Stone Bank School District
N68 W33866 Hwy K
Oconomowoc, WI 53066

DIABETIC CAREPLAN

Student:_____ Date of Birth: _____

Physician: _____ Physician Ph Number: _____

Do we have your permission to call the above physician, should questions arise regarding your child's health care here at school ? ☐ Yes ☐ No

How long has your child had diabetes ? _____

My child is able to calculate his/her own carbohydrates at meal and snack times. ☐ Yes ☐ No

My child is able to check his/her own blood sugars ☐ Yes ☐ No

My child is able to administer his/her own insulin ☐ Yes ☐ No

*If you checked "no" to any of the above questions, please notify the school nurse consultant, so that arrangements can be made to assist your child with this during school hours.

My child uses injections for insulin administration

Type of insulin _____
Time(s) of administration _____

Carbohydrates (15gms) Units eaten	=	Insulin Units to be injected
(_____)	=	(_____)
One (15gms)	=	_____
Two (30 gms)	=	_____
Three (45 gms)	=	_____
Four (60 gms)	=	_____
Five (75 gms)	=	_____
Six (90 gms)	=	_____
Seven (90 gms)	=	_____

Correction dose (Additional insulin based on blood sugar readings)

_____ to _____	=	_____	unit(s)
_____ to _____	=	_____	unit(s)
_____ to _____	=	_____	unit(s)
_____ to _____	=	_____	unit(s)
_____ to _____	=	_____	unit(s)
_____ to _____	=	_____	unit(s)

My child uses an insulin pump for insulin administration

Type of insulin_____

Pump Basal Rates:

Time_____to_____ Rate _____
Time_____to_____ Rate _____
Time_____to_____ Rate _____
Time_____to_____ Rate _____
Time_____to_____ Rate _____
Time_____to_____ Rate _____

Pump Bolus Rates (Additional insulin based on meals):

Carbohydrates (15gms) Units eaten	=	Pump setting
(_____)	=	(_____)
One (15gms)	=	_____
Two (30 gms)	=	_____
Three (45 gms)	=	_____
Four (60 gms)	=	_____
Five (75 gms)	=	_____
Six (90 gms)	=	_____
Seven (90 gms)	=	_____

Correction dose (Additional insulin based on blood sugar readings)

_____ to _____ = _____setting
_____ to _____ = _____setting
_____ to _____ = _____setting
_____ to _____ = _____setting
_____ to _____ = _____setting
_____ to _____ = _____setting

All medication to be taken at school requires a completed Medication Administration Form.

My child's target range for blood sugars is _____ to _____.

School Treatment Plan for Diabetic Emergencies

Hypoglycemia (low blood sugar)

Symptoms: Dizziness, drowsiness, confusion, rapid breathing, nausea, headache, sweating, shakiness, poor coordination
Child's usual symptoms:_____
If student is conscious give him/her sugar of food containing sugar (juice, hard candy, non-diet soda, glucose tablets)
Parents will provide _____for low blood sugar treatment.
They will be kept _____.
If student does not respond to treatment within 10 minutes or is unable or unwilling to eat or drink----CALL 911.
If student is refusing or unable to swallow, squirt glucose gel (in health room) into the side of student's mouth and massage into gums.
Notify parents

Hyperglycemia

Symptoms: Thirst, increasing urination, confusion, irritability, lethargy, unable to concentrate, dry mucous membranes.
Child's usual symptoms:_____

Have child drink water or diet beverage (NO SUGAR PRODUCTS OR FOOD)
Call parents and notify with blood sugar over _____.
If child is unconscious or disoriented-----CALL 911

I would like to be notified any time my child's blood sugar is:
Under_____
Over _____

If I cannot be reached by phone and my child does not respond to the above medication and treatment, I give my permission for school staff to call the physician listed above and follow his/her instructions. If the physician orders hospitalization or my child is exhibiting symptoms of a medical emergency, my child will be transported to the nearest hospital. I also understand that school staff can and will be informed of my child's health concerns in order to provide safe, appropriate care.

Parent Signature:_____Date:_____