SANTA FE ISD

PLAN OF CARE -DIABETES

Name: ____ Grade: ______ Age:

Address: ---Phone(H):-------------------

School: --

Mother:-- Phone (WK):-------------------------------

Father:______________________________ Phone (WK): ------------------------------

Guardian: ___________________________________ Phone (WK):------------------------

Emergency Contact #1: ______________________________Phone:-----------------------

Emergency Contact #2: _____________________________ Phone:------------------------

Physician Student Sees for Seizure: ________________________ Phone:----------------

Other Physician: ---Phone:----------------------------------

ALLERGIES: Food, Medication, etc. ---

Student wears a diabetic identification bracelet or necklace. _____Yes _____No
Insulin Pump: _____Yes _____No
Blood Glucose Target Range:
____

Current Insulin Treatment
Student will inject insulin at school _____Yes _____No
Student will self-prepare and inject _____Yes _____No
Student needs assistance with injection _____Yes _____No
Type of Insulin: Dose and Time
Pre Breakfast __________ Lunch __________ Supper __________ Bedtime-----------
Meals/Snacks: Times:
Breakfast _____ Snack _____ Lunch _____ PM snack _____ Dinner _____ BedtimeSnack _____

Student will generally bring one of the following for snack:
_________________ _________________ _________________ _________________

Exercise/Sport Activity
Student may participate in regular PE classes _____Yes _____No
Student may participate in after school sports _____Yes _____No
Student carries ___________________________ for treatment of Low Blood Glucose
A snack will be eaten if blood glucose is under _________________. Exercise should be delayed

if blood glucose is higher than _______________ or lower than _______________.

Blood glucose monitoring: Name of Monitor/Meter _______________________
Student is able to perform self-blood glucose testing _____Yes _____No
Student needs assistance to test _____Yes _____No
Student monitors blood glucose:
____Before Breakfast ____Before Exercise ____After Exercise
____Lunch ____Supper ____Bedtime
____Before AM Snack ____Before PM Snack

TREATMENT OF HIGH BLOOD SUGARS

1. If blood glucose is over ____________________, check urine for Ketones.
2. Give sugar free liquids (such as water) __________________ ounces per hour if Ketones are present.
3. **Contact parent:**
   If Ketones are positive and blood glucose is over ___________________.
   If child is vomiting with blood glucose higher than 400.

Comments/Special Instructions:
____
____
______
Notify parent if: ---

TREATMENT OF LOW BLOOD SUGARS
Symptoms student has experienced when having a low blood glucose include

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Signs and Symptoms of Low Blood Sugar:

A. Trembling	B. Shaky	C. Sweaty
D. Pale	E. Weak	F. Dizzy
G. Headache	H. Incoherent (as if drunk)	I. Irritable
J. Confused	K. Restless	L. Combative

Treatment for conscious student with Low Blood Sugar who is able to swallow:

1. Administer immediately sugar source such as:

Δ 3 glucose tablets **Δ 1/2 cup fruit juice** **Δ 6 oz. Regular soda**
Δ 1 fruit roll up **Δ 8 life savers** **Δ 1/2 candy bar**
Δ 2 tablespoons cake frosting from tubes
Δ glucose gel placed between cheek and side of gum

2. If symptoms do not improve in 15-20 minutes, repeat treatment

3. Notify parent of low blood glucose treatment given if ----------------------------
__________________________.
Comments/Special instructions
____

Treatment for student with low blood sugar who is unconscious or unable to swallow:
1. Administer Glucagon injection ______Yes ______No
2. Test blood glucose every 10 minutes.
3. Notify parent of low blood glucose.
4. Contact **911** after Glucagon.
5. **DO NOT** give liquids to drink while unresponsive.
Comments/Special Instructions --

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Physician Signature Date

_______________________________________ _________________
Parent Signature Date