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

11/1/21