Peyton Manning Children's Hospital at St.Vincent

Diabetes Care Plan

Student Name_____ DOB:_____ Grade_____Date_____

Diabetic Identification: Student wears a diabetic identification bracelet or necklace: _____Yes _____No

Daily Management Plan: Blood Glucose Target Range_____

Field Trip: staff will inform parent of all field trips and will take the following:

Cell phone / Copy of Health Care Plan/ Glucose Monitor/ Quick –acting sugar source

Exercise/Sport Activity:

Student may participate in regular physical education classes: ___ Yes ___ No

Student should not exercise if blood glucose level is below _____mg/dl or above ____ mg/dl.

STUDENT SELF-MANAGEMENT	Yes	No	Needs Assistance
Has student done their own blood glucose checks			
Has student been giving own insulin? __sub-q __pump			
Able to perform blood glucose checks? Meter used_____			
Able to calculate Carbohydrates?			
Prepare reservoir and tubing for pump?			
Troubleshoots alarms and pump problems?			

Supplies to be kept at School:

*Insulin or oral medications *Urine Ketone Strips * Blood glucose meter and testing supplies

*Glucagon emergency kit *Fast-acting source of glucose *Insulin pump and supplies

*Carbohydrate containing snack *Reservoir, infusion sets * Insulin pen, needles, cartridges

*Other _____

Food Plan (check all that apply.)

_____Will bring daily morning snack of _____carbohydrates to be eaten at _____a.m.

_____Will bring daily afternoon snack of _____ carbohydrates to be eaten at _____p.m.

_____On special occasions, student can eat same snack provided to classmates.

_____On special occasions, student will select alternate snack from supply provided by parent.

Blood Sugar Testing (check all that apply.)

_____Will not test at school.

_____Will be done by student everyday at _____

_____Will be done by student when symptoms are present.

Insulin Needs (check all that apply)

_____ Will not need insulin at school.

_____Will need insulin at school. Type of insulin and Dosage Schedule:_____

_____Will be using an insulin pump and is self-sufficient in its use.

Treatment of Low Blood Sugar (Hypoglycemia)

How often does a hypoglycemic reaction occur:_____

If blood glucose is under _____, treatment is _____

Symptoms student has experienced when having a low blood glucose include:_____

___Disorientation ___Irritability ___ Anxiety ___Headache ___ Hunger ___ Abdominal Pain

___Rapid Pulse ___ Sweating ___ Tremor___ Hyperactivity ___ Slurred speech ___ seizure

Treatment of High Blood Glucose (Hyperglycemia)

How often does a hyperglycemic reaction occur: _____

If blood glucose is under _____, treatment is _____

Symptoms student has experienced when having high blood glucose include: _____

___ nausea/Vomiting ___ Fever ___ Weakness ___ Listlessness ___ Dry Skin ___ Delirium

___ Slow Deep Noisy Breathing ___ Sweet Odor to Breath

_____

Notify Parents For: _____

_____

TO BE COMPLETED BY THE PARENT/GUARDIAN: I give permission to the school nurse, trained diabetes personnel, and other designated staff to perform and carry out the diabetes care tasks as ordered by the physician. I also consent to the release of information to staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I permit my child to manage his/her diabetic care and self-administer medication as approved by the school nurse and ordered by the physician.

PARENT/GUARDIAN SIGNATURE:_____ DATE _____