BEDFORD COUNTY PUBLIC SCHOOL
DIABETES HEALTH CARE PLAN & MEDICATION AUTHORIZATION

Name_____Age____Grade____Teacher_____

Parent/Guardian_____TP#_____

Other Emergency Contact_____TP#_____

Health Care Provider_____TP#_____

Type of Diabetes_____Date of Diagnosis_____

Blood Glucose Monitoring: Times to Check_____

This child ____Needs Supervision ____Needs Assistance____Is Independent with this task.

This child will need a snack around the following times_____.

Instructions for food during classroom parties_____.

Insulin: Type of delivery:☐ Insulin Pump☐ Insulin Pen☐ Syringe☐ No Insulin

Oral Hypoglycemic Medicine_____Dose_____Time_____

Type of Insulin and times to be given at school: _____

_____Units per _____grams carbohydrate or other base dose of insulin. _____

Insulin Correction Doses:

Give _____units if blood glucose is _____to_____mg/dl

Give _____units if blood glucose is _____to_____ mg/dl

Give _____units if blood glucose is _____to_____mg/dl

Give _____units if blood glucose is _____to_____mg/dl

Give _____units if blood glucose is _____to_____mg/dl

This Child ☐ Needs Supervision☐ Needs Assistance☐ Is Independent with this task.

Insulin pump use: Type_____Basal Rate_____

Type of Insulin in the pump_____

Type of Infusion set_____

Insulin/carbohydrate ratio_____Correction factor_____

This Child ☐ Needs Supervision☐ Needs Assistance☐ Is Independent with all pump care.

Hypoglycemia (Low Blood Sugar) This child's usual symptoms of hypoglycemia are:

_____

_____

_____

Treatment:_____

_____

Glucagon should be given if the student is unconscious, having a seizure or unable to swallow. If glucagon given 911 and parents should be called.

Hyperglycemia (High Blood Sugar): This child's usual symptoms of hyperglycemia are:

_____

_____

_____

Treatment:_____

_____

Check urine for ketones when blood glucose is above_____mg/dl.

Treatment for ketones_____.

Student should not exercise if blood glucose level is below_____mg/dl or above _____mg/dl or if moderate to large ketones are present.

Additional Information: _____

_____

This Diabetes Health Care Plan has been approved by:

_____ _____

Physician/Health Care Provider **Date**

I give permission for trained school personnel to follow this medical plan, administer insulin, glucagon and other emergency care for my child, and contact the physician if necessary. I assume full responsibility for providing the school with the medication and supplies needed, and providing medical updates as indicated. I also consent to the release of the information contained in this plan to any staff members that may need to know this information to maintain my child's health and safety. I understand that this care plan is valid for the current school year only. I give permission to fax this form to my child's medical office and school clinic.

_____ _____

Parent/Guardian Signature **Date**