



EISD Health Services

Diabetes Care Plan for _____ School: _____ Effective Date: _____
Date of Birth: _____ Grade: _____ Homeroom Teacher: _____

(To be completed by parents/health care team and reviewed with necessary school staff. Copies should be kept in student's classrooms school records)

Contact Information:

Parent/guardian # 1: _____ Address: _____
Telephone: Home: _____ Work: _____ Cell Phone: _____
Parent/guardian # 2: _____ Address: _____
Telephone: Home: _____ Work: _____ Cell Phone: _____
Student's Doctor/Health Care Provider: _____ Phone: _____
Nurse Educator: _____ Phone: _____
Other emergency contact: _____ Relationship: _____
Telephone: Home: _____ Work: _____ Cell Phone: _____
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 student uses: _____
Usual times to test blood glucose: _____
Times do extra BG tests (check all that apply): Before Exercise When student exhibits symptoms of hyperglycemia
 After Exercise When student exhibits symptoms of hypoglycemia
 Other (explain): _____
Can student perform Own blood glucose tests? Yes No Exceptions: _____
School personnel to monitor blood glucose level and dates of training: _____

Insulin:

Times, types, and dosages of insulin to be given during school:
Time: _____ Type(s): _____ Dosages: _____

School Personnel trained to assist with insulin injection and dates of training: _____
Can student give own injections? Yes _____ No _____
Can student determine correct amount of insulin? Yes _____ No _____
Can student draw correct dose of insulin? Yes _____ No _____

For students with insulin pumps:

Type of Pump: _____
Insulin/carbohydrate ratio: _____
Correction factor: _____
Correction factor bolus when _____
Is student competent regarding pump? Yes _____ No _____
Can student effectively troubleshoot problems? (e.g, ketosis or pump malfunction?)
Yes _____ No _____
Comments: _____

Meals and snacks eaten at school: (the carbohydrate content is important in maintaining a stable blood glucose level.)

Time	Food Content
Breakfast _____	_____
A.M. snack _____	_____
Lunch _____	_____
P.M. snack _____	_____
Dinner _____	_____
Snack before exercise? _____	Snack after exercise? _____
Yes ____ No. ____	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, if any: _____

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: _____

Blood Glucose Readings

< 40 _____

40-60 _____

60-80 _____

Loss of Consciousness or Seizure _____

Hyperglycemia (High Blood Sugar)

Usual symptoms of Hyperglycemia: _____

Treatment of Hyperglycemia: _____

Blood Glucose Readings

>240 _____

>300 _____

Circumstances when urine or blood ketones should be tested: _____

Treatment for ketones: _____

Target blood glucose readings _____ Notify Parent for blood glucose readings _____

Personnel trained in the symptoms and treatment of high and low blood sugar/ dates of training: _____

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 the blood glucose is below _____ mg/dl.

Supplies and personnel:

Location of supplies: Blood glucose monitoring equipment: _____ Insulin administration supplies: _____

Glucagon emergency kit: _____ Ketone testing supplies: _____

Snack foods: _____

Reviewed, signed, and dated by: HEALTH PROVIDER: _____ Date _____

PARENT: _____ Date _____; Acknowledged/received by: SCHOOL REPRESENTATIVE : _____ Date _____