administer insulin have the student do so.
5. Recheck blood sugar in _____ and contact parent/guardian immediately if blood sugar has not improved and/ or if student is not feeling better.
6. If blood sugar is below _____ mg/dL at recheck student may return to class/activity but should re-check blood glucose every _____.
7. Communicate with school nurse and/or parent/guardian.

If the student is

- Unconscious
- cannot communicate
- is vomiting
- or has difficulty breathing

CALL 911 IMMEDIATELY.

Contact school nurse or parent/guardian as quickly as possible.

Adopted from the National Association of School Nurses H.A.N.D.S^{sm} 2008