NORTH TONAWANDA CITY SCHOOL DISTRICT
STUDENT SERVICES

176 Walck Road♦ North Tonawanda, New York 14120-4097 ♦ [716] 807-3566 ♦ FAX: [716] 807-3524

Gregory J. Woytila
Superintendent of Schools

Michael P. Tambroni
Director of Student Services

DIABETIC CARE PLAN

Diabetic Care Plan for (student) _____
School _____ Effective Dates _____ - _____
DOB _____ Grade _____ Homeroom _____
To be completed by parents and health care provider and reviewed by necessary school personnel.Copies to be kept in the health office. Care Plans must be RENEWED ANNUALLY.

TARGET BLOOD GLUCOSE RANGE _____ mg/dl to _____mg/dl

_____ CHECK BLOOD GLUCOSE (If unsure of times, leave blank until student's schedule is available)

_____ before lunch ____:____am/pm _____ 1-2 hour after lunch _____:_____am/pm

_____ before snacks ____:____am/pm _____when student exhibits signs of hypoglycemia

_____before exercise/PE ____:____am/pm _____when student exhibits signs of hyperglycemia

_____ after exercise/PE ____:____am/pm _____before bus/dismissal _____:_____am/pm

_____INSULIN via SQ injection supplied by family.
_____INSULIN via insulin pump with SQ infusion set in place, reservoir pre-filled and pump programmed upon arrival of student at school.
_____INSULIN via insulin pen provided by family.

***Fill in those that apply*:**

TIME	**INSULIN TYPE**	**INSULIN DOSAGE**
_____	_____	_____
_____	_____	_____
_____	_____	_____

CARBOHYDRATE RATIO _____ # units of insulin per _____ gm CHO consumed.

CORRECTION CALCULATION (check those that apply)

_____ CORRECTION FACTOR: Blood sugar result minus _____ divided by _____ =bolus to be given

_____ Input blood glucose results into pump. Bolus will be given and displayed on screen.

_____ Input blood glucose results and CHO consumed into pump. Bolus will be given and displayed on screen.

OTHER: _____

CONTACT INFORMATION
Parent/Guardian _____Home _____Cell_____Work _____
Parent/Guardian _____Home _____Cell_____Work _____
Other emergency contact/relationship_____ _____
Home _____Cell_____Work_____
Doctor/Health Care Provider (who student sees for management of diabetes)
_____ Phone _____

DIABETIC CARE PLAN page 2 for (student)_____SCHOOL YR _____

HYPOGLYCEMIA

Typical symptoms of student _____
For blood glucose of< _____mg/dl, give a snack of _____gm CHO.
Recheck blood glucose in 15 minute, repeat snack/recheck until within targeted range.
Student will not be left unattended when experiencing hypoglycemia.
If child combative/uncooperative glucose/cake gel will be squeezed inside student's mouth, where it can be readily absorbed.If student is unconscious, having a seizure, or unable to swallow:
GLUCAGON _____mg IM will be administered and 911 should be called.

HYPERGLYCEMIA

Typical symptoms of student_____
For blood glucose> _____mg/dl, give insulin as noted on previous page under CORRECTION CALCULATION heading.
For blood glucose> _____mg/dl, urine ketones should be tested for.
If ketones are present, parent will be contacted by school nurse.
_____ oz of water over _____ hours should be consumed by student.
Student may use restroom as often as every 15 minutes as hyperglycemia causes increased urination.

SUPPLIES

Provided by family and to be kept in health office (snacks will also be available in PE office):
_____ Blood glucose meter, lancets, and strips
_____ Insulin and administration supplies
_____ Snack foods
_____ Urine ketone strips
_____ Low BG supplies in PE office (snacks, juice boxes, cake gel, soda, and/orglucose tabs)
_____ Glucagon administration kit
_____ Pump infusion set/tubing replacements
Students will have diabetic supplies with them during extracurricular activities.

Activity/Skill	Student Independent	School Assistance	Parent Involvement
Blood glucose monitoring			
Insulin dosage calculation			
Insulin bolus administration (pump)			
Able to draw up correct amount of insulin			
Insulin injection			
Interpret insulin pump alarms			
Corrective actions for pump alarms			
Infusion set change			
Disconnect infusion set from pump			
Selection of snacks and meals			
Treatment of mild hypoglycemia			
Treatment of mild hyperglycemia			
Testing for urine ketones			

_____ M.D. _____ DATE

_____PARENT/GUARDIAN _____ DATE

Must be signed by both physician and parent/guardian for orders to be in effect.

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Diabetic Field Trip Form

Must be used in conjunction with the Diabetic Health Care Provider forms

Date _____

Name _____ Grade _____
School _____ Date of Birth _____
School Nurse_____ Health Office Phone_____

Dear Parents/Guardians and Health Care Providers:

Our students who been diagnosed with Diabetes are often involved in school sponsored activities that require them to be off the school grounds or take place after school hours. The New York State Education Department has clear guidelines and regulations regarding school staff administering medication and performing treatments. These regulations and guidelines also state that each student who needs any medications or treatment must be assessed and declared as either self-directed or non-self-directed students.

If you feel that your child is unable to care for him/herself please contact the school nurse to set up a plan for school-sponsored off grounds events or after hour events.

For Self-Directed Students Only

For Parents/Guardians:

My child has been instructed in the proper use, understands the purpose and appropriate doses, frequency and use of all the necessary medication(s) and diabetic equipment that will be necessary to accommodate him/her on school sponsored trips, and after hours activities. I am requesting that my child be permitted to carry all medications and equipment whenever necessary. I feel that my child is responsible in self management. I understand that my child will be cared for in any emergency situation.

_____ _____
Parent/Guardian Signature Date

For the Health Care Provider:

This patient has been instructed in the proper use, understands the purpose and appropriate doses, frequency and use of all necessary medication(s) and diabetic equipment that will be necessary to accommodate him/her on school sponsored trips, and after hour activities. I have assessed this patient and find him/her to be self directed.

_____ _____ _____
Health Care Provider Signature Provider's Stamp Date