

DIABETES HEALTH CARE PLAN

Student Photo

STUDENT _____

GRADE/HOMEROOM _____

TRANSPORTATION _____ bus _____ car _____ driver

CONTACT TELEPHONE NUMBERS IN PRIORITY

Call *Name Telephone Number Relationship*

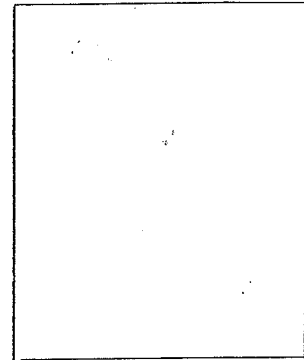
1. _____

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 _____