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. _____

PRESCRIBER _____
Phone _____ Fax _____

Blood Glucose Monitoring: Location _____

Student permitted to carry meter ❑ Yes ❑ No

❑ before lunch ❑ 1-2 hours after lunch
❑ before snacks ❑ when he/she feels low or ill
❑ after snacks ❑ before getting on the bus ❑ before exercise

Snack: ❑ Please allow a ____ gm snack at _____ ❑ before exercise

Treatment for Low Blood Glucose (Hypoglycemia)

_____ Student may treat "low" with food according to schedule below
_____ 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):

_____ Provide water and access to bathroom ____ See next page for insulin instructions (if applicable)

Comments:

_____ Always call parent for dosage

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

Call parent and/or prescriber when Blood Glucose is greater than ___and/or Ketones are _____

My child's insulin is administered via:

_____Vial/syringe _____Insulin Pen _____Insulin Pump

Can Student draw correct dose, determine correct amount, and give own injection? _____Yes _____No

INSULIN ❑ Student not taking Insulin at school

Insulin is located _____

Daily lunchtime dose: _____ Type of Insulin _____
(insulin/carb ratio or other)

Correction/Adjustment Scale: _____ Type of Insulin _____

_____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

Parental authorization should be obtained before administering a correction dose for high blood glucose levels (excluding lunchtime) _____ YES _____NO

For Students with **Insulin Pumps**

Type of pump:

Type of Insulin in pump:

Insulin/Carbohydrate Ratio: Correction Factor:

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

_____

The checklist below indicates the activities that are self-managed, those needing assistance from school personnel and those requiring parental involvement that must be performed during the school day in order for him/her to maintain glucose control.

Management of Diabetes in School

Activity/Skill Level	Independent Student	School Assistance	Parental Involvement
Blood Glucose Monitoring			
Insulin Dose Calculation			
Carbohydrate Counting			
Insulin Injection Administration			
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 _____ (Diabetes healthcare provider) on my child _____, to develop more effective ways of providing for the healthcare needs of my child at school.

Prescriber Signature _____ Date _____

Parent Signature _____ Date _____