

DIABETES HEALTH CARE PLAN (UPDATE ANNUALLY)

Child's Name: _____ Date of Birth: _____ Diabetes Type 1; Type 2 Date of Diagnosis: _____
 Child Care Program: _____ Classroom _____ Plan Effective Date(s) _____

CONTACT INFORMATION

Parent/Guardian #1: _____ Phone #'s: Home _____ Work _____ Cell _____
 Parent/Guardian #2: _____ Phone #'s: Home _____ Work _____ Cell _____
 Diabetes Health Care Provider _____ Phone Number: _____
 Other Emergency Contact _____ Relationship: _____ Phone # _____ or _____

EMERGENCY NOTIFICATION: Notify parents of the following conditions (If unable to reach parents, call Diabetes Healthcare Provider listed above)

- a. Loss of consciousness or seizure (convulsion) immediately after Glucagon given and 911 called.
- b. Blood sugars in excess of _____ mg/dl
- c. Positive urine ketones.
- d. Abdominal pain, nausea/vomiting, diarrhea, fever, altered breathing, or altered level of consciousness.

MEALS/SNACKS: Child can: Determine correct portions and number of carbohydrate serving Calculate carbohydrate grams accurately

Time/Location	Food Content and Amount	Time/Location	Food Content and Amount
<input type="checkbox"/> Breakfast _____	_____	<input type="checkbox"/> Mid-Afternoon _____	_____
<input type="checkbox"/> Midmorning _____	_____	<input type="checkbox"/> Before Activity _____	_____
<input type="checkbox"/> Lunch _____	_____	<input type="checkbox"/> After Activity _____	_____

If outside food for party or food sampling provided to class: _____

BLOOD GLUCOSE MONITORING AT CHILD CARE Yes No Type of Meter: _____

If yes, can child ordinarily perform own blood glucose checks? Yes No; Interpret results Yes No; Needs supervision? Yes No
 Time to be performed: Before Breakfast Before Activity
 Midmorning: before snack After Activity
 Before lunch Mid-afternoon
 Dismissal As needed for sign/symptoms of low/high blood glucose

Place to be performed: _____

OPTIONAL: Target Range for Blood glucose: _____ mg/dl to _____ mg/dl (completed by Diabetes Healthcare Provider).

INSULIN INJECTIONS DURING CHILD CARE HOURS: Yes No Parent/Guardian elects to give insulin needed at child care.

If yes, can child: Determine correct dose? Yes No
 Give own injections? Yes No
Insulin Delivery: Syringe/Vial Pen Pump

Standard daily insulin at child care: Yes No

Type: _____ Dose: _____ Time to be given: _____

Calculate insulin dose for carbohydrate intake: Yes No

If yes, use: Regular Humalog Novolog
 _____ # unit(s) per _____ grams Carbohydrate
 Add carbohydrate dose to correction dose

Draw up correct dose? Yes No
 Needs supervision? Yes No

Correction Dose of Insulin for High Blood Glucose: Yes No

If yes: Regular Humalog Novolog Time to be given: _____

Determine dose per sliding scale below (in units):

Blood sugar: _____ Insulin Dose: _____
 Blood Sugar: _____ Insulin Dose: _____

Use formula:
 (Blood glucose - _____) + _____ = _____
 units of insulin

OTHER ROUTINE DIABETES MEDICATIONS AT CHILD CARE Yes No

Name of Medication	Dose	Time	Route	Possible Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

EXERCISE, SPORTS, AND FIELD TRIPS

Blood glucose monitoring and snacks as above. Quick access to sugar-free liquids, fast-acting carbohydrates, snacks, and monitoring equipment. A fast-acting carbohydrate such as _____ should be available at the site. Child should not exercise if blood glucose level is below _____ mg/dl OR if _____

SUPPLIES TO BE FURNISHED/RESTOCKED BY PARENT/GUARDIAN: (Agreed-upon locations noted on emergency care)

- Blood glucose meter/strips/lancets/lancing device
- Fast-acting carbohydrate _____
- Insulin vials/syringe
- Ketone testing strips
- Carbohydrate-containing snacks
- Insulin pen/pen needles/cartridges
- Sharps container for classroom
- Carbohydrate free beverage/snack
- Glucagon Emergency Kit

MANAGEMENT OF HIGH BLOOD GLUCOSE (over _____ mg/dl)

✓Usual signs/symptoms for this child:

- Increased thirst, urination, appetite
- Tiredness/sleepiness
- Blurred vision
- Warm, dry, or flushed skin
- Other _____

Indicate treatment choices:

- Sugar-free fluids as tolerated
- Check urine ketones if blood glucose over _____ mg/dl
- Notify parent if urine ketones positive.
- May not need snack: call parent
- See "Insulin Injections: Correction Dose of Insulin for High Glucose"
- Other _____

MANAGEMENT OF VERY HIGH BLOOD GLUCOSE (over _____ mg/dl)

✓Usual signs/symptoms for this child

- Nausea/vomiting
- Abdominal pain
- Rapid, shallow breathing
- Extreme thirst
- Weakness/muscle aches
- Fruity breath odor
- Other _____

Indicate treatment choices:

- Carbohydrate-free fluids if tolerated
- Check urine for ketones
- Notify parents per "Emergency Notification" section
- If unable to reach parents, call Diabetes Health Care Provider
- Frequent bathroom privileges
- Stay with student and document changes in status
- Delay exercise
- Other _____

MANAGEMENT OF LOW BLOOD GLUCOSE (below _____ mg/dl)

✓Usual signs/symptoms for this child

- Hunger
- Change in personality/behavior
- Paleness
- Weakness/shakiness
- Tiredness/sleepiness
- Dizziness/staggering
- Headache
- Rapid heartbeat
- Nausea/loss of appetite
- Clamminess/sweating
- Blurred vision
- Inattention/confusion
- Slurred speech
- Loss of consciousness
- Seizure
- Other _____

Indicate treatment choices:

- If child is awake and able to swallow, give _____ grams fast-acting carbohydrate such as:
- 4oz. fruit juice or non-diet soda or
 - 3-4 glucose tablets or
 - Concentrated gel or tube frosting or
 - 8 oz. milk or
 - Other _____

Retest BG 10-15 minutes after treatment.
Repeat treatment until blood glucose over 80 mg/dl.
Follow treatment with snack of _____
if more than 1 hour till next meal/snack or if going to activity
 Other _____

IMPORTANT!!

If child is unconscious or having a seizure, presume the child is having low blood glucose and:

Call 911 immediately and notify parents.

- Glucagon ½ mg or 1 mg (circle desired dose) should be given by trained personnel.**
- Glucose gel 1 tube can be administered inside cheek and massaged from outside while waiting or during administration of Glucagon by staff member at scene.**
- Glucagon/Glucose gel could be used if child has documented low blood sugar and is vomiting or unable to swallow.**

Child should be turned on his/her side and maintained in this "recovery" position till fully awake.

SIGNATURES

I/we understand that all treatments and procedures may be performed by the child and/or trained staff within the child care or by EMS in the event of loss of consciousness or seizure. I also understand that the child care is not responsible for damage, loss of equipment, or expenses utilized in these treatments and procedures. I have reviewed this information sheet and agree with the indicated instructions. This form provides written instruction to be followed by child care personnel/staff.

Parent's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Child Care Staff Signature: _____ Date: _____

This document follows the guiding principles outlined by the American Diabetes Association