HARVESTCHRISTIANACADEMY

DIABETIC CARE PLAN

STUDENT NAME: _____ D.O.B: _____ Age at diagnosis: _____

Emergency Contact Information:

1. Name: _____Relationship:_____ Phone: _____

2. Name: _____Relationship:_____ Phone: _____

3. Physician Name: _____ Phone: _____

EMERGENCY PLAN

If student unconscious
OR
If blood sugar below _____

} **Give Glucagon** **Half syringe** **Whole syringe** **Call 911**

MONITORING

STEP 1: MONITORING: Check blood sugar at: _____

STEP 2:

If blood sugar below _____ Give the following:	If blood sugar above _____ Give the following:	If blood sugar above _____
Glucose tabs:	Insulin:	Check Ketones before exercising
Juice:	Other:	Other:
Other:		

Retest blood sugar in _____ minutes.

If blood sugar is less than _____ treat with _____

Follow treatment with a snack of _____

in ____ minutes or once blood sugar is greater than _____.

DAILY DIABETIC MANGAEMENT PLAN

Medication Name	Dose / Route	Time Given

Please answer the following questions:

SNACKS:

Snack Time(s): _____ _____ _____ _____

Is child following a prescribed meal plan?	Yes	No	(If so, please share it with the nurse)
Is a snack necessary before P.E./ sports	Yes	No	
Parents will send snacks with child daily?	Yes	No	
Parents to be notified in advance of class parties?	Yes	No	
Child may partake in class treats?	Yes	No	
Does child participate in after school sports?	Yes	No	
Is coach aware of child's diabetes?	Yes	No	

OTHER CONCERNS:

_____

_____

_____

AUTHORIZATIONS

_____ I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that _____ should be allowed to carry and use that medication by him/herself.

_____ It is my professional opinion that _____ should not carry his/her inhaled medication by him/herself.

Physician Signature: _____Date:_____

Parent/Guardian Authorization:

- I request this medication be administered as ordered by the student's licensed health care provider.
- I give Health Services staff permission to communicate with the health care provider about this medication.
- I understand that these medications may be administered by a trained staff member who has reviewed this care plan and the use of emergency medication.
- I agree that this medical information may be shared with school staff working with my child and 911 staff if needed.
- I assume responsibility for supplying medication to the school that will not expire during the course of its intended use. *Expired medication can not be administered!*
- Medication must be in the original prescription container with instructions as noted by above health care provider.

Parent/Guardian Signature: _____Date:_____