Union Township Schools
Diabetic Worksheet/Health Plan/ Physician's Order

Date Initiated:_____

Student:_____ DOB:_____

Allergies:_____

Medical Diagnosis Date:_____

Physician:_____ Phone:_____

Address_____

Contact Information

Mother/Guardian:_____

Address:_____

Telephone Home:_____Work:_____Cell:_____

Father/Guardian:_____

Address:_____

Telephone Home:_____Work:_____Cell:_____

Blood Glucose Monitoring

Target range for blood glucose is_____ mg/dl to _____mg/dl

Usual times to test blood glucose:_____ _____ _____

Times to do extra blood glucose tests: _____before exercise _____after exercise

_____Symptomatic

Type of glucose meter student uses _____

Insulin

Time	Types	Dosage
_____	_____	_____
_____	_____	_____

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 ration: _____ 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	_____	_____
Lunch	_____	_____
Mid-afternoon	_____	_____

Snack before exercise? □Yes □No

Snack after exercise? □Yes □No

Other times to give snacks and content/amount:_____

Preferred snack foods:_____

Food to avoid, if any:_____

Instructions for when food is provided to the class (as part of a class party or food sampling)_____

_____

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:_____

_____
Student will be escorted to the health office with any high or low blood sugar symptoms. Student has liberal bathroom privileges or a permanent hall pass especially if blood glucose has been elevated.
Glucagon should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow. If glucagon is required, it should be administered promptly. Weight less than 45 lbs 0.5 cc (1/2 of vial), Over 45 lbs. 1cc.the entire vial. Then 911 and then parent/ guardian called.

Hyperglycemia (High Blood Sugar)

Usual symptoms of hyperglycemia:_____

_____

Treatment of hyperglycemia:_____

Urine should be checked for ketones when blood glucose levels are above_____mgdl

Treatment for ketones:_____

Supplies to be Kept at School

Supplies at school will be kept in the health office.

_____Blood glucose meter, glucose test strips, batteries for meter
_____Lancet device, lancets
_____Urine ketone strips
_____Insulin vials and syringes
_____Fast-acting source of glucose
_____Carbohydrate containing snack
_____Glucagon emergency kit
_____Insulin pump/supplies
_____Insulin pen, pen needles, insulin

Signatures

This Diabetes Medical Management Plan has been approved by:

_____ _____
Student's Physician/Health Care Provider Date

I consent to the release of the information to all staff members and other adults who may need to know this information for my child's health and safety.

_____ _____
Student's Parent/Guardian Date