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:

☐ irritability, mood changes, crying
☐ headache
☐ tremors, shaky body parts
☐ hunger
☐ nausea
☐ sweating, cold, moist skin
☐ dizziness
☐ tired and pale
☐ other (list below):

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

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

***Websites**: diabetes.ca/kidsinyourcare endodiab.bcchildrens.ca*