School Year

20___-20___

Jackson-Madison County School System
Diabetes

Child's Information: **School:** _____

Name of Child:_____ Date of Birth: _____

Grade/Child's Age:_____ Homeroom Teacher or Instructor: _____

Emergency Information:

Parent(s') or Guardian(s') Names: _____

Mother's or Guardian(s') Telephone (W): _____ Father's Telephone (W): _____

Mother's or Guardian(s') Cell/Pager: _____ Father's Cell/Pager: _____

Mother's or Guardian(s') Telephone (H):_____ Father's Telephone (H): _____

Child's Healthcare Provider: _____ Healthcare Provider Telephone: _____

Child's Specialist Provider: _____ Specialist's Telephone: _____

Please provide names and contact information in the event a parent/guardian cannot be reached:

1:_____ Relation:_____ Telephone: _____

2:_____ Relation:_____ Telephone: _____

Preferred Local Emergency Department: _____

Preferred Comprehensive Regional Pediatric Center:

[ ] Jackson-Madison Co. General Hospital [ ] Le Bonheur– Memphis [ ] Tennova– Regional [ ] Vanderbilt– Nashville

My child has the following other illnesses/disabilities:_____

_____

Allergies:_____

Child's Limitations or Special Considerations:_____

Dietary and activity/exercise routines and schedules are as important as medications in the management of blood sugar (BS) in children with diabetes.

	AM	Mid-morning	Lunch	Mid-afternoon	Home
Blood Glucose Measurement Schedule. Insulin injection (Time/Dosage/ Type)					

DAILY MANAGEMENT SCHEDULE	Day of Week	Time	Snack If Necessary	Other Instructions
Physical Education				
Recess				

ALL OTHER CURRENT MEDICATIONS

Name of Medication	Dosage and Strength	Purpose	Day Schedule	Time of Day

Diabetics can have extremes of high and low blood sugar. Please check the box of the symptoms that occur in your child.

Is your child able to recognize symptoms of high and low blood sugar? ☐ Yes ☐ No

Signs and symptoms of Low Blood Sugar:

[ ] Shakiness, nervousness [ ] Speech difficulty [ ] Headache [ ] Nausea [ ] Fatigue [ ] Blurred vision [ ] Dizziness

[ ] Mood changes: irritability, crying. [ ] unusual paleness: moist, clammy skin, cold sweat.

Other_____

Signs and symptoms of High Blood Sugar:

[ ] frequent thirst [ ] frequent urination [ ] Mood changes: irritability crying, confusion, inappropriate responses [ ] Nausea [ ] Fatigue

Other _____

I understand that it is my responsibility to keep this information current.

Please notify School Nurse and provide an updated/current form on at least an annual basis.

Parent/Guardian's Signature:_____ Date:_____

Child's Name _____

Jackson-Madison County School System
Diabetes

EMERGENCY PLAN– THE ONLY TRUE EMERGENCY IN A DIABETIC IS LOW BLOOD SUGAR. IF CHILD IS UNRESPONSIVE/HAS SEIZURES DO NOT PUT ANYTHING, FOOD, ETC. IN THE MOUTH.

1. For absence of breathing and pulse. Begin CPR.
2. Delegate calls to 9-1-1, parent and school health services.
3. For seizure: Protect child by moving items away that may cause injury– e.g. desk, chairs. Do not restrain child.
4. Check blood glucose level.
5. If blood sugar ≤ 70 and child is breathing, but unresponsive, 1mg of Glucagon IM should be administered by nurse/trained personnel.

Preferred Local Emergency Department _____

Preferred Comprehensive Regional Pediatric Center:

[ ] Jackson– Madison Co. General Hospital [ ] Le Bonheur– Memphis [ ] Tennova– Regional [ ] Vanderbilt– Nashville

IF CHILD IS RESPONSIVE, PLEASE ADMINISTER THE FOLLOWING: ENSURE SUPPLIES ARE AVAILABLE.

1. Check blood sugar if possible. (If unable to check blood glucose levels, administer sugar flowed by a long-acting carbohydrate—See steps 1A and 2A below)
   - A. If blood sugar ≥70mg, no treatment necessary at this time.
   - B. If blood sugar ≤70mg, administer **ONE** of the following:
     - *Glucose Tablets (15 grams of carbohydrates) **OR**
     - * Glucose Gel (15 grams) **OR**
     - *4 ounces or ___cup of fruit **OR**
     - *4 ounces or ___cup of regular soft drink that contains sugar(for example, Coke)
2. Wait 15 minutes and recheck blood sugar.
   - A. If >70mg, give Child **ONE** of the following:
     - *2-4 peanut butter/cheese crackers **OR**
     - * 3 graham crackers **OR**
     - * lunch/ snack (if within 30 minutes of scheduled time)
   - B. If <70mg, repeat step 1B and 2A above until blood glucose levels are >70mg
3. Notify parents and school health services of low blood sugar<_____or high blood sugar > _____.

IT IS THE PARENT'S RESPONSIBILITY TO DETERMINE FOLLOW-UP STEPS.

Individual considerations:

Dietary and activity/exercise routines and schedules are as important as medications in the management of blood sugar (BG) in children with diabetes.

Doses and sliding scale can be modified within ____ units by parents. [ ] Yes [ ] No

Insulin Plan (injection to be given):	[ ] Breakfast	[ ] Lunch	[ ] Other:_____
Long Acting Insulin: Type/ Units……	_____/_____	_____/_____	_____/_____
Short Acting Insulin: Type/Units……	_____/_____	_____/_____	_____/_____
Pump Units……..	_____	_____	_____
Sliding scale for High Blood Sugar……	_____unit of BG >____ **OR**	_____unit of BG >____ **OR**	_____unit of BG >____ **OR**
(short action):	_____unit of BG >____	_____unit of BG >____	_____unit of BG >____

Other Instructions:_____

[ ] Please mail monthly blood sugar levels and any medical concerns to:_____

Address _____

Name of Other Medications	Dosage Strength	How Often

This child also has the following chronic illnesses/disabilities: _____

Medical Provider's Name: _____ Phone number: _____

Medical Provider's Signature: _____ Date: _____

School Nurse: _____ Contact Number: _____