Individual Diabetes Care Plan

This plan should be completed by the child's physician and parents/guardians and updated annually or sooner if changes are made to the child's care plan. It should be reviewed with appropriate center staff and copies stored in the child's classroom, file and the Emergency Binder.

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

Student information

Child's name: _____ Date of Birth: _____

Date of diabetes diagnosis: _____ ☐ Type 1 ☐ Type 2 ☐ Other: _____

Center: _____ School phone number: _____

Classroom: _____ Teacher: _____

Center Director: _____ Phone number: _____

Contact information

Parent/guardian 1: _____

Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email address: _____

Parent/guardian 2: _____

Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email address: _____

Child's physician/health care provider: _____

Name:

Address: _____

Telephone: _____ Emergency number: _____

Email address: _____

Other emergency contacts: _____

Name: _____ Relationship: _____

Telephone: Home: _____ Work: _____ Cell: _____

Individual Diabetes Care Plan

Checking blood glucose

Brand/model of blood glucose meter: _____

☐ **Keep a copy of the instructions for the blood glucose meter for your reference and ensure the meter is approved by the FDA for over-the-counter sale to the public without a prescription.**

Target range of blood glucose: *Before meals:* 90-130 mg/dL

Other: _____

Check blood glucose level:

☐ Before breakfast	☐ After breakfast	☐ Hours after breakfast	☐ 2 hours after a correction dose
☐ Before lunch	☐ After lunch	☐ Hours after lunch	☐ Before dismissal
☐ Mid-morning	☐ After physical activity	☐ Other: _____	

Preferred site of testing: ☐ Side of fingertip ☐ Other:

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

Student's self-care blood glucose checking skills:

☐ Independently checks own blood glucose
☐ May check blood glucose with supervision
☐ Requries a teacher or training diabetes personnel to check blood glucose
☐ Uses a smartphone or other monitoring technology to track blood glucose values

Continuous glucose monitor (CGM): ☐ Yes ☐ No Brand/model: _____

Alarms set for: Severe Low: _____ Low: _____ High: _____

Threshold suspend setting: _____

Additional Information for student with CGM

- Confirm CGM results with blood glucose meter check before taking action on the sensor blood glucose level. If the childhas signs or symptoms of hypoglycemia, check fingertip blood glucose level regardless of the CGM.
- Insulin injections should be given at least three inches away from the CGM insertion site.
- Do not disconnect from the CGM for sports activities.
- If the CGM becomes dislodged or malfunctions call the parent, emergency contact within 30 minutes orapplicable backup BGM as identified in the plan.

Individual Diabetes Care Plan

Additional information for student with CGM cont.

Student's Self-care CGM Skills	Independent?	
The student troubleshoots alarms and malfunctions.	☐ Yes	☐ No
The student knows what to do and is able to deal with a HIGH alarm.	☐ Yes	☐ No
The student knows what to do and is able to deal with a LOW alarm.	☐ Yes	☐ No
The student can calibrate the CGM	☐ Yes	☐ No
The student knows what to do when the CGM indicates a rapid trending rise or fall in the blood glucose level.	☐ Yes	☐ No

The center to call the parent if the CGM alarm goes off: Yes No
Other instructions for the school health team: _____

_____

Hypoglycemia treatment

Student's usual symptoms of hypoclycemia (list below): _____

_____

_____

If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than _____ mg/dL, treat with a fast-acting carbohydrate: _____oz. apple or orange juice; _____oz. milk; _____oz. soda; (not diet) # ___glucose tablets;

OR other _____

Recheck blood glucose in 15 minutes and repeat treatment if blood glucose level is less than mg/dL.

Additional treatment: _____

_____

If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movement):

- Position the student on his/her side to prevent choking
- Give glucagon: ☐ 1mg ☐ 1/2 mg ☐ Other (dose)
  - Route: ☐ Subcutaneous (SC) ☐ Intramuscular (IM)
  - Site for glucagon injection ☐ Buttocks ☐ Arm ☐ Thigh ☐ Other
- Call 911 (Emergency Medical Services) and the child's parents/gaurdians.
- Contact the student's health care provider.

Individual Diabetes Care Plan

Hyperglycemia treatment

Student's usual symptoms of hypoclycemia (list below): _____

_____

_____

If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than _____ mg/dL, treat with a fast-acting carbohydrate: _____oz. apple or orange juice; _____oz. milk; _____oz. soda; (not diet) # ___glucose tablets;

OR other _____

Re-check blood glucose every 15 minutes and repeat treatment if blood glucose level is less than _____mg/dL.

Additional treatment: _____

_____

If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movement):

- Position the student on his/her side to prevent choking
- Give glucagon: ☐ 1mg ☐ 1/2 mg ☐ Other (dose)
  - Route: ☐ Subcutaneous (SC) ☐ Intramuscular (IM)
  - Site for glucagon injection ☐ Buttocks ☐ Arm ☐ Thigh ☐ Other
- Call 911 (Emergency Medical Services) and the child's parents/gaurdians.
- Contact the student's health care provider.

Individual Diabetes Care Plan

Insulin therapy

Insulin delivery device: ☐ Syringe ☐ Insulin Pen ☐ Insulin Pump

Type of insulin therapy at school:

☐ Adjustable (basal-bolus) insulin ☐ Fixed insulin therapy ☐ No insulin

Ajustable (Basal-bolus) Insulin Therapy

- Carbohydrate Coverage/Correction Dose: Name of insulin: _____
- Carbohydrate Coverage:

  Insulin-to-carbohydrate ratio: Lunch: 1 unit of insulin per_____grams of carbohydrate

  Breakfast: 1 unit of insulin per _____ grams of carbohydrate Snack: 1 unit of insulin per_____grams of carbohydrate

Carbohydrate Dose Calculation Example
$\frac{\text{Total Grams of Carbohydrates to Be Eaten}}{\text{Insulin-to-Carbohydrate Ratio}}$ = Units of Insulin

Correction dose: Blood glucose correction factor (insulin sensitivity factor) =_____ Target blood glucose=_____mg/dL

Carbohydrate Dose Calculation Example
$\frac{\text{Current Blood Glucose - Target Blood Glucose}}{\text{Insulin-to-Carbohydrate Ratio}}$ = Units of Insulin

Correction dose scale (use instead of calculation above to determine insulin correction dose):

Blood glucose_____to_____mg/dL, give_____units Blood glucose_____to_____mg/dL, give_____units

Blood glucose_____to_____mg/dL, give_____units Blood glucose_____to_____mg/dL, give_____units

When to give Insulin:

Breakfast

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus corrrection dose when blood glucose is greater than_____mg/dL and_____hours since last insulin dose.

☐ Other: _____

Lunch

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus corrrection dose when blood glucose is greater than_____mg/dL and_____hours since last insulin dose.

☐ Other: _____

Snack

☐ No coverage for snack

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus corrrection dose when blood glucose is greater than_____mg/dL and_____hours since last insulin dose.

☐ Other: _____

Individual Diabetes Care Plan

Insulin therapy (continued)

Fixed Insulin Therapy Name of insulin:_____

☐_____ Units of insulin given pre-breakfast daily

☐_____ Units of insulin given pre-lunch daily

☐_____ Units of insulin given pre-snack daily

☐_____ Other

Parents/Guardians Authorization to Adjust Insulin Dose

☐ Yes ☐ No Parents/guardians authorization should be obtained before administering a correction dose.

☐ Yes ☐ No Parents/guardians are authorized to increase or decrease correction dose scale within the following range: +/-_____ units of insulin.

☐ Yes ☐ No Parents/guardians are authorized to increase or decrease insulin-to-carbohydrate ratio within the following range:_____ units per prescriped grams of carbohydrate, +/- _____grams of carbohydrate.

☐ Yes ☐ No Parents/guardians are authroized to increase or decrease fixed insulin dose within the following range: +/- _____ units of insulin.

Fixed Insulin Therapy

☐ Independently calculates and gives own injections.

☐ May calculate/give own injections with supervision.

☐ Requires a trained diabetes personnel to calculate dose and student can give own injection with supervision.

☐ Requires a trained diabetes personnel to calculate dose and give injection.

Additional Information

Brand/model of pump: _____ Type of insulin in pump: _____

Basal rate during school: Time: _____ Basal rate: _____

Time: _____ Basal rate: _____ Time: _____ Basal rate: _____

Time: _____ Basal rate: _____ Time: _____ Basal rate: _____

Other pump instructions: Time: _____

_____

Type of infusion set: _____

Appropriate infusion site(s): _____

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

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

☐ For suspected pump failure: Suspend or remove pump and give insulin by syringe or pen.

Individual Diabetes Care Plan

Additional information for student with insulin pump (continued)

Physical Activity

May disconnect from pump for sports activies: ☐ Yes, for____hours ☐ No

Set a temporary basal rate: ☐ Yes _____% temporary basal for_____hours ☐ No

Suspend pump use: ☐ Yes, for_____hours ☐ No

Student's Self-care Pump Skills	Independent?	
Counts carbohydrates	Yes	No
Calculates correct amount of insulin for carbohydrates consumed	Yes	No
Administers correction bolus	Yes	No
Calculates and sets basal profiles	Yes	No
Calculates and sets temporary basal rate	Yes	No
Changes batteries	Yes	No
Disconnects pump	Yes	No
Reconnects pump to infuse set	Yes	No
Prepares resevoir, pod, and/or tubing	Yes	No
Inserts infusion set	Yes	No
Troubleshoots alarms and malfunctions	Yes	No

Other diabetes medications

Name:_____ **Dose:** _____ **Route:** _____ **Times Given:** _____

Name:_____ **Dose:** _____ **Route:** _____ **Times Given:** _____

Other times to give snacks and content/amount: _____

_____

_____

Special event/party food permitted: ☐ Parents'/guardians' discretion ☐ Student discretion

Individual Diabetes Care Plan

Physical activity and sports

A quick-acting source of glucose such as:

☐ glucose tabs and/or ☐ sugar-containing juice must be available at the site of physical activites and sports.

Child should eat: ☐ 15 grams ☐ 30 grams of carbohydrate ☐ other: _____

☐ before ☐ every 30 minutes during ☐ every 60 minutes during ☐ after vigorous physical activity

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 urine/blood ketones are moderate to large. (See Administer Insulin for additional information for students on insulin pumps.)

Disaster Plan

To prepare for an unplanned disaster or emergency (72 hours), obtain emergency supply kit from parents/guardians.

☐ Countinue to follow orders contained in this individualized diabetes care plan

☐ Additional insulin orders as follows (e.g., dinner and nighttime): _____

_____

_____

☐ Other: _____

_____

Individual Diabetes Care Plan

Signatures

This Individual Diabetes Care Plan has been approved by:

_____

Child's Health Care Provider Date

I, (parent/guardian) _____, give permission to the center or other qualified staff or trained diabetes personnel of (center) _____ to perform and carry out the diabetes care tasks as outlined in (child) _____ _____ Individual Diabetes Care Plan. I also consent to the release of the information contained in this Individual 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 center staff or qualified trainer to contact my child's physician/health care provider.

Acknowledged and received by:

_____

Child's Parent/Guardian Date Date

_____

Child's Parent/Guardian Date Date

_____

Qualified Personnel Date Date

Individual Diabetes Care Plan

Guidelines for providing care

Parent Responsibilities:

- Complete, and meet with KCE Center Staff to discuss child's Individualized Care Plan.
- Provide and maintain all required supplies and equipment in good working order, including back-up supplies.
- Replace all required supplies and equipment as needed.
- Complete and submit all required documentation as required by KCE policies and state regulations,including the Daily Diabetes Care Information Sheet.
- Parent(s)/guardian(s) will be given copies of KCE menus and provide Staff carbohydrate counts for foods listed. Staff will determine the grams of carbohydrates consumed by the child based on carbohydrate counts provided by the parent/guardian and approximations of how much the child ate or will be served.
- Provide and label any fast-acting carbohydrates that might be needed to treat hypoglycemia.
- Provide updated orders from the physician each time a change occurs.
- Dispose of insulin pen or syringe needles from the safe container provided.
- Notify KCE Center Staff of any problems or concerns that might occur.
- If alarm sounds from insulin pump, parent/guardian must return to KCE Center within 30 minutes of being notified by KCE Center Staff.

KCE Center Staff Responsibilities:

- Successfully complete individualized care training for each child with diabetes in your care.
- Administer insulin in accordance with the child's Individualized Diabetes Care Plan.
- Parent(s)/guardian(s) will be given copies of KCE menus and provide staff carbohydrate counts for foods listed. Staff will determine the grams of carbohydrates consumed by the child based on carbohydrate counts provided by the parent/guardian and approximations of how much the child ate or will be served.
- For children with insulin pumps:
  - Check the insulin pump, infusion set, and tubing throughout the day to ensure everything isattached and functioning correctly.
  - Notify parent(s)/guardian(s) or the designated individual of any inconsistencies.
    - Parent/Guardian will come promptly to the center to correct them.
  - Staff will not accept direction over the phone to correct malfunctions of the pump, infusion set, ortubing.
  - Staff will notify parent/guardian or designated individual immediately if alarm sounds from insulin pump.
- Storage and Labeling:
  - The child's insulin, supplies, equipment will be clearly labeled with child's name, prescription number and expiration date.
  - Insulin, glucose monitoring supplies, syringes/pens and other equipment for insulin administration will be stored in a labeled container in his/her classroom, inaccessible to all children.
- Individual Child Diabetes Care Plan will be located in the child's classroom.
- Purchase a sharps container on Marketplace to dispose of needles from insulin pens and/or syringes as well as blood glucose monitor lancets.