Kids Go Further
AYS
AT YOUR SCHOOL

Plan of Care for Diabetes

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

AYS Program: _____ **School Year:** _____

Physician child sees for Diabetes:

_____ _____

Name (please print) (Physician's Phone Number)

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

_____

Current Insulin Treatment:

Breakfast type of insulin and dosage _____

Lunchtime type of insulin and dosage _____

Suppertime type of insulin and dosage _____

Bedtime type of insulin and dosage _____

Child will inject insulin at AYS: ☐ YES ☐ NO

Child will self-prepare and 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 Medication Consent form, completed by your child's doctor is required.

Have you returned this form 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 lunch _____after school

_____before dinner _____before bedtime

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 <u>whatever</u> AYS serves for the afternoon snack. ☐ YES ☐ NO

Exercise/Sport Activity:

My child may participate in after-school sports ☐ YES ☐ NO

Exercise should <u>be delayed</u> if blood sugar is lower than _____

OR higher than _____.

4/02; rev. 6/02, rev. 4/03, rev. 7/31/09

Plan of Care for Diabetes

HIGH blood sugar (*hyper*glycemia)

How often does high blood sugar occur? _____

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

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

☐ Increased thirst ☐ Increased urination ☐ Nausea and 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 and follow parental instructions for treatment.
2. If glucometer is not available, assess for last insulin intake, food intake, or illness.
3. If the child is unconscious, monitor ABC's and seek **Emergency Medical Services**.
4. Notify parent/guardian.

LOW blood sugar (*hypo*glycemia)

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

Review of above information and signatures for the _____ school year in AYS *(1st year)*:

_____ _____
Parent/Guardian Signature AYS Program Director's Signature

_____ _____
Date Date

Review of above information and signatures for the _____ school year in AYS *(2nd year)*:

_____ _____
Parent/Guardian Signature AYS Program Director's Signature

_____ _____

_____