

DIABETES HEALTH CARE PLAN

Student Photo

STUDENT _____

GRADE/HOMEROOM _____

TRANSPORTATION _____ bus _____ car _____ driver

CONTACT TELEPHONE NUMBERS IN PRIORITY

Call *Name* *Telephone Number* *Relationship*

1. _____

2. _____

3. _____

PHYSICIAN _____

Phone _____ Fax _____

Checking Blood Glucose Location _____

Student permitted to carry meter _____ yes _____ no

_____ before lunch _____ 1-2 hours after lunch _____ before exercise

_____ before snacks _____ when he/she feels low or ill

_____ after snacks _____ before getting on the bus

Treatment for Low Blood Glucose (Hypoglycemia)

_____ Student may treat "low" with food according to schedule under

if blood glucose is less than 70 give _____

if blood glucose is less than 50 give _____

Retest blood glucose 15 minutes after treating "low"

CALL PARENT WHEN BLOOD GLUCOSE IS LESS THAN _____

Notify Parent and record blood glucose value and treatment.

Snacks are provided by parent /guardian and located _____

Comments:

Will glucagon be provided? _____ yes _____ no

If yes describe the circumstances when it should be administered. _____

Amount to be administered _____ **mg(s) IM and call 911**

Treatment of High Blood Glucose (Hyperglycemia)

Can Student draw correct dose, determine correct amount, and give own injection? _____ yes _____ no

Comments:

_____ Always call parent for dosage

_____ Check urine for Ketones when Blood Glucose is over _____ mg/dl

Call parent/ and or doctor when Blood Glucose is greater than _____ **and/or Ketones are** _____

My child's insulin is administered via:

_____ Vial/syringe _____ Insulin Pen _____ Insulin Pump

Diabetes

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INSULIN

Daily lunchtime dose _____ Type of Insulin _____

Parental authorization should be obtained before administering a correction dose for high blood glucose levels.

_____ yes _____ no

Type of Insulin _____ Insulin is located _____

_____ units if blood glucose is _____ to _____ mg/dl
 _____ units if blood glucose is _____ to _____ mg/dl
 _____ units if blood glucose is _____ to _____ mg/dl
 _____ units if blood glucose is _____ to _____ mg/dl
 _____ units if blood glucose is _____ to _____ mg/dl

For Students with Insulin Pumps

Type of pump: _____ Basal rates: _____ 12am to _____

Type of insulin in pump: _____
 Type of infusion set: _____

Insulin/carbohydrate ratio: _____ Correction Factor: _____

_____ Parents are authorized to adjust the insulin dosage under the following circumstances:

Management of Diabetes in School

The checklist MANAGEMENT OF DIABETES IN SCHOOL indicates the activities that are self-managed, those needing assistance from school personnel and those requiring parental involvement. The following checked activities apply to _____, and must be performed during the school day in order for him/her to maintain glucose control.

ACTIVITY/ SKILL	Independent Student	School Assistance	Parental Involvement
Carbohydrate Counting			
Blood Glucose Monitoring			
Insulin Injection Dosage			
Insulin Injection Administered			
Treatment for Mild Hypoglycemia			
Selection of Snacks and Meals			
Testing of Urine Ketones			
Management of Insulin Pump			

Authorization for the release of information: I hereby give permission for _____ School to exchange specific, confidential medical information with _____ (physician/clinic) on my child _____ to develop more effective ways of providing for the healthcare needs of my child in school.

Physician Signature _____ Date _____

Parent Signature _____ Date _____