WARREN WOODS PUBLIC SCHOOLS

DIABETES HEALTH CARE PLAN

A review of health information completed by you indicates that your child has DIABETES. In order for us to meet his/her health and safety needs in the school environment, it is important that your and your health care provider/M.D. supply the following information. Please complete accurately and completely. We will utilize this information in planning for and responding to any needs that become apparent during school hours.

Child's Picture

Effective Date: _____

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

Student's Name: _____

DOB: _____ Grade: _____ Teacher: _____

Approved by: _____(health care provider)
Signature Date

Approved 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: _____

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: □ classroom □ school office □ other _____

* Contact Office

DIABETES EMERGENCY

IF UNCONSCIOUS OR HAVING A SEIZURE/OR UNABLE TO SWALLOW

- Identify student, note time and document
- Notify front office--activate response team/911
- Initiate code blue if necessary
- Evacuate any students in area to nearby classroom
- GIVE GLUCAGON (Trained Personnel) – Document DOSAGE _____
- Place student on side
- Notify parent (Admin. or designee)
- Monitor until EMS arrives
- Document on incident/accident report (Admin. or designee)

INSULIN

Insulin given during school: Time _____ Type _____Dosage _____(or see attached sliding scale)

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*

*Contact office at _____(phone)

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 not, contact office at _____ (phone)

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 provided by the parent and 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

Copy to Transportation: ☐ Yes ☐ No

Date Sent: _____

Source: U.S. Dept of Health and Human Services. "Helping the Student with Diabetes Succeed – A Guide for School Personnel"