DIABETES CARE PLAN

Frederick County Public Schools

School year ___________

Note: This form must be completed annually by the child's physician and parent

Child's Name ______________________________ DOB ____/____/____
Last First Middle

Mother ______________________________ Phone (H)__________ (w) ___________
Last First Middle

Father ______________________________ Phone (H)__________ (w) ___________
Last First Middle

BLOOD GLUCOSE TESTS

Blood Glucose Target Range ___________________________

Time(s) for blood glucose test ___________________________ Test done by ❑ Child ❑ Nurse or other trained personnel ❑ Either

LOW BLOOD GLUCOSE

For Blood Glucose below ____________ mg/dl, follow instructions below

1. If student is conscious and able to swallow, give one of the following:

Fast Acting Sugar➔	Glucose Tablets	Sugar	Soda	Other
Amount				

2. If student is less cooperative but conscious, give ❑ Oral glucose gel OR ❑ Cake icing/gel

3. If student is ❑ unconscious, ❑ having a seizure, ❑ having other symptoms such as ___________________________ administer Glucagon Emergency Kit and inform parent.

Any other action to be taken at school? ___________________________

HIGH BLOOD GLUCOSE

1. Test for urine ketones if blood glucose is above __________ mg/dl or if student complains of nausea, stomach pain or vomits.

   NOTE: If blood glucose is higher than __________ mg/dl, excercise should be avoided.

2. If urine ketones are positive or blood glucose is above __________ mg/dl, inform parents.

Any other action to be taken at school? ___________________________

INSULIN

Type of Insulin/dose ___________________________Time of injection(s) ___________________________

Injection given by ❑ Child ❑ Nurse or other trained personnel ❑ Either Location of diabetes care supplies ___________________________

MEALS AND SNACKS

Snack times _______________ Preferred snacks _______________ Location of snacks_______________

ACTIVITY TIMES

Physical education _______________ Recess _______________ Extracurricular _______________

Other trained personnel authorized by physician and parent to administer insulin or glucagon

_______________ _______________ _______________ _______________

SIGNATURES

Physician's Signature ___________________________ Date _______________

Physician name (Print) ___________________________ Phone _______________

Parent/Guardian ___________________________ Date _______________

School Nurse ___________________________ Date _______________

Once form is completed and ***signed*** *by physician, it must be reviewed and signed by the parent and the school nurse.*

4/00