Shakopee Public Schools, ISD #720

505 S. Holmes St., Shakopee, MN 55379

DIABETES CARE PLAN / ORDER FORM

Student's Name: _____

School: _____ **Grade**: _____ **Date of Birth**: _____

PHYSICIAN SECTION
(must be completed and signed by physician)

Blood glucose target range: _____ to _____ Routine testing time: _____

Supplemental testing time: _____

LOW BLOOD GLUCOSE

For blood glucose below _____mg/dl, follow steps 1, 2 or 3

1. **If the student is conscious and able to swallow, give one of the following:**

Fast acting sugar	Glucose tablets	Juice	Soda	Other
Amount				

2. **If student is less cooperative but conscious, give:**
   ❒ **Oral glucose gel (amount: _____) or** ❒ **Cakemate (amount: _____)**

3. **Recheck blood glucose after 10-15 minutes. Repeat above procedure if glucose is not improved and within target range. Recheck blood glucose in another 15 minutes.**

4. **If unconscious, trained school staff may administer Glucagon for severe hypoglycemia: ❒Yes ❒ No**

HIGH BLOOD GLUCOSE

1. **Test for urine ketones**
   - ❒ **if blood sugar is greater than _____ mg/dl.**
   - ❒ **if student complains of nausea, stomach pain or vomits.**
2. **If urine ketones are positive or blood glucose above _____ mg/dl,**
   - ❒ **Inform parent(s)/guardian(s)**
   - ❒ **Other action to be taken: _____**
3. **If blood glucose is higher than _____mg/dl, or moderate or large ketones, exercise should be avoided or delayed.**

INSULIN ADMINISTRATION AT SCHOOL

Type of insulin to be administered at school: _____

Time(s): _____

Amount(s): _____

Physician Signature: _____ Phone Number: _____

Fax Number: _____

Printed Name: _____

Address: _____

_____ Date: _____

Student's Name: _____

SUPPLIES TO BE PROVIDED BY PARENT/GUARDIAN:

- Blood glucose meter and lancets
- Glucose test strips; ketone test strips, if necessary
- Concentrated sugar (glucose tablets, juice or soda
- Extra snacks
- Insulin and insulin syringes (if ordered by physician)
- Glucagon emergency kit (if ordered by physician)

INSULIN GIVEN AT HOME:

Type: _____ Time(s) given: _____

Type: _____ Time(s) given: _____

Usual symptoms of low blood sugar: _____

Usual symptoms of high blood sugar: _____

BLOOD GLUCOSE TESTING at school: ❒ Yes ❒ No (Type of meter: _____)

Is student able to do own blood glucose testing? ❒ Yes ❒ No

Requested snack times: _____ a.m. _____ p.m. Amount of carbs: a.m.: _____ p.m.: _____

Lunch time: _____ Amount of carbohydrates to be eaten: _____

SCHOOL PARTIES:

Parent should provide alternate snacks that may be kept in the classroom for times when class has treats. Parent will be consulted for planned parties.

FIELD TRIPS:

Parent/guardian is encouraged to attend whenever possible.

PARENT PERMISSION:

I give permission for blood glucose testing, urine ketone testing, treatment of low and high blood glucose, and administration of insulin and glucagons if ordered by the physician to be carried out by the principal's designee.

Physician's orders must be on file before the school may provide services. I agree to provide all necessary supplies and equipment.

I understand that this request will not be valid for any period greater than one year or past the end of the current school year, whichever comes first.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian PRINTED NAME: _____