

Insulin Correction Doses:

Parental notification prior to administering correction dosage: Yes No

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

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Can student determine correct amount of insulin? Yes No

Can student draw up correct dose of insulin? Yes No

Can student give own injections? Yes No

Oral Diabetic Medication:

Medication: _____ Dosage: _____ Administer Time: _____

Medication: _____ Dosage: _____ Administer Time: _____

INSULIN PUMP:

Type of Pump: _____ Basal Rate: _____

Insulin/Carbohydrate ratio: _____ Correction factor: _____

Comments: _____

Student Pump Abilities/Skills:

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

Meals/Snacks:

Is student independent in carbohydrate calculations and management? Yes No

Breakfast time _____ Midmorning snack time _____

Lunch time _____ Midafternoon snack time _____

Snack before exercise: Yes No Type & Amount: _____

Snack after exercise: Yes No Type & Amount: _____

Instructions for when food is provided to class (e.g., parties, class projects):

Exercise & Sports:

Restrictions on activity, if any: _____
Student should not exercise if blood glucose level is less than _____mg/dl or greater than _____mg/dl or if moderate to large ketones are present.

Hypoglycemia (Low Blood Sugar):

Usual symptoms seen: _____
Treatment of hypoglycemia: _____
Administer Glucagon if student unconscious, having seizure(convulsion), or unable to swallow.
Route: _____, Dosage: _____, site for injection: arm thigh other: _____

Hyperglycemia (High Blood Sugar):

Usual symptoms seen: _____
Treatment of hyperglycemia: _____
Urine ketone check if blood glucose greater than _____mg/dl
Treatment for ketones: _____

Supplies at school (provided and maintained by parent and/or guardian):

- | | |
|---|--|
| <input type="checkbox"/> Blood glucose meter (test strips and batteries) | <input type="checkbox"/> Insulin pump and supplies |
| <input type="checkbox"/> Lancet device, lancets | <input type="checkbox"/> Insulin pen, pen needles, insulin cartridge |
| <input type="checkbox"/> Urine ketone strips | <input type="checkbox"/> Fast-acting source of glucose |
| <input type="checkbox"/> Insulin vials and syringes | <input type="checkbox"/> Carbohydrate containing snacks |
| | <input type="checkbox"/> Glucagon emergency kit |

Parent/Guardian Consent:

I give permission to the school nurse and other designated staff members of McHenry School District 15 to perform and carry out the diabetes care tasks as outlined by this Diabetic Treatment Plan. I also give permission for the nurse to contact the student's physician in regard to any medication and/or health concerns.

Parent/Guardian

Date

Parent/Guardian

Date

This Diabetic Treatment Plan is approved by:

Student's Physician/Health Care Provider

Date

Director of Health Services

Date