UTICA COMMUNITY SCHOOLS
DIABETES HEALTH CARE PLAN

Child's picture

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 _____

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♦ 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

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♦ 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