SCHOOL HEALTH PROGRAM

Orange County Schools

200 East King Street
Hillsborough, NC 27278

Diabetic Care Plan (DCP)

This plan should be completed by the student's personal diabetes health care team, including the parents/guardian. It should be reviewed with relevant school staff and copies should be kept in a place that can be accessed easily by the school nurse, trained diabetes personnel, and other authorized personnel.

Date of Plan: _____ This plan is valid for the current school year: _____

Student's Name: _____ Date of Birth: _____

Date of Diabetes Diagnosis: _____ ☐ type 1 ☐ type 2

School: _____ Bus am: _____ Bus pm: _____

Homeroom Teacher: _____ Grade: _____

School Nurse: _____ Phone: _____

AFTER SCHOOL ACTIVITY

☐ Student Athlete ☐ Band/Theater ☐ Afterschool ☐ Other: _____

CONTACT INFORMATION

Mother/Guardian: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email Address: _____

Father/Guardian: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email Address: _____

Student's Physician/Health Care Provider: _____

Address: _____

Telephone: _____ Email Address: _____

Other Emergency Contacts:

Name: _____ Relationship: _____

Telephone: Home _____ Work: _____ Cell: _____

DIABETIC SUPPLIES LOCATION

☐ In nurse station,_____

☐ Carries own supplies, back up supplies in nurses station **Y/N** **(circle one)**

CHECKING BLOOD GLUCOSE (BG)

Target range of BG: ☐ 70–130 mg/dL ☐ 70–180 mg/dL ☐ Other: _____

Check blood glucose level:

☐ Before lunch ☐_____ Hours after lunch

☐ 2 hours after a correction dose ☐ Mid-morning ☐ Before PE ☐ After PE

☐ Before dismissal ☐ Before class party/ food event ☐ Other: _____

☐ As needed for signs/symptoms of low or high blood glucose

☐ As needed for signs/symptoms of illness

Preferred site of testing: ☐ Fingertip ☐ Forearm ☐ Thigh ☐ Other: _____

Brand/Model of blood glucose meter: _____

Note: The fingertip should always be used to check blood glucose level if hypoglycemia is suspected.

Continuous glucose Monitor (CGM): ☐ Yes ☐ No

Brand/Model: _____ Alarms set for: ☐ (low) and ☐ (high)

Note: Confirm CGM results with blood glucose meter check before taking action on sensor blood glucose level. If student has symptoms of hypoglycemia, check fingertip blood glucose level regardless of CGM.

Additional Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event)

Special event/party food permitted: ☐ Parents/guardian discretion ☐ Student discretion

HYPOGLYCEMIA TREATMENT

Student's usual symptoms of hypoglycemia (list below):

_____

_____

If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than _____mg/dL, follow **student's emergency action plan**.

HYPERGLYCEMIA TREATMENT

Student's usual symptoms of hyperglycemia (list below):

_____

_____

For blood glucose greater than _____mg/dL AND at least _____hours since last insulin dose, give correction dose of insulin (see insulin therapy form in medication book).

Follow **student's emergency action plan**.

INSULIN THERAPY

Type of insulin therapy at school:

☐ Adjustable Insulin Therapy (see medication order and insulin therapy form)
☐ Fixed Insulin Therapy (see medication order)
☐ No insulin

Parental Authorization to Adjust Insulin Dose:

☐ Yes ☐ No Parents/guardian are authorized to increase or decrease correction dose scale
☐ Yes ☐ No Parents/guardian are authorized to increase or decrease insulin-to carb ratio
☐ Yes ☐ No Parents/guardian are authorized to increase or decrease fixed insulin dose

Additional information for student with insulin pump

Brand/Model of pump: _____ Type of infusion set: _____

☐ For blood glucose greater than _____ mg/dL that has not decreased within _____ hours after correction, consider pump failure or infusion site failure. Notify parents/guardian.

☐ For infusion site failure: Insert new infusion set and/or replace reservoir.
☐ For suspected pump failure: suspend or remove pump and give insulin by syringe/pen.

Student's self-care skills (check all that apply)	**Independent**	**Supervision**	**Nurse/DCP**	**N/A**
Checks own blood glucose				
Calculates and gives own injections				
Count carbohydrates				
Completes diabetic log				
Pump Skills				
Bolus correct amount for carbohydrates consumed				
Calculate and administer correction bolus				
Calculate and set basal profiles				
Calculate and set temporary basal rate				
Change batteries				
Disconnect pump				
Reconnect pump to infusion set				
Prepare reservoir and tubing				
Insert infusion set				
Troubleshoot alarms and malfunctions				

OTHER DIABETES MEDICATIONS

Name: _____Dose: _____ Route: _____ Times given: _____
Name: _____ Dose: _____ Route: _____ Times given: _____

PHYSICAL ACTIVITY AND SPORTS

A quick-acting source of glucose must be available at the site of physical education and sports.
Student should consume ☐ 15 grams ☐ 30 grams ☐ other_____
☐ before ☐ every 30 minutes during ☐ after vigorous physical activity ☐ other ____
If most recent blood glucose is less than _____ mg/dL, student can participate in physical activity when blood glucose is corrected and above _____ mg/dL.

Avoid physical activity when blood glucose is greater than _____ mg/dL or if ketones are moderate to large.

☐ Yes ☐ No May disconnect from pump for sports activities
☐ Yes ☐ No Set a temporary basal rate: _____% temporary basal for _____ hours
☐ Yes ☐ No Suspend pump use

SIGNATURES

☐ I, (parent/guardian): _____ give permission to the school nurse or another qualified health care professional or trained diabetes personnel to perform and carry out the diabetes care tasks as outlined in _____'s Diabetes Care Plan.
I also consent to the release of the information contained in this Diabetes Care Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety.
I also give permission to the school nurse or another qualified health care professional to contact my child's physician/health care provider to obtain any related health care information. I agree to provide the necessary equipment and supplies to the school nurse and to provide information about student's health status and/or updated medical management.

☐ I decline to have this individualized DCP for my child. In an emergency, I understand that the EMS (911) and I will be called.

Approved by: _____
Student's Parent/Guardian Date

Approved by:_____
Student's Physician/Health Care Provider Date

Received by:_____
School Nurse Date

Adapted from sample plan: www.yourdiabetesinfo.org