

School: _____ This information expires on June 30, _____

SCHOOL-BASED CARE PLAN for the STUDENT with DIABETES

Name: _____ Birth Date: _____

Address: _____

Parents or Emergency Contact: _____ Home Phone: _____

Work Phone: _____ Pager/Cell: _____

SYMPTOMS SPECIFIC TO STUDENT

Low blood sugar

High blood sugar

- 1. _____
- 2. _____
- 3. _____

- 1. _____
- 2. _____
- 3. _____

TO BE COMPLETED BY PHYSICIAN

The following activities will require supervision and/or assistance for _____ during the school day.

Please check all that apply.

- May self test?
- Blood glucose testing Daily at _____
- Blood glucose testing as needed per symptoms
- Target glucose range _____
- Low blood sugar range _____
- Intervention _____
- High blood sugar range _____
- Intervention _____

- Ketone Checks If glucose levels over _____ mg/dl
- Administer Glucagon For following symptoms _____
- Insulin administration See attached schedule
- Snack Daily at _____
- Snack As needed

Training for the above procedures will be provided by: _____

Parent/Guardian Signature

Physician Signature

Address

Phone