

**CLEVELAND CITY SCHOOLS  
DIABETIC HEALTH CARE PLAN**

<b>Name:</b>		<b>Grade:</b>
<b>Age:</b>	<b>School:</b>	
<b>Diagnosis:</b>		
<b>Target Glucose Range:</b>		
<b>Medications:</b>		<b>Dose/Time:</b>
<b>Type of insulin:</b>		
<b>Sliding scale: yes no (List below, if yes)</b>		
<b>Sliding scale regimen:</b>		
<b>Health Care Plan:</b>		
<b>1. Blood Glucose Monitoring:</b>		
<b>Type of Meter:</b>		<b>Time(s) of day to test:</b>
<b>Location of Meter:</b>		<b>Location of where to test:</b>
<b>Does student need assistance with blood glucose monitoring? yes no</b>		
<b>2. Recognition of Hypoglycemia (low blood sugar)</b>		
<b>Symptoms typically seen:</b>		
<b>Treatment of choice, provided by family:</b>		
<b>At what blood glucose level should treatment be given?</b>		
<b>Time of day most likely to occur:</b>		
<b>3. Recognition of Hyperglycemia (high blood sugar)</b>		
<b>Symptoms typically seen:</b>		
<b>Treatment: Liberal bathroom privileges and increase non-caloric fluid intake.</b>		
<b>Additional instructions for treatment:</b>		
<b>At what blood glucose level should parents be called?</b>		
<b>With persistent vomiting, call parents immediately.</b>		
<b>If blood sugar is greater than 300, check urine for ketones. If ketones are positive, then parent should be contacted and child should go home.</b>		
<b><u>KETONE STRIPS MUST BE PROVIDED BY PARENTS.</u></b>		
<b>If blood sugar is greater than 300 and ketones are negative, student may take insulin per physician's orders.</b>		
<b>If blood sugar is greater than 300 for more than 2 hours after administering insulin, then student should go home.</b>		
<b>4. Snacks</b>		
<b>Does student require snacks during school hours? Yes No</b>		
<b>If yes, at what times are snacks needed?</b>		

<b>List food items to be provided by family for snacks.</b>	
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<b><u>NOTE: STUDENT IS RESPONSIBLE FOR ALL MEAL PLANNING.</u></b>	
<b><u>Parent agrees to contact school nurse with any changes regarding treatment plan.</u></b>	
<b><u>Contact Information:</u></b>	
<b><u>Address:</u></b>	
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<b><u>Parent/Guardian:</u></b>	<b><u>Home phone:</u></b>
1. _____	<b><u>Work:</u></b> _____ <b><u>Cell:</u></b> _____
2. _____	<b><u>Work:</u></b> _____ <b><u>Cell:</u></b> _____
<b><u>Emergency contact:</u></b>	<b><u>Phone:</u></b>
<b><u>Primary Care Physician:</u></b>	<b><u>Phone:</u></b>
<b><u>Speciality MD:</u></b>	<b><u>Phone:</u></b>
<b><u>School Nurse:</u></b>	<b><u>Phone:</u></b>
<b><u>Parent Signature</u></b>	<b><u>Date:</u></b>
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