

# Diabetes Care Plan

Childs Name: \_\_\_\_\_

Grade: \_\_\_\_\_ Div: \_\_\_\_\_

Facility Name: \_\_\_\_\_ Facility Address: \_\_\_\_\_

Child's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

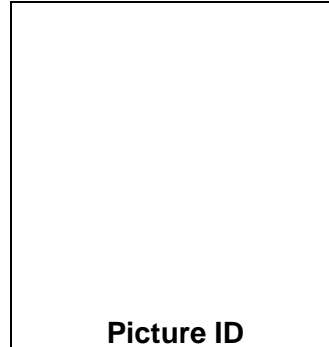
Parent/Guardian: \_\_\_\_\_

Phone (home/cell): \_\_\_\_\_ Phone (work): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Phone (home): \_\_\_\_\_ Phone (work): \_\_\_\_\_

Health Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_



Picture ID

## HISTORY:

Date of Diagnosis: \_\_\_\_\_

Student wears a Medic-Alert

Time of day when low blood sugar is likely to occur: \_\_\_\_\_

Morning Snack Time: \_\_\_\_\_ Type of Snack: \_\_\_\_\_

Afternoon Snack Time: \_\_\_\_\_ Type of Snack: \_\_\_\_\_

## USUAL SYMPTOMS OF LOW BLOOD SUGAR:

- |   |   |
|---|---|
| <input type="checkbox"/> irritability, mood changes, crying | <input type="checkbox"/> sweating, cold, moist skin |
| <input type="checkbox"/> headache                           | <input type="checkbox"/> dizziness                  |
| <input type="checkbox"/> tremors, shaky body parts          | <input type="checkbox"/> tired and pale             |
| <input type="checkbox"/> hunger                             | <input type="checkbox"/> other (list below): _____  |
| <input type="checkbox"/> nausea                             |   |

## CARE PLAN INFORMATION:

Medications (list): \_\_\_\_\_ Medication expiry date: \_\_\_\_\_

Location of emergency kit: \_\_\_\_\_

Names of staff oriented to plan: \_\_\_\_\_

Emergency plan review date (to do yearly): \_\_\_\_\_

Field Trip Plans: \_\_\_\_\_

## TREATMENT OF LOW BLOOD SUGAR:

1. Recognize signs and symptoms of low blood sugar. If possible, have student test their blood sugar.
2. GIVE SUGAR
  - 175mL (3/4cup) of fruit juice/pop (not diet)
  - Or 3 tsp sugar or glucose gel
  - Or 4 glucose tablets (15g)
  - Or: \_\_\_\_\_
3. Wait 15 minutes. If there is no improvement, re-test blood sugar (if possible) and try step 2 again.

**If the student is unconscious or has a seizure activate the emergency plan**

## EMERGENCY PLAN:

- Call 911 (*state the student has diabetes*)
- Protect student from injury: Lower to the floor and turn student onto side; do not restrain movement; do not put anything into student's mouth.
- Contact parent/guardian

*It is the parent's responsibility to notify the facility of any change in the student's condition.*

Sign below if you agree with above information & plan:

\_\_\_\_\_  
Health Care Provider (ie. Dr/Specialist/NP)      Date

\_\_\_\_\_  
Parent/Guardian      Date

Diabetes Care Plan is provided as a resource from Vancouver Coastal April 2013

