AUSTIN Independent School District | Health Services and Nursing

# Diabetes Care and Treatment Plan

The student's physician and parent/guardian should complete this form. The completed plan will be reviewed by the school nurse, unlicensed diabetes care assistants and other authorized personnel.

**PART A This section is to be completed by a medical authority licensed by The State of Texas to Write Medical Prescriptions.**

**Student's Name:** _____ **Date of Birth:** _____ **Effective Date:** _____

**DIABETES DIAGNOSIS:**

☐ Type 1 ☐ Type 2 ☐ Gestational ☐ Age of Onset: _____

**Blood Glucose Monitoring**

| Target Blood Glucose | Target range for blood glucose: | Type of blood glucose meter student uses: |
|---|---|---|
| mg/dl | _____mg/dl to _____mg/dl | _____ |

Usual times to test blood glucose:

Time to do extra tests (check all that apply):

☐ Before exercise ☐ When student exhibits symptoms of hyperglycemia

☐ After exercise ☐ When student exhibits symptoms of hypoglycemia

Other (explain): _____

Can student perform own blood glucose test? ☐ Yes ☐ No ☐ Exceptions

**INSULIN: Times, types, and dosages of insulin to be given during school:**

Time: _____ Type of Insulin _____ Dose _____

Time: _____ Type of Insulin _____ Dose _____

If flexible dosing is used:

Time: _____ Type of Insulin _____ Dose _____ Unites/ _____
Grams of carbohydrates

Can student determine correct amount of insulin?
☐ Yes
☐ No

Can student draw correct dose of insulin?
☐ Yes
☐ No

**Insulin Correction Dose:**

1. Give _____ unites of _____ insulin SQ blood Glucose is _____ to mg/dl above_____mg/dl OR
2. Blood glucose below_____mg/dl = no additional insulin

_____Units of _____Insulin Name Insulin subcutaneously if blood glucose is ____mg/dl to _____mg/dl

_____Units of _____Insulin Name Insulin subcutaneously if blood glucose is ____mg/dl to _____mg/dl

Notify Parent if blood glucose is over _____mg/dl

Notify doctor if blood glucose is over _____mg/dl

**Insulin Pumps**

Basel Rates: _____ _____12 am to _____

Type of Insulin in Pump _____ Type of Infusion Set: _____

Insulin/ Carbohydrate ratio: _____ Correction Factor: _____

Is student competent regarding pump? ☐ Yes ☐ No

Can student effectively troubleshoot problems? ☐ Yes ☐ No

**For Students Taking Oral Diabetes Medications:**

Time: _____ Name of Medication _____ Dose _____

Time: _____ Name of Medication _____ Dose _____

**Unable to Swallow, Loss of Consciousness, or Seizure:**

☐ Glucose gel, 1 mg. of Glucagon IM or Sub-Q and Call 9 -1-1

**Exercise and Sports:**

Restrictions on activity, if any: _____

Students should not exercise if blood glucose is:

- below _____ mg/dl OR
- above _____ mg/dl if moderate to large amounts of ketones are present

**This Diabetes Medical Management Plan Has Been Approved By:**

SIGN HERE

_____ _____

Physician's Signature Date

_____ _____

Phone Number Fax Number

SIGN HERE

_____ _____

Name of Physician's Diabetes Educator Phone Number

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## Diabetes Care and Treatment Plan continued

**PART B: This Section To Be Completed By A Parent/ Legal Guardian**

**Student's Name:** _____ **Date of Birth:** _____

School: _____ Grade: _____ Student ID# _____

Rides School Bus: ☐ Yes ☐ No Bus#: _____ Takes Glucophage or Glucotrol ☐ Yes ☐ No

Particular concerns: _____

Insulin Delivery Method: ☐ Injection ☐ Insulin pump ☐ Combine glucose monitoring/ insulin system: ___

Other Information: _____

**Parent/ Guardian #1**

Name: _____ Address: _____

Home Phone # _____ Work# _____ Cell # _____

**Parent/ Guardian #2**

Name: _____ Address: _____

Home Phone # _____ Work# _____ Cell # _____

**Emergency Contact**

Name: _____ Relationship: _____

Home Phone # _____ Work# _____ Cell # _____

**Physician**

Name: _____ Phone: _____

Does the student wear a medical alert bracelet/ necklace? ☐ Yes ☐ No

**Parent Authorization Signature:**

As parent/guardian of the above named student, I give permission for use of this health plan and for the school nurse to contact my child's healthcare provider(s) regarding the above condition.

I also give permission to the School Nurse, the Unlicensed Diabetes Care assistant (UDCA) and any other designated staff members of my child's school to perform and carry out the diabetes care tasks as outlined by child's Diabetes Management and Treatment Plan. I also consent to the release of the information contained in this Diabetes Management Treatment Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

**I agree to provide the school with all the supplies and medication(s) necessary to carry out the treatment plan for my child as indicated by my child's physician/healthcare provider.**

**I also agree to notify the school should there be any changes to my child's treatment plan at any time throughout the school year.**

_____ _____ _____

Parent/ guardian signature | Parent/ guardian name (print) | Date

My child is knowledgeable in the management of his/her diabetes and it is my wish that he/she can be allowed to manage his/her diabetes independently while at school or at an off campus event. My child will seek assistance from the school nurse or diabetes care attendant as needed or in the event of a medical emergency.

**Parent Signature:** _____ **Date:** _____

**Student Signature:** _____ **Date:** _____

**This diabetes management plan has been reviewed by the school nurse and unlicensed diabetes care assistant.**

_____ _____

School Nurse Signature | Date

_____ _____

Unlicensed Diabetes Care Assistant Signature | Date