



Plan of Care for **Diabetes** (©AYS, Inc.)

Child's Name: _____ **Date of Birth:** _____ **Age:** _____

AYS Program: _____

Physician child sees for Diabetes: _____

Name (please print) Phone Number

Allergies: List any allergies i.e. foods, medications, the environment, etc. _____

Current insulin treatment:

Breakfast type of insulin & dosage _____

Lunchtime type of insulin & dosage _____

Suppertime type of insulin & dosage _____

Bedtime type of insulin & dosage _____

Child will inject insulin at AYS: _____ YES _____ NO

Child will self-prepare & inject insulin at AYS: _____ YES _____ NO

Child needs assistance with injection of insulin at AYS: _____ YES _____ NO

Would medication(s) need to be given during normal program hours?YES/NO

Would medication(s) need to be given during non-school day programs?YES/NO

If **yes** to either question, an AYS permission slip, completed by your child's doctor is required. Have you returned this permission slip to the AYS program director? YES/NO

My child will use a glucometer at AYS ___YES ___NO

My child will need assistance using his/her glucometer ___YES ___NO

My child's target blood glucose range is:

_____ before breakfast	_____ before dinner
_____ before lunch	_____ before bedtime
_____ after school	

Meals/snacks schedule:

My child is to eat an after school snack _____ YES _____ NO

I will provide AYS with an afternoon snack for my child _____ YES _____ NO

I give my approval to have my child eat whatever AYS serves for the afternoon snack.
_____ YES _____ NO

Exercise/sport activity:

My child may participate in after school sports _____ YES _____ NO

Exercise should be delayed if blood sugar is lower than _____
OR higher than _____.

My child carries _____
for treatment of a low blood sugar. A snack of _____ should
be eaten if my child's blood sugar is lower than _____.

HIGH blood sugar (hyperglycemia)

How often does high hyperglycemia occur? _____

When is the usual time of day hyperglycemia reaction occurs? _____

Symptoms your child has experience with a **high blood sugar reaction**:

___ Increased thirst ___ Increased urination ___ Nausea & vomiting ___ Listlessness

___ Weakness ___ Sweet odor to breath ___ Slow deep noisy breathing ___ Delirium

___ Others _____

+++If my child's blood sugar is **above** _____, his/her treatment is:

The usual procedure at AYS for a child with diabetes and HIGH blood sugar:

1. Obtain glucometer reading & follow parental instructions for treatment.
2. If glucometer is not available, assess for when last insulin was taken, food intake, or illness.
3. If the child is unconscious, monitor ABC's & seek **Emergency Medical Services**.
4. Notify parent/guardian.

LOW blood sugar (hypoglycemia)

How often does a low blood sugar reaction occur? _____

When is the usual time of day a low blood sugar reaction occurs? _____

Symptoms your child has experienced when having a **low blood sugar reaction**:

___ Hunger ___ Headache ___ Jitteriness ___ Disorientation ___ Irritability

___ Inattention ___ Sweating ___ Anxiety ___ Rapid pulse ___ Drowsiness

___ Slurred speech ___ Seizure ___ Others _____

+++If my child's blood sugar is **below** _____, his/her treatment is :

The usual procedure at AYS for a child with diabetes and LOW blood sugar:

1. Obtain glucometer reading & follow parental instructions for treatment.
2. If glucometer is not available, treat as low blood sugar & give a sugar source ex. 4 oz of juice or pop, 6 lifesavers, 2-3 glucose tablets. If unconscious, do not give anything by mouth, but call for **Emergency Medical Services**.
3. Check for resolution of symptoms & increase in blood sugar.
4. If child is not improving, seek **Emergency Medical Services**.
5. Notify parent/guardian.

Review of above information & signatures for this school year in AYS:

Parent/Guardian Signature

AYS Program Director's Signature

Date

Date

Review of the above information & signatures for the next school year in AYS:

Parent/Guardian Signature

AYS Program Director's Signature

Date

Date