



HEALTH SERVICES

Student: _____	Grade: _____
DOB: ___/___/___	School: _____
Teacher: _____	Year: _____

DIABETES HEALTH CARE PLAN

EMERGENCY CONTACT INFORMATION:

Parent/Guardian: _____ Home #: _____ Work #: _____ Cell #: _____
 Parent/Guardian: _____ Home #: _____ Work #: _____ Cell #: _____
 Physician/Clinic: _____ Phone: _____
 Hospital of choice: _____ Phone: _____

- Blood Glucose Target Range: _____ -- _____ mg/dl Allergies: _____

Blood Glucose Monitoring

- Meter Type:** _____
- Glucose testing times: _____
- Glucose testing as needed for symptoms of hypoglycemia/hyperglycemia
- Student will need assistance with testing and glucose management.
- Student requires supervision only for testing and glucose management

Diabetes Management

- No insulin at school** **Insulin at school**

Current Regimen:

- 4 shots/day 2 shots/day Pump/Humalog/Novalog Lantus/Humalog/Novalog

- ✓ Long-acting insulin: Given at home Given at school

- Lantus NPH Other: _____

Dose: _____ Time: _____

Dose: _____ Time: _____

- ✓ Short-acting insulin:

Correction Insulin:

- BG _____ -- _____ give _____ units
 BG _____ -- _____ give _____ units
 BG _____ -- _____ give _____ units
 BG _____ -- _____ give _____ units
 BG _____ -- _____ give _____ units

Device used:

- Pen
 Syringe
 Pump

- Frequency of correction: 2 Hr 3 Hr 4 Hr Meal time only

Adjustment needed for PE activity: _____

Mealtime Management:

- ✓ # units/carbohydrate (15 gm): _____ Routine daily snack required
- ✓ Adjustment for: Snacks Meals Times: _____

Student Name _____

EMERGENCY PLAN

STUDENT MUST BE ACCOMPANIED WHEN SYMPTOMATIC: **DO NOT LEAVE ALONE**

HYPOGLYCEMIA (low blood sugar)

Signs or symptoms of hypoglycemia usually exhibited by student:

- | | | | |
|--|---|--|------------------------------------|
| <input type="checkbox"/> Mood changes: (circle all that apply) | <input type="checkbox"/> Irritability | <input type="checkbox"/> Crying | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Shaky/Nervous | <input type="checkbox"/> Heart Pounding | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Unusually pale, clammy skin | |
| <input type="checkbox"/> Drowsiness/Fatigue | <input type="checkbox"/> Loss of consciousness | | |
| <input type="checkbox"/> Hunger | <input type="checkbox"/> Numbness, tingling lips/tongue | | |
| <input type="checkbox"/> Other: _____ | | | |

Does the student recognize these symptoms? Yes No

Treatment of hypoglycemia:

If blood sugar is _____ or below, treat:

- Quick energy food such as ½ cup juice or non-diet soda, or 2-3 glucose tabs.
- Wait 10-15 minutes, and recheck blood glucose. DO NOT LEAVE STUDENT.
- If symptoms continue, call parent or student's doctor.
- If student is not responding to energy source, is confused, or becomes unconscious, CALL 9-1-1, and immediately contact parents.
- Do not attempt to give food or fluid if unconscious or seizing.
- Other: _____

HYPERGLYCEMIA (high blood sugar)

Signs and symptoms of hyperglycemia usually exhibited by student:

- | | | |
|---|------------------------------------|--|
| <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Nausea | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Rapid breathing |
| <input type="checkbox"/> Hot/flushed skin | <input type="checkbox"/> Confusion | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Other: _____ | | |

Does student recognize these symptoms? Yes No

Treatment of hyperglycemia:

- If blood glucose is above _____, check for ketones.
- If blood glucose is above _____, notify parent.
- If ketone test shows moderate or large ketones, contact parent or doctor.
- If blood glucose is elevated and student is ill/vomiting, call parent.
- Push water.
- DO NOT HAVE STUDENT EXERCISE

Physician Signature: _____

Date: _____

Parent Signature: _____

Date: _____

School Nurse Signature: _____

Date: _____

- We ask you to complete this form at the beginning of every school year to ensure that we have the most current information on your child.
- The school district intends to use the requested information to provide for child's health and safety while at school.
- The information you provide will be shared only with staff in the school district whose jobs require access to this information to ensure your child's safety.
- If we are unable to reach you or your designee during an emergency, we will call 911 for assistance if needed.
- I give permission for the school health services staff to consult with my child's physician about questions regarding the listed medication/medical condition