WARRIOR RUN SCHOOL DISTRICT

4800 Susquehanna Trail, Turbotville, PA 17772 · 570-649-5138 · Website: www.wrsd.org

Dear Parent(s)/Guardian(s),

Enclosed is a School Diabetic Management Plan. Please take a few minutes to complete this important form. Although diabetes is controllable, it can be very serious. This plan is to ensure your child receives the best care possible while he/she is in school.

A parent's input on their child's health is important. With your cooperation, we can work together in controlling your child's asthma. Thank you for your time and assistance.

Sincerely,

Health Room Nurses

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School Management Diabetic Care Plan

Date: _____

Student name:_____
Grade:_____
Home address:_____
Parent contact:_____Phone:_____
Parent/emergency contact:_____Phone:_____
Physician contact:_____Phone:_____

1. CURRENT INSULIN REGIMEN:

1. Student can give his/her own insulin: _____ Yes _____ No
2. Student will need supervision in giving own insulin: _____Yes_____No
3. Type (s) of insulin used:_____
4. Dose taken: Pre-breakfast:_____ Noon: _____ Pre-dinner:_____ Pre-bed:_____
   Dose time: _____ _____ _____ _____
5. **Does current regimen require possible administration of insulin during the school day or activities?**

   _____ Yes _____ No (if yes, see section 5)

Please Note:

1. Student's insulin and glucose tester should be kept in the Health Office (may take on class trips)
2. We need a written physician's order for insulin administration (when and how much)
3. Student is expected to report to Health Office if insulin is required

2. ACTIVITY AND EXERCISE

1. **Exercise should be delayed or avoided if the blood glucose is higher than _____ mg/dl (or) lower than _____ mg/dl.**
2. Please specify any conditions under which your student SHOULD NOT exercise or participate in sports: _____

3. MEALS & SNACKS

1. **Routine meal and snack times:**

Breakfast: _____ AM Snack: _____ Lunch: ____ PM Snack:_____ Dinner:____ Bed:_____

Please Note:

1.Classroom teachers will be advised to allow your student to eat a snack in classroom if needed
2. Student's family is expected to supply student with daily snacks, juice and supply extra snacks and juice to be stored in Health Office (with student's name)
3. Student is responsible for CARRYING A SNACK, juice or glucose tablets with him/her AT ALL TIMES.

4. BLOOD GLUCOSE TESTING:

1. Routine testing times: AM:_____ Noon: _____ PM: _____ Bedtime:_____
2. Supplemental testing times:
   _____Before exercise _____Before snacks_____ AM _____PM
   _____After exercise _____ Symptoms feeling high or low glucose

   _____ When ill _____ Other:_____

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Please note:

Teachers will be advised that he/she should be allowed to test ANY TIME.

5. HIGH BLOOD GLUCOSE

1. Please note your student's symptoms: _____Thirst ____Nausea ____Stomach ache _____Headache ____ Tired ____ Other (specify)_____
2. If blood glucose is greater than ____ mg/dl, check the urine for ketones using_____ _____
3. Notify the parents ( ) or physician ( ) if ketones are positive, or when:_____ _____
4. Please specify what follow up is to be done:_____ Insulin administration ____ Drink Water _____ Rest in health office ____ No phys. Ed _____ Other (specify)_____

_____

Please note:

1. Student is to report to the Health Office if they test high and symptoms interfere with classroom activity or concentration.
2. Student is to report school time high and low readings on their chart in Health Office.
3. Student is to have ketone/glucose testing supplies available at school.

6. LOW BLOOD GLUCOSE

1. Please specify your student's symptoms: ___ Headache ___ Shaky ___ Weakness ___ Irritable ___ Sleepy ___ Dizzy ___ Pale ___ Sweaty ___ Other (specify) _____
2. If blood glucose is less than ____ mg/dl, student should drink &/or eat IMMEDIATELY, as follows: _____

   * After the administration of drink/food above, the student's symptoms should improve within 15 minutes. If not, student to repeat drink &/or food above, and report to the Health Office with an escort.
3. If student is unable to safely drink or eat anything, please do the following:
   _____ Administer glucagon injection (written MD order needed with labeled glucagon medication).
   _____ Other (specify):_____
4. If student begins to lose consciousness or having a seizure, IMMEDIATELY call:
   ____ Paramedics ____ parents ___ physician
5. Please add any other information necessary:_____

Please Note:

1. If student is "low", he/she is to drink/eat IMMEDIATELY in classroom.
2. If student's symptoms persist 15 minutes <u>after</u> eating/drinking, student should report to Health Office <u>with an escort.</u>

*This form is accurate and complete to best of my knowledge.

* This information may be shared with the school staff and bus driver(s).

Parent Signature: _____ Date:_____