DIABETIC CARE GUIDE

Student_____ **School** _____ **Grade**_____

Mother/Guardian_____ Home Phone_____ Work_____

Father/Guardian_____ Home Phone_____ Work_____

Other emergency contact_____ Phone_____

Doctor name_____ Phone_____

Target range for blood glucose:_____ Mg/dl TO_____ Mg/dl **NOTIFY PARENTS IN THE**

FOLLOWING SITUATIONS:_____

_____

MEALS AND SNACKS

Foods to avoid, if any:

Breakfast time_____ a.m. Midmorning snack?_____ a.m. Lunch time_____ a.m. /p.m.

Afternoon snack _____ p.m Dinner time_____ p.m. Bedtime snack_____ p.m.

Snack before exercise? **YES NO** Snack after exercise? **YES NO** Other time to give snacks_____

Preferred snack foods_____

EXERCISE AND SPORTS

Restrictions of activity, if any_____

Child should not exercise if blood glucose is below _____ mg/dl or above _____ mg/dl

HYPOGLYCEMIA

Usual symptoms when having an episode of hypoglycemia (low blood glucose)_____

_____

Preferred foods to treat hypoglycemia _____

IN THE SCHOOL

Where are diabetes care supplies kept?_____

Where are supplies of snack food kept?_____

BLOOD GLUCOSE TESTS

Usual times to test blood glucose:_____ _____ _____ _____

Times to do extra test: before exercise after exercise other _____

Can student do own blood glucose tests? **YES NO** Type of blood glucose meter_____

KETONE TESTING

Times/criteria:_____ Action to be taken:_____

Can student do own test? **YES NO**

INSULIN

Types of insulin taken:_____

Usual times of insulin injections :_____ _____ _____ _____ Can child give own injections? **YES NO**

(School personnel are not authorized to give insulin/glucogon injections.)

Parent/Guardian Signature_____ Date_____

Physician Signature_____ Date_____