MUNDELEIN HIGH SCHOOL

DIABETES: ASSESSMENT AND CARE PLAN

School Year:______/______

STUDENT:________________________________ **Birthdate:**______________ **ID:**_____________

PARENT/GUARDIAN NAME:____

HOME PHONE:______________________________**CELL PHONE:**_______________________________

PARENT/GUARDIAN NAME:____

HOME PHONE:______________________________**CELL PHONE:**_______________________________

In the event we are unable to reach you:

EMERGENCY PHONE CONTACT:

____

Name (other than parent) Relationship Home Phone Cell Phone

DIABETIC MANAGEMENT(to be completed by parent with physician's assistance):

Condition: Diabetes type I________ Diabetes type II________ Child's age when diagnosed__________

Usual blood glucose testing times (at home):____

Target blood glucose range:____

Insulin type and dosage:____

Administration times:____

Current medications (other than insulin):____

Time(s) of daily blood glucose testing (at school):____

Satisfactory blood glucose range where no action is needed:____

For Hypoglycemia:

If blood glucose is *LESS THAN or EQUAL TO:*____
Usual symptoms of hypoglycemia____
Intervention:____
____
____

For Hyperglycemia:

If blood glucose is *GREATER THAN or EQUAL TO:*____
Usual symptoms of hyper glycemia:____
Intervention:____
____
Should student test for ketones in urine?____
Action if ketones are present:____

Other health concerns, if any:____

Has student received diabetic education?____

From whom?____

Is student able to check blood glucose levels? ______________________ Administer insulin? _________________________

Does student have an insulin pump? ____

Does student have a continuous glucose monitor? ____

Name of physician treating your child's diabetes:____

____
Physician's address city phone fax

Physician's signature:____**Date:**_________________________

Additional comments:____
____
____
____
____

May the school nurse contact physician in case there are any questions or concerns in making an emergency plan for your child? Yes________ No________

Parent/Guardian signature:____**Date:**_________________________

Received/Reviewed by:____**Date:**_________________________
School nurse

1/2018