

**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