Genesee Intermediate School District

SCHOOL PLAN FOR A CHILD WITH DIABETES

To be completed by parents/health care team and reviewed with necessary school staff annually.
Copies should be kept in the student's classroom and school record.

COORDINATED SCHOOL HEALTH

Child's Picture

Student's Name _____

DOB _____

Grade _____ Teacher _____

Effective Dates _____

CONTACT INFORMATION

Parent/Guardian #1 Telephone: Home _____ Work _____ Cell _____
Parent/Guardian #2 Telephone: Home _____ Work _____ Cell _____
Student's Doctor/Health Care Provider _____ Phone _____
Other Emergency Contact _____ Phone _____
(Relationship to Student)
Notify Parent/Guardian in the following situations _____
_____
_____

LOCATION OF SUPPLIES

Monitoring equipment _____ Snack foods _____
Insulin supplies _____ Emergency box _____
Glucagon kit _____ Sharp disposal _____
Ketone testing supplies _____

BLOOD GLUCOSE TESTING

Target range for blood glucose _____ mg/dl to _____mg/dl
Type of blood glucose meter _____
Usual times to test blood glucose _____ A.M. _____ P.M.
_____ A.M. _____ P.M.
Times to do extra tests _____Before exercise _____ After exercise
_____ When student has symptoms of high blood sugar
_____ When student has symptoms of low blood sugar
Can student perform own blood glucose tests? _____ Yes _____ No*
Exceptions _____ Supervised? _____ Yes _____ No*
Where the student can perform blood glucose testing
_____ Classroom _____ School Office _____ Other

* *Contact office*

INSULIN

Insulin given during school *(see attached sliding scale)* Time _____ Type _____ Dosage _____
Can student give own injection? _____ Yes _____ No
Parent authorization to adjust insulin dose? _____ Yes _____ No

FOR STUDENTS WITH INSULIN PUMP

Type of pump: _____ Insulin/Carbohydrate ratio _____ Correction factor _____
Is student competent regarding pump? _____ Yes _____ No
Can student troubleshoot problems (pump malfunction) _____ Yes _____ No

MEALS AND SNACKS

	Time	Food/Amount
Breakfast	_____	_____
A.M./Snack	_____	_____
Lunch	_____	_____
P.M. Snack	_____	_____

Source of Glucose, such as _____ should be available at all times.
Preferred snack foods _____
Instructions for class functions (ex., class parties) _____

EXERCISE AND SPORTS

Does your student participate in sports or after-school activities? _____ Yes _____ No
A snack such as _____ should be readily available at the site of exercise and sports.
Restrictions on activity (if any) _____
Student should not exercise if blood glucose is below _____ mg/dl or above _____ mg/dl
Snack before exercise? _____ Yes _____ No After exercise? _____ Yes _____ No

HYPOGLYCEMIA (Low Blood Sugar)

Usual symptoms of hypoglycemia _____
_____
Treatment of hypoglycemia _____
_____

IMPORTANT:

1) DO NOT GIVE INSULIN!!!!!

2) DO NOT LEAVE STUDENT ALONE!!!!!!

Glucagon should be given if the student is unconscious, having a seizure, or unable to swallow. The student should be placed on his/her side in case of vomiting. Emergency assistance should be called and parents notified.

HYPERGLYCEMIA (High Blood Sugar)

Usual symptoms of hyperglycemia _____
_____
Treatment of hyperglycemia _____
_____
When to check for urine ketones _____
_____
Treatment for ketones _____
_____

Adapted from the Position Statement of the American Diabetes Association 2001 Guidelines

Trained school personnel _____ Dates of Training _____
Trained school personnel _____ Dates of Training _____
Trained school personnel _____ Dates of Training _____

Emergency Plan completed? _____Yes _____ No

Parental Checklist

It is the parent's responsibility to be sure students have all necessary supplies available. Students with diabetes must have the following items available at school:

_____ Authorization to Administer Medication(s) Form for Insulin and Glucagon (signed by the physician)
_____ A Diabetes Medical Management Plan (signed by the physician)
_____ Medication(s) ordered by their physician
_____ Blood glucose testing supplies (meter, test strips, and extra batteries for meter)
_____ Lancet device, lancets, gloves, alcohol swabs
_____ Urine ketone strips
_____ Insulin pump supplies
_____ Insulin pen, pen needles, insulin cartridges
_____ Fast-acting source of glucose
_____ Carbohydrate/protein containing snack
_____ Glucagon emergency kit
_____ Water bottles

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I give my permission to the school nurse, trained diabetes personnel and other designated staff members of _____ to perform and carry out the diabetes care tasks as outlined by _____'s Diabetes Medical Management Plan.
I also consent to the release of information contained in the Diabetes Medical Management Plan to all 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.

Any change in this document must be approved and signed by the physician.

Acknowledged and received by:

_____ _____
Student's Parent/Guardian *Date*

_____ _____
Physician *Date*

_____ _____
School Representative *Date*