REED-CUSTER

Diabetic Health Care Plan

Student: _____ DOB: _____ School Year: _____

School (circle one): RCPS RCIS RCMS RCHS Grade: _____ Teacher: _____

Parent/Guardian & Phone(s): _____

Physician & Phone: _____

KNOWN ALLERGIES: _____

A Diabetic Health Care Plan is needed on all diabetic students. The following plan will provide instructions according to the glucose levels or hypoglycemic reactions found. It allows one to begin treatment in the case of a hypoglycemic or hyperglycemic reaction. The treating HEALTH CARE PROFESSIONAL will provide the instructions & medication management during the student's school hours.

	Check ☑ all that apply
Date of Diagnosis:	☐ Type 1 ☐ Type 2 ☐ Other: _____
Glucose Target Range:	☐ 70 – 130 mg/dl ☐ 70 – 180 mg/dl
When to check glucose levels:	☐ Before Lunch ☐ After Lunch ☐ Before PE ☐ After PE ☐ Beginning of School ☐ At Dismissal ☐ Other: _____
Site for checking:	☐ Finger ☐ Forearm ☐ Other: _____
Glucometer Type:	
Insulin pump? ☐ No ☐ Yes	If yes, what type of pump:
Insulin Management:	
Carbohydrate Coverage:	
Snack Types:	
Activity Plan:	

Choose ☑ appropriate action for student during school hours:

- ☐ Independently checks own glucose levels
- ☐ Independently cares for insulin pump
- ☐ May check glucose levels with adult supervision
- ☐ Requires school nurse or trained diabetic care aid to check blood glucose levels

Hypoglycemic Treatment:	Student's Common Symptoms:
If glucose level < _____mg/dl:	☐ Give quick acting glucose product equal to _____ grams of carbohydrate ☐ Glucagon ➢ ☐ ½ mg or ☐ 1 mg ➢ ☐ SC or ☐ IM
If after 15 minutes and glucose level < _____mg/dl:	Additional treatment:
If unable to eat, drink, unconscious or unresponsive:	1. ☐ Glucagon ➢ ☐ ½ mg or ☐ 1 mg ➢ ☐ SC or ☐ IM 2. **CALL 911** 3. Then call parents & Administration/Principal

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Check ☑ all that apply

Hyperglycemic Treatment:	Student's Common Symptoms: ☐ Dry mouth ☐ Extreme thirst ☐ Nausea ☐ Vomiting ☐ Chest pain ☐ Severe abdominal pain ☐ Heavy breathing ☐ Shortness of breath ☐ Increasing lethargy or sleepiness ☐ Decreased level of consciousness ☐ Other (specify) _____
If glucose level > _____mg/dl:	Urine: Ketones every _____ hours **until** –
If glucose level > _____mg/dl and at least _____ hrs since last insulin dose:	Additional treatment:
☐ Oral Treatment	Give extra water and non- sugar containing drinks (NOT FRUIT JUICES) Give _____ ounces per hour **until** –
☐ Continuous Pump	Directions per doctor:
Emergency Treatment:	1. **CALL 911** 2. Then call parents & Administration/Principal

Authorization to provide diabetic care, release of health care information and acknowledgement of Responsibilities:

As provided by the Care of Students with Diabetes Act, I hereby authorize Reed-Custer School District and its employees, as well as any and all delegated care aides named in the Diabetic Health Care Plan or later designated by the district to provide diabetic care to my child: _____, consistent with the Diabetic care plan. I authorize the performance of all duties necessary to assist my child with the management of his/her diabetes during school hours.

I acknowledge that it is my responsibility to ensure that the school is provided with the most up to date and complete information regarding my child' diabetes and treatment. Therefore, I consent to the release of information about my child's diabetes and treatment by my child's health care provider: _____, to representatives of Reed-Custer School District. I further authorize district representatives to communicate directly with the health care provide mentioned above.

I also understand that the information in the Diabetic Health Care Plan will be released to appropriate school employees and officials who have responsibility caring for my child and may need to know this information to maintain my child's health and safety.

Pursuant to Section 45 of the Care of Students with Diabetes Act, I acknowledge that the District and District employees are not liable for civil or other damages as a result of conduct, other than willful or wanton misconduct, related to the care of a student with diabetes.

Health Care Provider Signature: _____ DATE: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____