For Clinic Office Use Only
Date:_____ Reviewed By: _____
Glucagon Expiration: _____

Student's Name: _____

Summer 2024

DIABETES CARE PLAN
For Students Who Receive Insulin By Pump

DOB: _____ **Grade (2024-2025)** _____
Date Diagnosed: _____ Last Hospitalization: _____

BLOOD GLUCOSE MONITORING

At school, blood glucose should be checked by: School Staff Student
Where (clinic, classroom, etc.): _____
Target range for blood glucose is _____mg/dl to _____mg/dl.

Check the times that blood glucose should be checked at school. Once the student's class schedule is available, as needed, we will work with the family to make a daily glucose monitoring schedule.

☐	Mid-morning	☐	Before Recess	☐	Before PE	☐	Mid-Afternoon
☐	Before lunch	☐	After Recess	☐	After PE	☐	Before afternoon sports
Other/Comments:							

Student should not exercise if blood glucose is below _____ mg/dl or above _____ mg/dl.

INSULIN REGIMEN for Students using INSULIN PUMP

Is student competent regarding pump? Yes☐ No☐
Basal Rate: _____
Bolus Dosage determined by: School Staff☐ Student☐ Parent☐
Bolus dose administered by: School Staff☐ Student☐

Times of scheduled Boluses: _____

Insulin/Carbohydrate Ratio: _____
Correction Factor: _____
Sliding Scale: _____

SCHEDULED SNACKS

*Snacks must be brought from home. Remind student to eat a snack? Yes☐ No☐
Target Amount/Food Content of Snacks: _____

Check times that snacks are to be eaten at school. Once the student's class schedule is available, as needed, we will work together to make a daily snack schedule.

☐	Mid-morning	☐	Before Recess	☐	Before PE	☐	Before afternoon sports
☐	Mid-afternoon	☐	After Recess	☐	After PE	☐	Other

LUNCH:

Student selects☐ Tray prepared by lunch provider☐
Target Amount/Food content of Lunch: _____

CLASS PARTIES:

Instructions/Restrictions when food is provided to the class, e.g. class parties

EMERGENCY INSTRUCTIONS:

1. Check blood glucose
2. If student is unresponsive or unable to swallow, administer _____mg Glucagon (provided to Clinic by parents for emergency use only) if blood glucose is low (below_____mg/dl).
3. Call 911 immediately and notify parents.
4. Turn student on his/her side.
5. Other Instructions:

Is there a history of an adverse reaction to Glucagon? Yes ☐ No ☐

LOW BLOOD GLUCOSE: Below _____ mg/dl

Usual symptoms of **LOW** blood glucose for this student—check all that apply:

☐	Change in personality/behavior	☐	Headache	☐	Inattention/Confusion
☐	Pallor	☐	Rapid Heartbeat	☐	Slurred Speech
☐	Weak/Shaky/Tremulous	☐	Nausea/Loss of Appetite	☐	Loss of Consciousness
☐	Tired/Drowsy/Fatigued	☐	Clammy/Sweating	☐	Seizures
☐	Dizzy/Staggering Walk	☐	Blurred Vision	☐	Other

Treatment of **LOW** blood glucose:

HIGH BLOOD GLUCOSE: Above _____ mg/dl

Usual symptoms of **HIGH** blood glucose for this student—check all that apply:

☐	Increased or Extreme Thirst	☐	Warm, Dry, or Flushed Skin	☐	Blurred Vision
☐	Increased Urination	☐	Nausea/Vomiting	☐	Weakness/Muscle Aches
☐	Increased Appetite	☐	Abdominal Pain	☐	Fruity Breath Odor
☐	Tired/Drowsy	☐	Rapid, Shallow Breathing	☐	Other

Treatment of **HIGH** blood glucose:

Parent/Guardian (call first)

Name_____

Phone_____

Parent/Guardian (call second)

Name_____

Phone_____

Emergency Contacts (contacted only if unable to reach both parents)

Name_____

Phone_____

Name_____

Phone_____

Parent Signature_____**Date**_____

Please return form to:
Terry Sherali, Director of Student Services, tsherali@schenck.org
282 Mt. Paran Road, NW, Atlanta, Georgia 30327 p.404-252-2591