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| goodlogo2 | |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  | |  | |  |  | School |  | | Student | DOB: | | Year: | | Matric: |  | School: | |  | | | | | |  |  |  | |  | | |  |  | |

**Diabetic Care Plan:** **Hyperglycemia (High Blood Sugar)**

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| --- | --- |
| **High blood sugar for my child is:** |  |

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|  | | Causes of Hyperglycemia | | | | | | | | |  | | Onset | | | | | | |  | |
| * Too much food * Too little insulin * Decreased activity | | | | | | | * Illness * Infection * Stress | |
| * Over time – several hours or days | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | Symptoms | | | | | | | | | | |  | | | | |
|  | Blood Sugar | | |  | | |  | | | Blood Sugar | |  | | |  | | | Blood Sugar | | |  |
|  | | |  | | |  | |  | | |  | | |  | | |  |
|  |  | | |  | | |  | | |  | |  | | |  | | |  | | |  |
| Mild | | | | |  | | | Moderate | | | | | |  | | Severe | | | | | |
| * Thirst * Frequent urination * Fatigue/sleepiness * Increased hunger * Stomach pains * Flushing of skin * Other:   \_\_\_\_\_\_\_\_\_ | | | | | * Mild symptoms plus: * Dry mouth * Lack of concentration * Nausea * Stomach cramps * Vomiting * Weight Loss * Blurred vision * Other:\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | * Mild and moderate symptoms plus: * Labored breathing * Very weak * Confused * Sweet, fruity breath * Unconscious | | | | | |
| ***Circle student’s usual symptoms*** | | | | | ***Circle student’s usual symptoms*** | | | | | | ***Circle student’s usual symptoms*** | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | Actions Needed | | | | | | | | | | | | | | | |  | | |
| * Allow free use of the bathroom. * Encourage student to drink water or sugar-free drinks. * Contact the school nurse or trained diabetes personnel to check urine or administer insulin, per student’s Diabetes Medical Management Plan. * If student is nauseous, vomiting, or lethargic, call the parents/guardian or 911 call for medical assistance if parent cannot be reached. | | | | | | | | | | | | | | | |

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Date Parent Signature School Nurse