Bradley County Schools Student Health Plan **Diabetes**

Student Name _____ Grade_____
Date of Birth ____/____/____ Teacher_____

TO BE COMPLETED BY PARENT / GUARDIAN:

YES NO Student is treated at home with oral medication
YES NO Student requires testing of blood sugar level during school hours
Type of meter :_____
Does student need assistance with blood glucose meter use? Yes No
YES NO Student requires insulin during school hours:
YES NO Student receives insulin via syringe or pen
YES NO Student has an insulin pump
Type of pump _____
Student requires supervision with use of pump? Yes No
YES NO Student will require a snack during school hours to be provided by parent?

Signs and symptoms usually experienced by student
Low Blood Glucose level:_____
High Blood Glucose level:_____

**Primary Care Provider / Routine Physician: Dr._____
Phone_____ Fax_____
**Physician who manages students medication regimen:
Dr_____
Phone_____ Fax_____

I understand that the student / parent is responsible for all meal planning by either providing lunch or calculating carbs based on monthly lunch calendar provided to each student. I also agree to contact the school nurse with any changes in treatment plan and provide necessary testing supplies for my student.

****Orders from Physician will be requested for blood glucose monitoring times, correction doses, carbohydrate ranges allowed, and treatment of symptoms. My signature serves as consent for information to be requested from or exchanged with the physician(s) listed above.**

Parent / Guardian Signature _____ Date ____/____/____

FOR SCHOOL NURSE USE ONLY:
Plan reviewed by _____ Date ____/____/____
_____Physician Orders Requested: ____/____/____. Received ____/____/____
_____Added to DD
_____Confidential Medical Alert notification to Grade level teachers, Cafeteria Mgr., PE Teacher, and specialty teachers (Library, Labs, Music, etc)
Medication Location : _____
Other: _____