Diabetic School Health Care Plan

Plan for _____ _____ _____ _____
(Student Name) (D.O.B) Grade Homeroom

Target Range for Blood Glucose: _____ to _____

Notify parents when: **Blood glucose** Greater than _____
Less than _____
Whenever: _____.

Blood Glucose:
Checked at **:** _____ _____ _____ _____**times.**
Extra tests (initial all that apply) _____ Before Gym
_____ After Gym
_____ Whenever feels low
_____ Other _____
Child can perform own glucose testing with adult supervision? Yes_____ No_____

Insulin: Type _____
Delivered by:_____
Basal Rate to date_____
Child may operate pump with nurse supervision? Yes _____ No _____.

Food bolus Formula_____

Formula for Correction _____
Correct for blood glucose levels over _____.
Extra Insulin store in _____ **Expiration Date**_____
Side effects _____**Additional Directions**_____

Food: Foods to avoid (if any)_____

Breakfast Time_____
Mid –morning snack time_____ type_____
Lunch Time_____

Snack for mid afternoon? No _____ Yes_____ Time_____
Snack **before** exercise? No _____ Yes_____ Time_____
Snack **after** exercise? No _____ Yes _____ Time_____
Classroom celebrations please do_____

Hypoglycemia:
Symptoms_____
If Blood glucose : 69-79 then_____
59-69 then_____
49-59 then_____
<49 then _____
If Blood glucose low at meal /snack time_____
_____
Give ***Glucagon*** _____mg IM or SC (circle one) **when**_____
And Do This:_____

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Hyperglycemia:

Symptoms:_____

If blood glucose level > _____ correct by formula.
If blood glucose level > _____ then … (initial all that apply)
_____ Check Ketones
_____Check site/ air bubbles
_____Encourage water intake
_____ Notify Parent for further instructions

Restrict Physical activity when _____

AdditionalDirections_____

_____

Gym Days:

Post Gym: If blood glucose < 100 treat by _____
If blood glucose 101-120 give_____
If blood glucose 121-150 do _____
If blood glucose >150 then _____

Field trips: (Initial)

_____ I or my designee will accompany my child as chaperone and be responsible for my child's medical needs.

_____ If I will not be able to attend any trips I will notify the school nurse so arrangements may be made.

Consent: (Initial)

_____Yes ____No The Nurse may display my child's picture to appropriate staff for her safety.
_____Yes ____No I give permission to the nurse to share information with appropriate staff for optimum safety for my child.

Child Responsibilities:_____

_____

Contact Numbers:

Mother:_____ _____ _____ _____
Name Home phone # Cell # Work #

Father: _____ _____ _____ _____
Name Home phone # Cell # Work #

Parent signature: _____ Date: _____

Health Care Provider _____ _____ _____
Print name Work # Emergency #

Provider'sSignature:_____
Date_____

If Parent not available contact _____ at_____
who is_____to my child.

AdditionalComments:

_____

_____
