Kansas Diabetes Health Care Plan

Parent/Guardian/Student to Complete **Date of Plan:** _____

Student's Name: _____ Date of Birth: _____ Grade: _____

Physical Condition: • Diabetes Type 1 • Diabetes Type 2

Contact Information

Mother/Guardian: _____ Daytime phone: _____ Cell _____

Father/Guardian: _____ Daytime phone: _____ Cell _____

Other Emergency Contacts:

Name: _____ Relationship: _____

Daytime phone _____ Cell _____

STUDENT SELF-MANAGEMENT	YES	NO	NEEDS ASSISTANCE
Has student done his/her own blood glucose checks?			
Has student been giving own insulin? ☐sub-q injection ☐pump			
Able to perform blood glucose checks? Meter student uses:			
Able to calculate Carbohydrates (Carbs)?			
Prepare reservoir and tubing for pump?			
Troubleshoots alarms and pump problems?			

Carbs allowed: Breakfast _____ Mid-morning snack _____ Lunch _____ Mid-afternoon snack _____

Type of pump: _____ Type of Insulin in pump_____ Type of infusion set: _____

Algorithm available? ☐yes ☐no Insulin to carbohydrate ratio:_____ Sensitivity: _____

Bolus Range: _____ Basal rates: (____ ___ to ___) (____ ___ to ___) (____ ___ to ___) (____ ___ to ___)

Snack before exercise? ☐yes ☐no # of Carbs _____ Snack after exercise? ☐yes ☐no # of Carbs _____

Foods to avoid, if any: _____

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event):_____

_____

Exercise/Sports and Field Trips

When he/she participates, a fast-acting carbohydrate such as _____ should be immediately available.

Restrictions on activity

Student should not exercise if blood glucose level is below_____ mg/dl or above_____mg/dl .

If moderate to large urine ketones are present -- can student participate in exercise. ☐ yes ☐no

Notify parent if urine ketones are present. ☐yes ☐no

Parent/guardian will be notified if student refuses medication, appropriate testing and/or intervention for abnormal blood sugar.

Supplies to be Kept at School

- Insulin or oral medications
- Glucagon emergency kit
- Insulin pen, pen needles, insulin cartridges
- Other (list)
- Urine ketone strips
- Fast-acting source of glucose
- Carbohydrate containing snack
- Blood glucose meter and testing supplies
- Insulin pump and supplies
- Reservoir, infusion sets, etc.

TO BE COMPLETED BY THE PARENT/GUARDIAN: I give permission to the school nurse, trained diabetes personnel, and other designated staff members of _____ school to perform and carry out the diabetes care tasks as ordered by the physician. I also consent to the release of the information to staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I permit my child to manage his/her diabetic care and self-administer medication as approved by the school nurse and ordered by the physician.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

SELF MANAGEMENT CONSENTS:

TO BE COMPLETED BY SCHOOL NURSE

The student demonstrated appropriate use, knowledge and skills of testing tools, equipment and medications to manage his/her diabetic care as ordered by physician.

SCHOOL NURSE SIGNATURE _____

DATE: _____

TO BE COMPLETED BY STUDENT

I have been instructed in the proper use of monitoring tools, equipment and medication. I will manage my diabetes and administer medications as prescribed by my physician.

STUDENT SIGNATURE _____

DATE: _____