School-Based Care Plan for the Student with Diabetes

This information expires on June 30, 20____

Name:_____ Birth Date:_____ Address:_____

Parents or Emergency Contact:_____

Home Phone:_____Cell:_____ Work:_____

Symptoms Specific to Student

Low blood sugar	High blood sugar
1._____	l._____
2._____	2._____
3._____	3._____

To Be Completed by Physician

The following will require supervision and/or assistance for this student during the school day:

Please check all that apply

☐May self test

☐Blood glucose testing daily at_____

☐Blood glucose testing as needed per symptoms

☐ Target glucose range _____

☐Low blood sugar range_____

☐Intervention_____

☐Low blood sugar range_____

☐Intervention_____

☐High blood sugar range_____

☐Intervention_____

☐Ketone checks if glucose level over_____mg/dl

☐Insulin administration see attached schedule

☐Administer Glucagon for following symptoms_____

☐Snack daily at_____

☐Snack as needed_____

Training for the above procedures will be provided by:_____

_____
Parent/Guardian Signature

_____
Physician Signature

_____
Physician address/phone