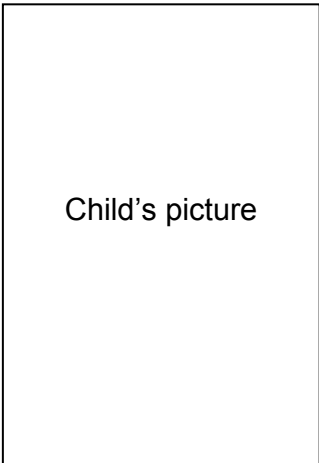


UTICA COMMUNITY SCHOOLS DIABETES HEALTH CARE PLAN

EFFECTIVE DATE: _____

*To be completed by parents/health care team and reviewed with necessary school staff-
copies should be kept in the student's classroom and school record.*



Student's Name: _____

DOB _____ Grade: _____ Teacher: _____

Reviewed by: _____ (health care provider)

Signature

Date

Acknowledged by: _____ (parent/guardian)

Signature

Date

Acknowledged by: _____ (school rep.)

Signature

Date

◆ Contact Information

Parent #1 Name _____ Parent #2 Name _____

Parent/Guardian #1: Telephone-Home _____ Work _____ Cell _____

Parent/Guardian #2: Telephone-Home _____ Work _____ Cell _____

Student's Doctor/Health Care Provider _____ Phone _____

Other Emergency Contact _____ Relationship _____ Phone _____

Notify parent/guardian in the following situations: _____

Trained school personnel: _____ Dates of training _____

Trained school personnel: _____ Dates of training _____

Trained school personnel: _____ Dates of training _____

◆ Location of Supplies

Monitoring equipment _____ Ketone testing supplies _____

Insulin supplies _____ Emergency box _____

Glucagon kit _____ Sharp disposal _____

Snack foods _____

◆ Blood Glucose Testing

Target range for blood glucose _____ mg/dl to _____ mg/dl Type of blood glucose monitor _____

Usual times to test blood glucose: _____ A.M. _____ P.M.

_____ A.M. _____ P.M.

Times to do extra tests (circle all that apply) Before exercise After exercise

When student has symptoms of high blood sugar

When student has symptoms of low blood sugar

Can student perform own blood glucose tests? Yes No*

Exceptions: _____ Supervised? Yes* No

Where the student can perform blood glucose testing (circle): Classroom School Office Other _____

*Contact office

UTICA COMMUNITY SCHOOLS DIABETES HEALTH CARE PLAN

◆ Insulin

Insulin given during school: Time _____ Type _____ Insulin/Carb ratio _____ Correction Factor _____

Can student give own injection? Yes No*

Can student determine correct amount of insulin? Yes No* Can student draw correct dose of insulin? Yes No*

It is my understanding that a designee of the building administrator will be administering insulin. _____

* Contact office _____ (parent/guardian signature)

◆ For students with insulin pumps

Type of pump: _____ Insulin/Carbohydrate ratio _____ Correction factor _____

Is student competent regarding pump? Yes No*

Can student troubleshoot problems (pump malfunction) Yes No* *If no, contact office

◆ Meals and Snacks

Time

Food/Amount

Breakfast _____

A.M. Snack _____

Lunch _____

P.M. Snack _____

Source of glucose, such as _____ should be available at all times.

Preferred snack foods: _____ Foods to avoid, if any _____

Instructions for class functions (ex: class parties): _____

◆ 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 blood glucose is below _____ mg/dl or above _____ mg/dl

Snack before exercise? _____ Snack after exercise? _____

◆ Hypoglycemia (Low blood sugar)

Usual symptoms of hypoglycemia: _____

Treatment of hypoglycemia: _____

Glucagon should be given if the student is unconscious, having a seizure, or unable to swallow. The student should be placed on his/her side in case of vomiting; emergency assistance called and parents notified.

◆ Hyperglycemia (High blood sugar)

Usual symptoms of hyperglycemia _____

Treatment of hyperglycemia: _____

When to check for urine ketones: _____

Treatment for ketones: _____

◆ Transportation

Special Needs Medical Information Form Completed? Yes No Sugar Source on Bus? Yes No

Adapted from the Position Statement of the American Diabetes Association 2001 Guidelines