

HEALTH CARE PLAN FOR DIABETES MANAGEMENT

Student _____ Date of birth ___/___/___ School/Grade _____

◆ Mother/Guardian's Name _____ Employer _____
Home Address _____ City/Zip _____
Home Phone (____) _____ Pager (____) _____ Cell Phone (____) _____
Work Phone (____) _____ Work Hours _____

◆ Father/Guardian's Name _____ Employer _____
Home Address _____ City/Zip _____
Home Phone (____) _____ Pager (____) _____ Cell Phone (____) _____
Work Phone (____) _____ Work Hours _____

Physician for diabetic care _____ Phone (____) _____

Age when diagnosed _____ Date of last diabetic checkup _____

BLOOD SUGAR TESTING: (Check ALL that apply.)

- _____ Will not test at school.
- _____ Will be done by student everyday at _____
- _____ Will be done by student when symptoms are present.
- _____ Will need assistance from an adult. *Physician's Authorization must be signed.*
- _____ Will *not* need assistance from an adult.
- _____ Testing supplies will be kept at school in _____

Physician Authorization

I have reviewed and approved the Health Care Plan for Diabetes Management. I understand that specialized health care services will be performed by designated school personnel under the training and supervision provided by the School District Nurse. This consent shall remain in effect through the end of the current school year unless discontinued or changed in writing.

_____/_____/_____(____)_____
Physician's Signature Date Print physician's name Phone

INSULIN NEEDS: (Check ALL that apply.)

- _____ Will *not* need insulin at school.
- _____ Will need insulin at school. Complete "**Authorization to Administer Insulin.**"
- _____ Will be using an insulin pump and is self-sufficient in its use.

FOOD PLAN: (Check ALL that apply.)

- _____ Will bring daily morning snack of _____ carbohydrates to be eaten at _____ a.m.
- _____ Will bring daily afternoon snack of _____ carbohydrates to be eaten at _____ p.m.
- _____ Will eat _____ carbohydrate servings or _____ grams of carbohydrate at lunch.
- _____ on special occasions, student can eat same snack provided to classmates.
- _____ On special occasions, student will select alternate snack from supply provided by parent.

FIELD TRIPS: staff will inform parent of all field trips and will take the following:

- Cell phone
- Copy of Health Care Plan
- Glucose monitor
- Quick-acting sugar source

LOW BLOOD SUGAR SYMPTOMS/ PLAN OF ACTION: (*check ALL that apply.*)

_____ Blurred vision _____ Fatigue _____ Irritability _____ Trembling
_____ Dizziness _____ Headache _____ Personality change _____ Weakness
_____ Fast heartbeat _____ Hunger _____ Sweating _____ Other _____

TEACHERS: *Student with symptoms MUST be escorted to the Health Room*

- + If student is experiencing symptoms, **TEST BLOOD SUGAR.** If result is under _____, student will drink/eat the following: _____
_____ (Parent will provide appropriate drinks and/or food.)
- * Retest blood sugar in _____ minutes. If under _____, repeat above treatment. If student is feeling better, he/she can: _____
- * *IF STUDENT BECOMES UNCONSCIOUS due to a severe low blood sugar, call 911 & parent.*
- * *IF STUDENT WHO IS USING AN INSULIN PUMP BECOMES UNCONSCIOUS due to a severe low blood sugar, trained staff will disconnect tubing from insulin pump call 911 & parent.*

HIGH BLOOD SUGAR SYMPTOMS I PLAN OF ACTION: (*Check ALL that apply.*)

_____ Blurred vision _____ Frequent urination _____ Nausea/vomiting
_____ Drowsiness _____ Heavy, labored breathing _____ Stomachache
_____ Extreme thirst _____ Hunger _____ Other _____

- * Test blood sugar, if over _____ student should drink large amounts of water. Teachers: Allow use of a water bottle m. class and use of the restroom. as needed.
- * If student is using an insulin pump and blood sugar is over 240 for 2 readings in a row, call parent.

The above information will be shared with staff who have a need to know.

I understand that specialized health care services stated in the Health Care Plan for Diabetes Management will be performed by designated school personnel under the training and supervision provided by the School District Nurse. This consent shall remain in effect through the end of the current school year unless discontinued or changed in writing.

_____/_____
Student's Signature Date Parent/Guardian's Signature Date

Return form to:

Anna Hahn-Olig R.N.
PORT EDWARDS PUBLIC SCHOOLS
801 Second Street
Port Edwards, WI 54469