

GENEVA COMMUNITY UNIT SCHOOL DISTRICT #304
DEPARTMENT OF NURSING
DIABETIC MANAGEMENT PLAN

CHILD NAME: _____ Grade: _____
School Year: _____ Date: _____

According to your child's health records, he/she has been diagnosed with diabetes. To allow us to better care for your child, please provide us with the following information and return it with parent and physician signature to the school nurse's office.

Diagnosis _____ Age of onset _____

Glucose Monitoring

Locations for testing (as developmentally appropriate) _____

Times: Before AM Snack _____ Before Exercise _____
Before Lunch _____ After Exercise _____
When Symptomatic x _____ Other _____

Target Blood Glucose Range

Pre-meal (ex. 70-110, 70-180) _____ Other _____

Should NOT exercise if BG is below _____ mg/dl or above _____ mg/dl

Carbs at Meals & Snacks

AM Snack _____ Parties _____
Lunch _____ PM Snack _____
Before After School Activity _____

Medications

Intermediate or Long-acting Insulin at HOME (NPH, Lantus, Levemir) _____ Time of Day _____

Rapid or Short-acting Insulin (Apidra, Humalog, NovoLog, Regular) _____

- Insulin to Carb Ratio (**I:CR**) _____ units of Insulin to _____ grams of Carbohydrates
Parent may adjust **I:CR** plus or minus 1- 5 grams. _____ YES _____ NO
- Correction Factor (**CF**, insulin sensitivity) $CF = \frac{\text{units insulin}}{\text{mg/dl over Target BG}}$
CF Formula; Child's BG minus Target BG plus Correction Factor = Insulin Dose

Insulin Pump

Type _____ Basal Rates: Time _____ Rate (units per hour) _____
Time _____ Rate (units per hour) _____
Time _____ Rate (units per hour) _____
Time _____ Rate (units per hour) _____

Routine School Management - Level of Independence

Please use the following; *Fully Independent=I* (routine management in any location of building including school bus), *Developing Independence=DI* (manages with nurse oversight), *Dependent = D* (needs nurse to perform all tasks.)

_____ Safe Disposal of Materials	_____ Administering Insulin Dose
_____ Blood Glucose Testing	_____ Managing/troubleshooting Pump
_____ Urine Ketone Testing	_____ Handling "highs/lows"
_____ Calculating Insulin	_____ Self-carrying Supplies
_____ Calculating Carbs	_____ Communicating Needs to Adults/Teachers

Management of Hyperglycemia (High BG) to Prevent Diabetic Ketoacidosis

Symptoms- Hyperglycemia: hunger, thirst, frequent urination, dry/itchy skin, fatigue, vision changes

Insulin by Injection

- If BG is above 250mg/dl, wash hands and recheck
- If BG is still above 250mg/dl and it has been 2hrs since the last dose of (Apidra, Humalog or NovoLog) give a correction dose & check urine for ketones
- Drink 6-8oz of no calorie beverage every 30mins.
- When urine ketones are **moderate or large**, call to parent to report
- Check BG and ketones every 2hrs and repeat correction dose until BG and ketones are normal

Insulin by Pump

- If BG is above 250mg/dl, wash hands and recheck
- If ketones are **negative**, check pump and site. Change site if needed. Give correction bolus by pump. Recheck BG in one hour.
- If ketones are **positive**, give correction by syringe. Change site if needed. Recheck BG in 1hr.
- Drink 6-8oz of no calorie beverage every 30mins.
- If BG has not decreased after 1hr, give another correction bolus by syringe.
- Report to parent & recheck BG and ketones every 2hrs until normal.

Management of Hypoglycemia (Low BG) When Conscious

Symptoms- Hypoglycemia: shakiness, sweating, fatigue, hunger, rapid pulse, irritability, headache, vision changes

- Follow the rule of 15
- If BG is less than 70mg/dl or symptomatic (70-100mg/dl), eat/drink 15grams of carbs
- 15grams of carbs = 3 glucose tabs, 4oz of juice or regular soda, 6-7 hard candies, 1 tablespoon honey
- Recheck BG in 15mins. If BG is not above 70mg/dl eat/drink another 15grams of carbs
- Recheck BG in 15mins. If not above 70mg/dl contact parent

Management of Hypoglycemia (Low BG) When Unconscious or Seizing

- Give **Glucagon** _____mg subcutaneously.
- Call 911. Call parent. Turn on side. Do not force eating or drinking.

Child Needs

1. ALL children with life threatening health conditions such as Diabetes are advised to wear a medical identification tag on their person at all times.
2. Supplies and annual paperwork should be in the school nurse’s office prior to the first day of school. For those children who are independent in their management, backup supplies are recommended for the school nurse’s office.

***Please contact your Certified School Nurse for questions or requests for additions to this standard plan.**

Physician Name: _____

Phone number: _____

Physician Signature _____

Date _____

The diabetic management plan may be shared with school staff to support your child's safety in school. Parents are encouraged to discuss their child's medical needs with the transportation department as well as sponsors/coaches working with your child before or after school hours.

Parent Signature _____

Date _____