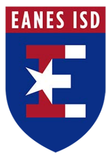

Diabetes Care Plan for ______________________________ School: ________________________ Effective Date: __________
Date of Birth: _______________ Grade: ____________ Homeroom Teacher: ____________________________
(To be completed by parents/health care team and reviewed with necessary school staff. Copies should be kept in student's classrooms school records)

Contact Information:
Parent/guardian # 1: ________________________ Address: ____
Telephone: Home: _________________ Work: __________________ Cell Phone: _____________________
Parent/guardian # 2: ________________________ Address: ____
Telephone: Home: _________________ Work: __________________ Cell Phone: _____________________
Student's Doctor/Health Care Provider: __________________________________ Phone: ______________________
Nurse Educator: __________________________________ Phone: ______________________
Other emergency contact:. __________________________________ Relationship: ______________________
Telephone: Home: _________________ Work: __________________ Cell Phone: _____________________
Notify parent/guardian in the following situations: ____
____

Blood Glucose Monitoring:
Target range for blood glucose: _______ mg/dl to _______ mg/dl. Type of blood glucose meter student uses: ______________________
Usual times to test blood glucose: ____
Times do extra BG tests (check all that apply): ___ Before Exercise ___ When student exhibits symptoms of hyperglycemia
___ After Exercise ___ When student exhibits symptoms of hypoglycemia
___ Other (explain): ____
Can student perform Own blood glucose tests? ___ Yes ___ No Exceptions: _________________________________
School personnel to monitor blood glucose level and dates of training: ____
____

Insulin:
Times, types, and dosages of insulin to b e given during school:

Time:	Type(s):	Dosages:
_____	____________	________________
_____	____________	________________
_____	____________	________________

School Personnel trained to assist with insulin injection and dates of training:: ______________________________________
____
Can student give own injections? Yes ____ No _____
Can student determine correct amount of insulin? Yes ____ No _____
Can student draw correct dose of insulin? Yes ____ No _____

For students with insulin pumps:
Type of Pump: ______________________________
Insulin/carbohydrate ratio: _________________________
Correction factor: ______________________________
Correction factor bolus when ______________________

Is student competent regarding pump? Yes ____ No ____
Can student effectively troubleshoot problems? (e.g, ketosis or pump malfunction?)
Yes ____ No ____
Comments: ____
____
____

Diabetes Care Plan for ______________________________ School: ________________________ Effective Date: ___________

Meals and snacks eaten at school: (the carbohydrate content is important in maintaining a stable blood glucose level.)

	Time	Food Content
Breakfast	_______	______________________
A.M. snack	_______	______________________
Lunch	_______	______________________
P.M. snack	_______	______________________
Dinner	_______	______________________

Snack before exercise'? Yes ____ No.____

Snack after exercise? Yes ____ No.____

Other times to give snacks and content/amount: ____________________

____

____

A source of glucose such as ____________________________
Should be readily available at all times.
Preferred snack foods: ____________________________
Foods to avoid, if any: ____________________________
Instructions for when food is provided to the class, e.g., as part of a class party or food sampling. ____________________________

____

Hypoglycemia (Low Blood Sugar)

Usual symptoms of Hypoglycemia: ____________________________

____

Treatment of hypoglycemia:____________________________

Blood Glucose Readings

< 40 ____________________________

____

40-60 ____________________________

____

60-80 ____________________________

____

Loss of Consciousness or Seizure ____________________________

____

Hyperglycemia (High Blood Sugar)

Usual symptoms of Hyperglycemia: ____________________________

____

Treatment of Hyperglycemia:____________________________

Blood Glucose Readings

>240 ____________________________

____

>300 ____________________________

____

Circumstances when urine or blood ketones should be tested:____________________

____

Treatment for ketones:____________________________

____

Target blood glucose readings ____________________**Notify Parent for blood glucose readings** ____________________________

Personnel trained in the symptoms and treatment of high and low blood sugar/ dates of training: ____________________________

____

Exercise and Sports:

A snack such as ____________________________ should be readily available at the site of exercise or sports.

Restrictions on activity (if any): ____________________________

Student should not exercise if the blood glucose is below ________________ mg/dl.

Supplies and personnel:

Location of supplies: Blood glucose monitoring equipment: ____________________ Insulin administration supplies: ____________________

Glucagon emergency kit: ____________________ Ketone testing supplies: ____________________

Snack foods: ____________________________

Reviewed, signed, and dated by: **HEALTH PROVIDER**: ____________________________ Date ____________

PARENT: ____________________ Date _________; **Acknowledged/received by: SCHOOL REPRESENTATIVE** : ____________________ Date ________