Anchorage School District

DIABETES CARE PLAN (INJECTIONS)

STUDENT PHOTO

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH (MM/DD/YYYY)
SCHOOL	SCHOOL FAX		GRADE

EFFECTIVE DATE: **END DATE:**

DIABETES HEALTHCARE PROVIDER INFORMATION

Name:

Phone #: Fax #:

Monitor Blood Glucose – test ... (reference Hypo/Hyperglycemia Treatment Protocol for BG < 70 and BG ≥ 250)

☒ If student has symptoms of high or low blood glucose

Breakfast ☒ Before ☐ After Exercise /PE/gym/recess: ☒ Before ☐ After

Lunch: ☒ Before ☐ After ☐ Before leaving school

Snack: ☐ Before ☐ After ☐ Other : _____

Where to test: ☐ Classroom ☒ Health office ☐ Other: _____

☒ **Without moving student if has low blood glucose symptoms**

Continuous Glucose Monitoring: Type of CGM: _____

Student may use reading from CGM for: ☐ Insulin dosing ☐ End of day check ☐ Before activity check

Perform a finger stick: ☐ Blood glucose is rapidly changing when dosing insulin ☐ To confirm hypoglycemia

☐ Hyperglycemia ☐ Calibrations ☐ Other: _____

Routine Daily Insulin Injection:

Insulin Delivery: ☐ Syringe/vial ☐ Pen ☐ Smart Pen

Insulin Type: ☐ rapid acting (Insulin Lispro/Insulin Aspart/FIASP) ☐ other: _____

Step 1. BLOOD GLUCOSE CORRECTION

☒ USE THE FOLLOWING PARAMETERS TO CALCULATE CORRECTION DOSE

Target blood glucose: _____ mg/dL **Insulin sensitivity factor:** _____

(Current Blood Glucose – Target Blood Glucose) / **Insulin Sensitivity Factor** = _____ **Units of Insulin**

When to give correctional insulin:

☒ Before breakfast ☐ Before lunch ☐ Other: _____

☒ All BG/SG results to be entered into the Smart Pen to determine dosing.

Do not give correction dose more than once every 3 hours.

☐ Use correction scale

Glucose range	Insulin Units
mg/dL	
mg/dL	
mg/dL	
mg/dL	
mg/dL	
mg/dL	
mg/dL	

Step 2. CARBOHYDRATE COVERAGE

Bolus Meal Insulin: ☒ Before eating or ☒ After eating

☒ If BG <70 before a meal, treat with carbohydrate per Hyperglycemia Treatment Protocol.

☒ USE THE FOLLOWING PARAMETERS TO CALCULATE CARBOHYDRATE COVERAGE DOSE

BREAKFAST 1 unit of insulin per _____ grams of carbohydrate

LUNCH 1 unit of insulin per _____ grams of carbohydrate

AM SNACK 1 unit of insulin per _____ grams of carbohydrate

PM SNACK 1 unit of insulin per _____ grams of carbohydrate

Total Gram of Carbohydrates to Be Eaten / **Insulin-to-Carbohydrate Ratio** = _____ **Units of Insulin**

When to give carbohydrate coverage insulin:

☐ Breakfast ☐ Lunch ☐ Snack ☒ All carbohydrate intake ☐ Other: _____

Step 3. MEALTIME TOTAL INSULIN DOSE				
Blood Glucose Correction + Carbohydrate Coverage= Insulin Dose Round doses to the nearest: ☐ Half unit ☒ Whole unit				
MEDICATION	**Frequency**	**DOSE**	**ROUTE**	**NOTES**
☐ Tresiba or Insulin Glargine	Once daily at _____	_____ units	Subcutaneous	Injection to be witnessed or performed by the nurse or trained staff.
☐ PRN Baqsimi*	PRN Severe Hypoglycemia	☐ 3 mg	Intranasal	
☐ PRN Glucagon	PRN Severe Hypoglycemia	☐ 1 mg ☐ 0.5 mg	IM or SC Injection	Administration site includes buttocks, arm, or thigh by the nurse or trained staff.
☐ Gvoke*	PRN Severe Hypoglycemia	☐ 1 mg ☐ 0.5 mg	IM or SC Injection	Administration site (buttocks, arm, or thigh) by the nurse or trained person.

*** You may use either Baqsimi or Gvoke to treat severe hypoglycemia. You would not use both in a single event.***

Exercise and Sports

- A quick-acting source of glucose such as glucose tabs or sugar-containing juice should be available at the site of physical activity or sports.
- Do not exercise with moderate to large ketones per Hyperglycemia Treatment Protocol.

☒ Student should monitor blood glucose hourly.
☐ Student should eat _____ **grams of carbohydrates:**
☐ Before ☐ Every 30 minutes during ☐ Every 60 minutes during ☐ After vigorous activity
☒ If pre-exercise blood glucose is **less than 70 mg/dL**, student can participate in physical activity once blood glucose is corrected and **above 120 mg/dL.**
☒ If pre-exercise blood glucose is **less than 120 mg/dL**, student can participate in physical activity once they consume a **15 gram** snack with protein.
☐ If student is to exercise right after breakfast/lunch, student should subtract ___ gm from carbohydrate count.

Parent/Guardian Authority to Adjust Insulin Dose
Dose adjustment allowed up to 20% higher or lower ☒ Yes ☐ No

HCP Assessment of Student's Diabetes Management Skills:

Skill	Independent	Needs Supervision*	Cannot do	Notes
Check blood glucose	☐	☐	☐	
Count carbohydrates	☐	☐	☐	
Calculate insulin dose	☐	☐	☐	
Injection	☐	☐	☐	
Troubleshoot CGM alarms	☐	☐	☐	

*The RN or other trained staff are expected to observe for accuracy & completion of the skill.

- ***For blood glucose ≥ 250 mg/dL, repeat blood glucose check in 2 hours. If blood glucose remains ≥250 mg/dL, check urine ketones and refer to Hyperglycemia Treatment Protocol.***
- ***Check ketones with signs of illness including abdominal pain, upset stomach and vomiting.***
- ***For blood glucose less than 70 mg/dL, refer to the Hypoglycemia Treatment Protocol.***

Other health concerns:

Notes:

HEALTHCARE PROVIDER **Electronically signed or signed by:**	**Date:**

Student Name: **Allergies**

PARENT / GUARDIAN AUTHORIZATION

I request that the medication(s) and diabetes care outlined on this plan be given to my child. **I will provide needed medications or supplies for care in school.**

Employees and agents of the Anchorage School District ("ASD") strive to provide treatment consistent with the appropriate standard of care, but are not infallible. I agree to release, defend, indemnify, and hold harmless ASD from any liability for the risks or results of the care, which may include INJURY, ILLNESS, or DEATH, or the manner in which it is administered, including for NEGLIGENCE. I will notify ASD immediately if the medications or protocols change. I give permission for the exchange or release of health information between the medical provider listed above and ASD as part of the provision of my child's care. I agree for the nurse to share health information with ASD staff on a need-to-know basis for my child's safety and to foster academic success.

I understand that ANY remaining diabetes care supplies will be disposed of at the end of the school year, unless I pick up the remaining supplies by the last school day, as indicated on the ASD school year calendar.

PARENT / GUARDIAN NAME (PRINTED)	RELATIONSHIP TO CHILD	TELEPHONE NUMBER
PARENT / GUARDIAN (SIGNATURE)		DATE

NURSE PLAN REVIEW

I have reviewed the *Diabetes Care Plan* for accuracy and ensure that all required fields and signatures are completed before providing care to a student. I approve of the agreement arranged between the physician, parent, nurse, and student for the management of the student's health needs. I will conduct training with school staff, as needed, to ensure the safety and well-being of the student in the school setting.

NURSE NAME (PRINTED)	
NURSE SIGNATURE	DATE