HEAD START

Tri-County Community Council, Inc.
2499 Cypress St. Westville, Fl 32464
(850) 548-9900 FAX (850) 548-5644

DIABETIC HEALTH CARE PLAN

Child's Name:_____ D.O.B.:____/____/____

Parent/Guardian Name:_____ Phone:_____

Parent/Guardian Name:_____ Phone:_____

Emergency Contact:_____ Phone:_____

Allergies:_____

Insurance:_____

Health Care Provider:_____ Phone:_____

Teacher/Family Advocate:_____ Site:_____

Is Medication identification worn daily? ☐ Yes ☐ No

Blood Glucose Monitoring:

Target range for blood glucose is _____ to _____
Usual times to test glucose: 1)_____ 2)_____ 3)_____ 4)_____
Times to do extra blood glucose tests (check all that apply)

- ☐ Before exercise
- ☐ After exercise
- ☐ When child exhibits symptoms of hyperglycemia/hypoglycemia
- ☐ Other
  (explain):_____

Can student perform own blood glucose tests? ☐ Yes ☐ No

Insulin:

Will insulin be needed during program hours? ☐ Yes ☐ No
Types, times and dosages of insulin injections?

Time	Type(s)	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who will administer the injection?_____ Phone:_____

Meals and snacks eaten at school:

The carbohydrate content of food is important in maintaining a stable blood glucose level.

Meal/Snack	Time	Food Content/Amount
Breakfast	_____	
_____	Mid-morning snack	_____
_____		
Lunch	_____	
_____		
Mid-afternoon snack	☐ Yes ☐ No	
_____		
Snack before exercise	☐ Yes ☐ No	
_____		
Snack after exercise	_____	
_____		

Other times to give snacks (content/amount):_____

_____

_____

A source of glucose, such as _____, should be readily available at all times.

Preferred snack food:

_____

_____

_____

Foods to avoid:

_____

_____

_____

Instructions for when food is provided to the class as part of a party, celebration or holiday:

Restrictions on activity: ☐ Yes ☐ No (if yes, please list and

comment)_____

_____

_____

_____

Child should not exercise if his/her blood glucose level is below _____mg/dl or above _____mg/dl.

HYPOGLYCEMIA (Low blood sugar):

Usual symptoms of hypoglycemia for your

child:_____

_____

_____

_____

Treatment directives

forhypoglycemia:_____

_____

_____

_____

DIABETIC CARE PLAN continued

HYPERGLYCEMIA (High blood sugar):

Usual symptoms of hyperglycemia for your

child:_____

_____

_____

_____

Treatment directives for

hyperglycemia:_____

_____

_____

_____

Circumstances when urine ketones should

betested:_____

_____

Field Trips:

Special accommodations needed for field

trips:_____

_____

_____

_____

_____

_____

_____

_____

Designated classroom staff will monitor and assist child on the field trip and fill out appropriate forms per the Health Services Coordinator and parent/guardian.

Name:_____
Date:_____/_____/_____

Name:_____
Date:_____/_____/_____

Training Needs:

Specialized training for classroom staff is necessary to accommodate a child with diabetes. The parent/guardian will need to set up a time with the classroom staff, Family Advocate, and Health Services Coordinator. *See separate classroom Emergency Plan. Post in classroom with parent/guardian permission and signature.

Please make the child's Primary Care Provider aware that the child will be attending Head Start and bring any directives from the PCP, bring any pertinent medical documentation, and bring supplies being provided by the parent/guardian.

A comprehensive plan will be created and be subject to monitoring and changes as needed.

Classroom and family staff that have been trained in the symptoms and treatment of high and low blood sugar, the daily monitoring and meal plan, the emergency plan, and the disaster plan are:

Name:_____
Date:_____/_____/_____

Name:_____
Date:_____/_____/_____

Name:_____
Date:_____/_____/_____

Name:_____
Date:_____/_____/_____

DIABETIC CARE PLAN continued

Name:_____ Date:_____/_____/_____

Transportation:

Will Head Start be providing transportation to and from site? ☐ Yes ☐ No

If yes, parent will need to assist with the Transportation Emergency Plan and list of supplies required for emergency treatment while in transport. The bus monitor will be trained and the emergency plan will be kept in the route book. Supplies will be in a backpack that goes back and forth with the child on every bus ride. ***See separate Transportation Emergency Plan.**

Parent Directives:

Equipment and supplies provided by parent/guardian	o Glucometer o Blood Glucose Strips o Lancets o Ketone Strips o Sharps Container o Alcohol Wipes o Glucose Source o Extra Snacks o Medications	Disaster Supplies: o Medications for 3 days o Specific instructions for administering o Supplies for 3 days o Medical Contacts o Out-of-Town Contacts

Out-of-Town Contacts:

Name:_____ Date:_____/_____/_____

Name:_____ Date:_____/_____/_____

Supplies:

Where are supplies for testing blood glucose/ketones kept?_____

_____

Where are supplies for administering insulin kept?_____

_____

Where are supplies of snack foods kept?_____

_____

Physician Directives: (please attach any medical directives and/or documentation)

_____ _____

Parent/Guardian Signature Date Parent/Guardian Signature Date

_____ _____