

This information will be used to formulate a Life Threatening Emergency Care Plan that will be distributed to staff.

Student: _____ DOB: _____

School: _____ Grade: _____

Relation	Name	Phone	Phone	Email
Mother				
Father				
Emergency Contact				

HISTORY

Age of onset: _____ Last A1C: _____ Date: _____

Date of hospitalization: _____

Other illness or disability: _____

Does your student take the school bus to school: Yes No: _____

Physician who manages diabetes: _____ Phone: _____

INSULIN DELIVERY

Injections Yes Humalog or Novolog? Target BG= _____ Correction Factor= _____

Insulin: Carb ratio B'fast ____:____ Lunch ____:____ Dinner ____:____ Lantus or Levemir? ____u at ____ am/pm

Pump Yes Type _____

CGM Yes Type _____

STUDENT'S SELF CARE ABILITY LEVEL

	Independent	Needs Assistance
Testing BG		
Counting Carbs		
Calculating insulin doses		
Administering Insulin		
Treating mild hypoglycemia		
Checking/interpreting ketones		
Changing pump site (if on pump)		

NUTRITION

What time does student eat breakfast? _____ What time does student get breakfast insulin? _____

Does your student: Bring lunch from home? Buy lunch from school?

Does your student require a snack between meals? No Yes When? _____

Is your student compliant with diet? Yes No: _____

EXERCISE

Ever experience low BG's with PE or activity? No Yes: _____

Does your student need a snack before physical activity? No Yes: _____

Involved in after school activities at school (ie: YMCA)? No Yes: _____

SYMPTOMS LOW BLOOD SUGAR: (Check symptoms that your student has experienced)

- weakness hunger shaky fast heartbeat sweating anxious dizzy drowsy
 pale skin irritable lack of concentration/daydreaming other: _____
 headache blurry vision confusion poor coordination slurred speech weakness
 behavior change: _____
 loss of consciousness: When? _____

GLUCAGON DOSE: _____

At what blood glucose level do symptoms appear? _____

Can your student recognize hypoglycemia? No Yes _____

When has student experienced hypoglycemia? _____

Has your student ever not responded to treatment: No Yes _____

TREATMENT OF LOW BLOOD SUGAR (what works for your child?)

For BG < _____ Treat with: _____ Carbs (ie: _____)

For BG < _____ Treat with: _____ Carbs (ie: _____)

Call parents:

after 1st treatment and still symptomatic after 2nd treatment and still symptomatic any time BG < _____

SYMPTOMS OF HIGH BLOOD SUGAR: (Check symptoms your student has experienced)

- thirst frequent urination fatigue sleepy increased hunger sweet breath blurred vision
 weight loss stomach pains flushing of skin lack of concentration dry mouth nausea
 stomach cramps vomiting labored breathing very weak confused unconscious
 other: _____

TREATMENT OF HIGH BLOOD SUGAR

drink water exercise Insulin correction (if >3 hours from last dose)

check ketones if BG > _____ (Parent will be called if moderate to large ketones present to take student home for Sick Day care.)

Parent Signature

Date