Wadsworth City Schools
524 Broad Street, Wadsworth, OH 44281
Phone: 330.336.3571
FAX: 330.335.1313

DIABETES HEALTH CARE PLAN

Student: _____

Grade/Homeroom: _____

Transportation: _____ bus _____ car _____ driver

Student Photo

CONTACT TELEPHONE NUMBERS IN PRIORITY:

Call	Name	Telephone No.	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 one 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

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: _____ 12 am 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 Carbohydrate Counting	Independent Student	School Assistance	Parental Involvement
Blood Glucose Monitoring			
Insulin Injection Dosage			
Insulin Injection Administered			
Treatment of 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 information with _____ (physician/clinic) on my child, _____ , to develop more effective ways of providing the healthcare needs of my child in school.

Physician Signature: _____ Date: _____

Parent Signature: _____ _____