ARCHBISHOP MOLLOY HIGH SCHOOL

83-53 Manton St., Briarwood, NY 11435-1697 | Phone: 718.441.2100 | Fax: 718.943.3173 | Web: www.molloyhs.org

Diabetes Health Care Plan ______________________ **Effective Date:** ____________
(name of child)

To be completed by parents and the health team. This document should be reviewed with necessary school staff and kept in the child's classroom and school records.

Date of Birth ____________ Grade ____________ Homeroom Teacher ____________

Phone numbers for parent(s)/guardian(s)

Parent/guardian # 1 ____________ Parent/guardian # 2 ____________
Address: ____________ Address: ____________
Work Phone: ______ Home: ______ Work Phone: ______ Home: ______
Cell Phone: ____________ Cell Phone: ____________

Childs doctor/health care provider: Other emergency contact:
Name: ____________ Relationship: ____________
Phone: ____________ Work Phone: ______ Home: ______
Nurse Educator: ______ Phone: ______ Cell Phone: ____________

Notify parent/guardian in the following situations ____________

Blood Sugar Monitoring

Target range for blood sugar: ________ mg/dl to ________ mg/dl
Usual times to check blood sugars: ________ ________

Times to do extra checks (check all that apply):
___ Before exercise ___ When child exhibits symptoms of high blood sugars
___ After exercise ___ When child exhibits symptoms of low blood sugars
___ Other (explain): ____________

Can child perform own blood sugar checks? ___Yes ___No Exceptions: ________
Type of blood sugar meter: ____________
School personnel trained to monitor blood sugars ____________

Insulin and diabetes Medications

Times, types, and dosages of insulin injections/ or diabetes medication to be given during school:

Time________ Type________ Dosage________

School personnel trained to assist with insulin and or / diabetes medication ____________
Can child give own injections? ___Yes ___No
Can child determine correct amount of insulin? ___Yes ___No
Can child draw correct dose of insulin? ___Yes ___No

For Students with Insulin Pumps

Type of pump: ________ Insulin/Carbohydrate ratio: ________ Correction factor ________
Is student competent regarding pump? ___Yes ___No
Can student effectively troubleshoot problems (e.g. ketosis, pump malfunction)? ___Yes ___No

Meals and Snacks

Eaten at School **Time:** **Food content / amount:**

(The carbohydrate content of the food is important in maintaining blood sugar level)

Breakfast ____________ ______________________________

Midmorning snack ____________ ______________________________

Lunch ____________ ______________________________

Midafternoon snack ____________ ______________________________

Dinner ____________ ______________________________

Snack before exercise? ___Yes ___No ______________________________

Snack after exercise? ___Yes ___No ______________________________

Other times to give snacks and the content / amount ______________________________

A source of glucose, such as ____________________ should be readily available at all times.

Preferred snack foods: ______________________________

Foods to avoid, if any: ______________________________

Foods preferred for school / class parties: ______________________________

Exercise and Sports

A snack such as ____________________ should be readily available at the site of exercise and sports.

Restrictions on activity, if any: ______________________________

Child should not exercise if blood sugar is below ____________ mg /dl.

Hypoglycemia (Low blood sugar)

Usual symptoms: ______________________________

Treatment: ______________________________

School personnel trained to administer glucagon:

____

(Glucagon should be given if child is unconscious, having a seizure (convulsion), or unable to swallow. If required, glucagon should be given promptly, and then call 911 (or other emergency assistance) and parents immediately.

Hyperglycemia (High blood sugars)

Usual symptoms: ______________________________

Treatment: ______________________________

Circumstances when urine ketones should be checked: ______________________________

Treatment for ketones: ______________________________

In the School

Locations of supplies: Blood glucose monitoring equipment: ______________________________

Insulin administration supplies: ____________________ Glucagon emergency kit: ____________________

Ketone testing supplies: ____________________ Snack foods: ____________________

Personnel trained in the symptoms and treatment of low and high blood sugar: ____________________

Reviewed by: X ______________________________

(child's health provider and date)

Acknowledge and received by : X ______________________________

(parent / guardian and date)

Please Stamp:

American Diabetes Association
Cure / Care / Commitment

Emergency Hypoglycemia (low blood glucose) Care Plan For a Student with Diabetes

Photo

Student's Name

Grade/Teacher Date of Plan

Mother/Guardian Father/Guardian

Home Phone Work Phone Cell Home Phone Work Phone Cell

School Nurse/Trained Diabetes Personnel Contact Number(s)

Never send a child with suspected low blood sugar anywhere alone.