

### DIABETES HEALTH CARE PLAN

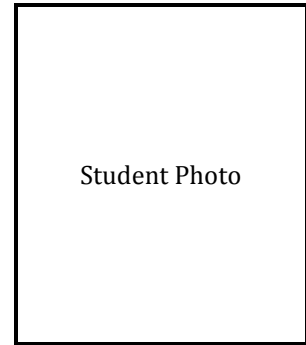
Student: \_\_\_\_\_

Grade/Homeroom: \_\_\_\_\_

Transportation: \_\_\_\_\_ bus \_\_\_\_\_ car \_\_\_\_\_ driver

**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                 | Independent Student | School Assistance | Parental Involvement |
|--------------------------------|---------------------|-------------------|----------------------|
| Carbohydrate Counting          |                     |                   |                      |
| 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: \_\_\_\_\_