Parents: Please complete this form to assist the school in meeting the specific needs of your child with diabetes. Please return to your school nurse by _____.

DIABETES
SCHOOL CARE PLAN

Student Name: _____ School: _____

Grade: _____ Student #: _____ Birth date: _____

TYPE OF INSULIN REGIMEN (PLEASE CIRCLE):

Humalog & NPH Humalog & Lente Humalog & Ultralente

Regular & NPH Regular & Lente Regular & Ultralente

Other: _____

BLOOD GLUCOSE MONITORING:

Type of meter: _____ Time(s) of day to test: _____

Location of meter: _____ Location of where to test: _____

Does child need assistance with blood glucose monitoring? ❑ Yes ❑ No

RECOGNITION OF HYPOGLYCEMIA (LOW BLOOD GLUCOSE)

Symptoms typically seen: _____

Treatment of choice, provided by family: _____

At what blood glucose level treatment should be given: _____

Time of day most likely to occur: _____

RECOGNITION OF HYPERGLYCEMIA (HIGH BLOOD GLUCOSE)

Symptoms typically seen: _____

Treatment: Liberal bathroom privileges and increase non-caloric fluid intake.

Additional instructions for treatment: _____

At what blood glucose level should parents be called? _____

If vomiting, call parents immediately.

SNACKS

Does child require snacks during school hours? ❑ Yes ❑ No

If yes, at what times are snacks needed? _____

List food items to be provided by family for snacks: _____

_____

SPECIAL PARTIES/FIELD TRIPS

Special parties, field trips & other events will occur during the school year. How would parents like to be contacted about these events? _____

Handling special occasions at school:

My child will be responsible for making his/her own choices: ❑ Yes ❑ No

I will provide appropriate substitutions for my child: ❑ Yes ❑ No

OTHER SCHOOL PERSONNEL

Please check which other school personnel should be aware of this Diabetes School Care Plan:

❑ Substitute Teachers ❑ Principal/Asst. Principal ❑ Office Staff
❑Bus Driver(s) ❑ Librarian ❑ Lunch Room Personnel
❑Classroom Representative ❑Other: _____

EMERGENCY TELEPHONE NUMBERS

Parent/Guardian Name: _____ Phone #: _____

Parent/Guardian Name: _____ Phone #: _____

Alternate Contact: _____ Phone #: _____

SIGNATURES

_____ _____
Parent/Guardian Signature Date

_____ _____
School Nurse Signature Date

_____ _____
Physician Signature (required) Date

Developed by an ad hoc committee of the Utah Diabetes Control Program, Advisory Board including: Sherry Hardy, MS, RD, CDE, Dawn Higley, NR, MS, CDE, Kandi Hillam, RN, CDE, Lucie Jarrett, RN,MS, CDE, Marcie Johnson,RN, Erin Maughan, RN, and Carol Rasmussen, RN, CDE.

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