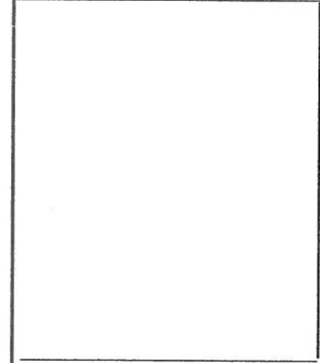
DIABETES HEALTH CARE PLAN School___________________.



STUDENT ____
GRADE/HOMEROOM____

TRANSPORTATION ________bus __________ car __________ driver

CONTACT TELEPHONE NUMBERS IN PRIORITY

Call *Name* *Telephone Number* *Relationship*

1. ____
2. ____
3. ____

PRESCRIBER____
Phone_________________________________ __ Fax ________________

Start Date _________ **End Date** __________

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

Proprietary information of PSI Affiliates, Inc. May not be copied without consent.

Student Name: ______________________________

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 ___________________