The Public Schools of Brookline
School Health Services

Date of Plan: _____

Diabetes Health Care Plan

To be completed by the student's health care team and parents/guardian. Plan will be kept with the school nurse and reviewed with school staff on a need to know basis.

Student's Name: _____

Date of Birth: _____ Date of Diabetes Diagnosis: _____

Grade: _____ Homeroom Teacher: _____

Physical Condition: Diabetes type 1___ Diabetes type 2___

Contact Information :

Mother/Guardian: _____
Address: _____
_____
Telephone: Home _____ Work _____ Cell_____
Father/Guardian: _____
Address: _____
_____
Telephone: Home _____ Work _____ Cell _____

Student's Doctor/Health Care Provider:
Name: _____
Address: _____
Telephone: _____ Emergency Number: _____
Other Emergency Contacts:
Name: _____
Relationship: _____
Telephone: Home _____ Work _____ Cell _____

Notify parents/guardian or emergency contact in the following situations: _____
_____
_____

Blood Glucose Monitoring:
Target range for blood glucose is 70-150 70-180 Other _____
Usual times to check blood glucose _____
Times to do extra blood glucose checks (*check all that apply*)
before exercise
after exercise
when student exhibits symptoms of hyperglycemia
when student exhibits symptoms of hypoglycemia
other (explain): _____
Can student perform own blood glucose checks? Yes No
Exceptions: _____
_____
Type of blood glucose meter student uses: _____
_____

Insulin: Calculation and administration of insulin must be supervised by a registered nurse. Students may self administer if determined to be age-appropriate by PCP, parent and school nurse.

Usual Lunchtime Dose:
Base dose of Humalog/Novolog /Regular insulin at lunch (circle type of rapid-/short-acting insulin used) is _____ units or does flexible dosing using _____ units/ _____ grams carbohydrate.

Use of other insulin at lunch:
_____ intermediate/NPH/lente _____ units *or*
_____basal/Lantus/Ultralente _____ units.

Correction Doses:
Parental authorization should be obtained before administering a correction dose for high blood glucose levels. Yes ___No ____

_____ units if blood glucose is _____ to _____ mg/dl

_____ units if blood glucose is _____ to _____ mg/dl

_____ units if blood glucose is _____ to _____ mg/dl

_____ units if blood glucose is _____ to _____ mg/dl

_____ units if blood glucose is _____ to _____ mg/dl

Can student give own injections? Yes___ No___
Can student determine correct amount of insulin? Yes___ No ___
Can student draw correct dose of insulin? Yes___ No ___

For Students with Insulin Pumps:
Type of pump: _____ Basal rates: _____ 12 am to _____
_____ _____ to _____
_____ _____ to _____

Type of insulin in pump: _____
Type of infusion set: _____
Insulin/carbohydrate ratio: _____ Correction factor: _____

Student Pump Abilities/Skills: Needs Assistance?
Count carbohydrates Yes ___No ___
Bolus correct amount for carbohydrates consumed Yes___ No___
Calculate and administer corrective bolus Yes___ No___
Calculate and set basal profiles Yes___ No___
Calculate and set temporary basal rate Yes___ No___
Disconnect pump Yes___ No ___
Reconnect pump at infusion set Yes___ No___
Prepare reservoir and tubing Yes___ No___
Insert infusion set Yes___ No ___
Troubleshoot alarms and malfunctions Yes___ No___

For Students Taking Oral Diabetes Medications:
Type of medication: _____ Timing: _____
Other medications: _____ Timing: _____

Meals and Snacks Eaten at School:
Is student independent in carbohydrate calculations and management? Yes___ No ___
Meal/Snack Time Food content/amount
Breakfast _____ _____
Mid-morning snack _____ _____
Lunch _____ _____
Mid-afternoon snack _____ _____
Dinner _____ _____
Snack before exercise? Yes___ No___

Other times to give snacks and content/amount:
_____
Preferred snack foods:
_____
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 and Sports:
A fast-acting carbohydrate such as _____ should be available at the site of exercise or sports.
Restrictions on activity, if any: _____ student should not exercise if blood glucose level is below _____ mg/dl or above _____ mg/dl or if moderate to large urine ketones are present.

Hypoglycemia (Low Blood Sugar):
Usual symptoms of hypoglycemia: _____
_____
Treatment of hypoglycemia:_____
_____

Glucagon: yes____ no____
Provided by the parent and given if the student is unconscious, having a seizure (convulsion), or unable to swallow.
Route _____ Dosage _____

Site for glucagon injection: _____arm, _____thigh, _____other.

*If glucagon is required, administer it promptly. Then, call 911 (or other emergency assistance) and inform the parents/guardian.

Hyperglycemia (High Blood Sugar) :
Usual symptoms of hyperglycemia: _____
_____
_____
Treatment of hyperglycemia: _____
_____
Urine should be checked for ketones: no_____ yes_____when blood glucose levels are above _____ mg/dl.

Treatment for ketones: _____
_____

Supplies to be Kept at School :
_____Blood glucose meter
_____Blood glucose test strips
_____Batteries for meter

_____ Lancet device, lancets, gloves, etc.
_____Urine ketone strips
_____Insulin pump and supplies
_____Insulin pen, pen needles, insulin cartridges
_____Fast-acting source of glucose
_____Carbohydrate containing snack
_____Glucagon emergency kit

Signatures:

This Diabetes Health Care Plan has been approved by:

_____ _____
Student's Physician/Health Care Provider Date

I give permission to the school nurse or other designated staff members of _____ school to perform and carry out the diabetes care tasks as outlined by _____'s Diabetes Health Care Plan. I also consent to the release of the information contained in this Diabetes Health Care Plan to all 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.

Acknowledged and received by:

_____ _____
Parent/Guardian Date

_____ _____
School Nurse Date