School:____This information expires on June 30, _______________

SCHOOL-BASED CARE PLAN for the STUDENT with DIABETES

Name:____Birth Date:_____________________

Address:____

Parents or Emergency Contact:______________________________________Home Phone:__________________

Work Phone:______________________________________Cell:____

SYMPTOMS SPECIFIC TO STUDENT

Low blood sugar	High blood sugar
1.____	1.____
2.____	2.____
3.____	3.____

The following activites will require supervision and/or assistance for _________________________during the school day. Please check all that apply.

☐	May self test?	Independently_______________ With supervision________________
☐	Blood glucose testing	Daily at ____
☐	Blood glucose testing	as needed for symptoms:___________________________________
☐	Target glucose range	____
☐	Low blood sugar range	____
☐	Intervention	____
☐	Ketone checks	If glucose levels over ___________________________________mg/dl
☐	Administer glucagons	For following symptoms:_____________________________________
☐	Insulin administration	See attached schedule &/or insultin algorithm.
☐	Scheduled snacks	____

____ **Parent/Guardian Signature** **Date**

____ **Physician Signature** **Date**

____ **Address**

____ **Phone Number**