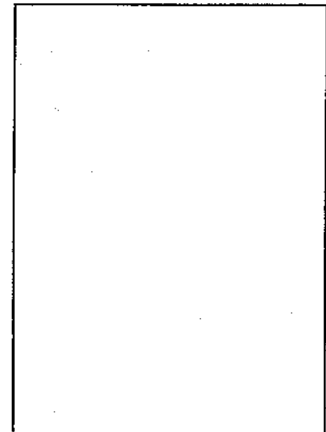
DIABETIC HEALTH CARE PLAN

Student Photo



STUDENT ______________________________
GRADE/HOMEROOM______________________________
TRANSPORTATION ________bus __________car __________driver

CONTACT TELEPHONE NUMBERS IN ORDER OF PRIORITY

Call *Name* *Telephone Number* *Relationship*

1. ______________________________
2. ______________________________
3. ______________________________

PHYSICIAN______________________________
Phone______________________ Fax______________

Check 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
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 ___________

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

Call parent and or doctor when blood glucose is greater than _______________

My child's insulin is administered via:
__________Needle/syringe __________Insulin Pen __________Insulin Pump

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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 ______
_____ _____ to ______
_____ _____ 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 (…)ding assistance from school personnel and those requiring parental involvement. The following checked a…vities 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			
Selection of Snacks and Meals			
Treatment for Mild Hypoglycemia			
Testing for 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 ____________________

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