**BLOOD GLUCOSE MONITORING**

- Target range: __________ mg/dl to __________ mg/dl
- Usual times to test blood sugar: __________________________________________________________________________
- **Contact parent if blood sugar is below __________ mg/dl or above __________ mg/dl**
- How will the parent be notified of daily blood sugar levels?
- Time: __________
- My child’s insulin is administered via: □ Needle/Syringe □ Insulin pen □ Insulin pump □ Oral medication
- Current level of student’s ability to administer insulin and count carbohydrates:
  - □ Independent □ Staff to perform until student is independent and then supervise □ Staff to supervise student

**INSULIN ADMINISTRATION**

- Carb: Insulin Ratio: __________ : __________
- Type of pump: __________
- Users manual from the pump company will be provided to the School Nurse: □ NO □ YES
- Trouble shooting the pump alarms and codes: □ Student is independent □ Student requires assistance
- Insulin administered by: □ Bolus □ Dual wave
- Student’s ability to administer bolus: □ Student is independent □ Student requires assistance

**LUNCH**

- Lunch Time: __________
- Will student be eating a school lunch? □ NO □ YES
- Child’s ability to count carbohydrates: □ Independent □ Needs assistance
- If the student requires assistance counting carbs, when he/she brings a bag lunch from home, the parent is responsible for writing down the # of carbohydrates that they packed and for sending a note in the student’s lunch.

**SNACKS**

- Student will carry a snack in his/her backpack and be permitted to eat a snack in the classroom and/or on the bus as needed.
- Extra snacks will be stored: □ In the School Nurse’s office □ In the classroom □ Other (explain) __________
- Scheduled snacks should be eaten at what times? __________________________________________________________________________

**PHYSICAL EDUCATION/SPORTS**

- P.E Time and Days: __________________________________________________________________________
- Participates on the following sports team and has practices when? : __________________________________________________________________________
- Times to do extra blood sugar checks (check all that apply) □ Before exercise □ After exercise □ other (explain)
- □ Yes, explain: __________________________________________________________________________
- □ NO □ YES, explain: ____________________________________________________________________
- Student may carry a parent provided snack.
- **Student should not exercise if blood sugar is below __________ mg/dl or above __________ mg/dl.**

**BATHROOM**

- Allow bathroom privileges without restriction
PARTIES

- The child with diabetes can participate in parties just like all the other children. The teacher will notify the parent/guardian when a party will take place and include information about what food will be served so that they can decide with the child what he/she may have to eat.
- The parent will provide a “party box” of substitute snacks to be stored in the classroom: ☐ NO  ☐ YES

FIELD TRIPS

- The child’s meter, insulin and a sugar source should always accompany the child with diabetes on any field trip.
- A Trained Diabetic Care Personnel will be accompanying the student on field trips.
- Other necessary field trip accommodations:

HPYPOGLYCEMIA (low blood sugar)

- My child’s usual symptoms of low blood sugar: ____________________________________________________.
- If the student exhibits the above signs/symptoms he/she should check blood sugar and/or be accompanied to the school nurse for monitoring.
- Notify parent/guardian if blood sugar is < __________ mg/dl
- Treatment for low blood sugar: ____________________________________________________ and recheck in 15 minutes.
- If student is conscious, but unable to swallow, cake icing or instant glucose gel will be placed inside the cheek.
- Will Glucagon be kept at school?: ☐ NO  ☐ YES  If yes, Glucagon will be administered per the physician’s order if the student becomes unconscious and/or is seizing, 911 will be called, and the parent will be notified.

HYPERGELYCEMIA (high blood sugar)

- My child’s usual symptoms of high blood sugar: ____________________________________________________
- Check ketones if blood sugar >: __________ mg/dl. Notify parent if (+) ketones.
- Notify parent/guardian if blood sugar is > __________ mg/dl
- Student needs to drink water and should be allowed to have water bottle in classroom.

CONTACT INFORMATION

Parent/Guardian: ____________________________________________ ☐ Mother ☐ Father ☐ Step-mother ☐ Step-father ☐ Guardian
Telephone #: (home) ___________________________    (work) ___________________________    (cell) ___________________________

Parent/Guardian: ____________________________________________ ☐ Mother ☐ Father ☐ Step-mother ☐ Step-father ☐ Guardian
Telephone #: (home) ___________________________    (work) ___________________________    (cell) ___________________________

Emergency Contact: __________________________________________
Telephone #: (home) ___________________________    (work) ___________________________    (cell) ___________________________

Name of Physician/Clinic treating student for diabetes: ______________________________________________________
Telephone #: __________________________________ Fax #: _________________________________________________

I understand that two or more Diabetic Care Personnel will be identified and trained by the school nurse. I agree that the parent is responsible for providing the school with their child’s Treatment Plan and Management Plan completed by the Health Care Provider, phone numbers for the parent/guardian, emergency contacts and physician, blood sugar testing supplies, insulin administration supplies, back-up supplies for insulin pump users, ketone testing supplies, if necessary and supplies and instructions for treating low and high blood sugar including snacks, juice and a water bottle. I further understand that all insulin vials &/or insulin pen refills must be replaced every 30 day once opened.

Parent/guardian Signature: __________________________________ Date: ___________________________

School Nurse Signature: __________________________________ Date reviewed: ___________________________

TRAINED DIABETIC CARE PERSONNEL (identified and trained by the School Nurse)

1.) ____________________________________________  2.) ____________________________________________