Viroqua Area Schools
HEALTH SERVICES

100 Blackhawk Drive Viroqua, WI 54665 Phone: (608) 637-1509 MS/HS, (608) 637-1103 Elementary
Fax: (608) 637-8034 MS/HS or (608) 637-1211 Elementary

HEALTH CARE PLAN FOR DIABETES MANAGEMENT

Student: _____ Date of Birth: _____ Grade: _____

Parent/Guardian Contact #1: Name: _____ Phone: _____

Parent/Guardian Contact #2: Name: _____ Phone: _____

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.

_____ Will ***not*** need assistance from an adult

_____ Testing supplies will be kept at school in _____

INSULIN NEEDS: (*Check all that apply.*)

_____ Will NOT need insulin at school.

_____ Will need insulin at school via Insulin Pen. Is independent: _____ Needs assistance: _____

_____ Will need insulin at school via syringe/vial. Is independent: _____ Needs assistance: _____

_____ Will be using an insulin pump. Is independent: _____ Needs assistance: _____

Even if independent, still needs to check in with the Health Office to document reading.

FOOD PLAN: (Check all that apply.)

_____ Will eat breakfast at school, count carbs, and administer insulin.

_____ Will eat snack at school, count carbs, and administer insulin.

_____ Will eat lunch at school, count carbs, and administer insulin.

_____ Will bring own lunch to school, count carbs, and administer insulin.

_____ 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, Other (e.g. Glucagon if provided by parent). All staff in contact with diabetic students will be trained through the Wisconsin DPI and the health office on proper checking of blood sugars and proper use of insulin administration.

(Continued on next page…)

Hypoglycemia - LOW BLOOD SUGAR SYMPTOMS/ PLAN OF ACTION: (*Check all that apply to your child*)

_____ Blurred vision _____ Fatigue _____ Irritability _____ Trembling

_____ Dizziness _____ Headache _____ Personality change _____ Weakness

_____ Fast heartbeat _____ Hunger _____ Sweating _____ Other _____

TEACHERS: ***Student with symptoms MUST be escorted to the Nurse's Office.***

If student is experiencing symptoms, **TEST BLOOD SUGAR.**

If result is under _____, student will consume _____grams carbs.

If result is under _____, student will consume _____grams carbs.

Retest blood sugar in _____minutes. If under _____, repeat above treatment. If student is feeling better, he/she can: _____.

***** If student is not improving, notify parent / seek medical help *****

***** If student is unconscious or unable to consume carbs, administer _____ mg glucagon at _____ site.**

Hyperglycemia - HIGH BLOOD SUGAR SYMPTOMS/ PLAN OF ACTION: (*Check all that apply* to your child)

_____ 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 water bottle in class and use of restroom as needed.

If student is using an insulin pump and blood sugar is over _____ for _____ 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.

_____/ _____

Parent/Guardian's Signature Date

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