PHYSICIAN'S
DIABETES HEALTH CARE PLAN
Fowlerville Community Schools

Diabetes Care Plan for _____ Effective Dates_____

To be completed by Physician/Health Care Team & Parent/Guardian and reviewed with necessary school staff. Copies should be kept in student's classroom and school records.

Date of Birth: _____ Grade _____ Teacher _____

Contact Information

Parent/Guardian #1_____ Address_____
Telephone (H)_____(Cell)_____ (Work)_____
Parent/Guardian #2_____ Address_____
Telephone (H)_____(Cell)_____ (Work)_____
Other Emergency Contact: _____ Relationship: _____
Telephone (H)_____(Cell)_____ (Work)_____

Student's Doctor/Health Care Provider: _____ Ph:_____
Nurse Educator:_____ Ph:_____
Notify parent/guardian in the following situations: _____
_____

Blood Glucose Monitoring

Target range for blood glucose_____mg/dl to_____ mg/dl
Type of blood glucose meter used:_____
Usual times to test blood glucose:_____

Times to do extra tests (check all that apply)

_____ Before exercise _____ When student exhibits symptoms of hyperglycemia (high)
_____ After exercise _____ When student exhibits symptoms of hypoglycemia (low)
_____ Other (explain) _____

Can student perform own blood glucose tests? ____Yes ___No Exceptions_____
School personnel trained to monitor blood glucose level and dates of training:_____

Insulin

Times, types, and dosage of insulin injections to be given during school:

Time	Type(s)	Dosage
_____	_____	_____
_____	_____	_____

School personnel trained to assist with insulin injection and dates of training:_____
_____
_____

Can student give own injection? __Y __N
Can student determine correct amount of insulin? __Y __N
Can student draw correct dose of insulin? __Y __N

For Students with Insulin Pumps

Type of pump:_____
Insulin/carbohydrate ratio:_____
Is student competent regarding pump?
_____ Yes _____No
Can student effectively troubleshoot problems (eg., ketosis. pump malfunction)?
_____ Yes _____No
Comments:_____
_____
_____
_____
_____

MEALS AND SNACKS EATEN AT SCHOOL

(The carbohydrate content of the food is important in maintaining a stable blood glucose level.)

Time	Food Content/Carbs.
Breakfast _____	_____
A.M. Snack _____	_____
Lunch _____	_____
P.M. Snack _____	_____
Dinner _____	_____

Snack before exercise?
___Yes ___No _____

Snack after exercise?
___Yes ___No _____

Other times to give snacks and content/amount:
_____
_____

A source of glucose, such as _____
_____should be readily available at all times.
Preferred snack foods_____
Foods to avoid _____
Instructions for when food is provided to the class, e.g., as part of a class party or food sampling:
_____
_____

Hypoglycemia (Low Blood Sugar)

Usual symptoms of hypoglycemia _____
_____
Treatment of hypoglycemia _____
_____
School personnel trained to administer glucagons and dates of training_____
_____
_____
Glucagon should be given if the student is unconscious, having seizure (convulsion), or unable to swallow. If required, glucagons should be administered promptly and then 911 (or other emergency assistance) and parents should be called.

Hyperglycemia (High Blood Sugar)

Usual symptoms of hyperglycemia _____
_____
_____
_____
Treatment of hyperglycemia _____
_____
Circumstances when urine or blood ketones should be tested _____
_____
Treatment for ketones_____
_____

Exercise and Sports

A snack such as _____should 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.

Supplies and Personnel

Location of supplies:
Blood Glucose monitoring equipment:_____
Glucagon emergency kit:_____ Ketone testing supplies_____
Snack foods:_____

Reviewed by _____ _____
Student's Health Provider Date

Received by _____ _____
Parent/Guardian Date

Received by _____ _____
School Representative Date