



Diabetes Health Care Plan

Healthcare Plan for: _____ Birth Date: _____

Childcare Name: _____ Date: _____

Quarterly Reviews: _____ / _____ / _____

Parent/Guardian #1

Parent/Guardian #2

Name	Name
Relationship	Relationship
Home Phone ()	Home Phone ()
Work Phone ()	Work Phone ()
Cell Phone ()	Cell Phone ()
Pager Number ()	Pager Number ()

Alternate Emergency Contact #1

Alternate Emergency Contact #2

Name	Name
Relationship	Relationship
Home Phone ()	Home Phone ()
Work Phone ()	Work Phone ()

Healthcare Provider

Diabetes Provider

Name	Name
Address	Address
Phone ()	Phone ()



Diabetes Health Care Plan

Child's Name: _____ Birth Date: _____

BLOOD GLUCOSE MONITORING

Target range for blood glucose is _____ mg/dl to _____ mg/dl

WHEN DOES YOUR CHILD REQUIRE BLOOD SUGAR TESTING?

- Before breakfast Time _____
- Mid-afternoon Time _____
- Mid-morning Time _____
- Before dinner Time _____
- Before lunch Time _____
- Other (I.e. before exercise/field trips/naps) _____

Does your child perform blood sugar testing without assistance? Yes No

If yes, when might additional help be necessary? _____

SYMPTOMS YOUR CHILD SHOWS BEFORE AN INSULIN REACTION (LOW BLOOD SUGAR)

- Shaky
- Anxious
- Blurry vision or other vision change
- Sweating, clammy skin
- Dizzy
- Hungry
- Weak, tired
- Headache
- "Spacing out", quiet
- Fussy, irritable, cranky
- "Heart beating fast"
- Other _____

When is this most likely to occur (e.g. Before lunch. After school)? _____

What is the best way of giving your child sugar? _____

What foods/juices does your child like best? _____

SYMPTOMS OF HIGH BLOOD SUGAR

The onset of symptoms is gradual--over days. Intervention in the child care setting is generally not required.

DIET:

My child's diet includes (Check one and refer to "My Meal Plan" on page five):

- Counting carbohydrates
- The Exchange diet

Foods family will supply _____



Diabetes Health Care Plan

Child's Name: _____ Birth Date: _____

Diabetes Blood Sugar Plan

What To Do Based on Blood Sugar Readings

If Blood Glucose Is:	Intervention (Food, Juice, Other)	Other Requirements:
Under 60		Call Parent/Guardian
61-80		Call Parent/Guardian
80-100		
101-125		
126-200		
201-240		Call Parent/Guardian
Over 240		Call Parent/Guardian

Signatures

This Health Plan has been reviewed and approved by:

Parent/Guardian _____ Date _____

Health Care Provider _____ Date _____

I agree to implement this health plan and to provide staff training necessary for implementation:

Child Care Provider's Signature _____

Date _____



Diabetes Health Care Plan

Child's Name: _____ Birth Date: _____

SPECIAL CONSIDERATIONS

EXERCISE AND SPORTS

A snack such as _____ should be available at the site of exercise or sports.

Restrictions on activity, if any _____

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

OTHER ISSUES

Does the child carry a sugar source with them? ____yes ____no

Does the child wear a Medic-Alert bracelet? ____yes ____no

Are their restrictions on party foods that the child can be offered? ____yes ____no

If yes, give examples of what the child can eat at a party: _____

Does child ride the bus to school? ____yes ____no

If yes, should any special supplies (such as food) be kept on the bus or does the child carry food with them? _____

FIELD TRIPS

The following supplies should accompany the child on a field trip: _____

Please share any other information we should know while your child is in our care: _____

EARTHQUAKE AND DISASTER INFORMATION

An emergency kit with all instructions, medications, supplies and food for 72 hours has been supplied by _____, and is kept (location) _____

_____. A current medication administration form is on file. The emergency kit and the medication administration form will be replenished/renewed every six months.

Date _____ Date _____ Date _____ Date _____

SUPPLIES AND PERSONNEL

Where are the supplies for testing blood glucose levels kept? _____

Where are supplies for administering insulin kept? _____

Where are supplies for testing ketones kept? _____

Where is glucagon kept? _____

Where are supplies of snack foods kept? _____

Staff trained in the symptoms and treatment of low and high blood sugar: _____

Staff trained to perform blood glucose testing, insulin administration, glucagon administration: _____

This Health Plan has been reviewed and approved by:

Parent/Guardian _____ Date _____ Health Care Provider _____ Date _____

I agree to implement this Health Plan and to provide staff training necessary for implementation:

Child Care Provider's Signature _____ Date _____

Adapted from Juvenile Diabetes Foundation



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MY MEAL PLAN

Breakfast	Examples
_____ Carbohydrate Choices:(__ grams)	
_____ Protein Choices	
_____ Fat Choices	
Snack	Examples
_____ Carbohydrate Choices:(__ grams)	
_____ Protein Choices	
_____ Fat Choices	
Lunch	Examples
_____ Carbohydrate Choices:(__ grams)	
_____ Protein Choices	
_____ Fat Choices	
Snack	Examples
_____ Carbohydrate Choices:(__ grams)	
_____ Protein Choices	
_____ Fat Choices	
Dinner	Examples
_____ Carbohydrate Choices:(__ grams)	
_____ Protein Choices	
_____ Fat Choices	
Snack	Examples
_____ Carbohydrate Choices:(__ grams)	
_____ Protein Choices	
_____ Fat Choices	



Diabetes Health Care Plan



Carbo Counting and Kids

MILK 15 Grams Carbo	<ul style="list-style-type: none"> * 1 Cup milk * 1 Cup sugar free yogurt 	FRUIT 15 Grams Carbo	<ul style="list-style-type: none"> * 1 Medium fruit * 1/2 Banana * 1 Cup melons or berries * 12 -15 Grapes or melon balls * 2 Tablespoons raisins * 1/2 Cup canned fruit * 1/2 Cup juice * 1/4 Cup dried fruit
STARCHES 15 Grams Carbo	<ul style="list-style-type: none"> * 1 Slice bread * 1/2 Bagel, English muffin, hamburger or hotdog bun * 1/2 Cup noodles * 1/3 Cup rice * 1/2 Cup hot cereal * 3/4 Cup cold cereal * 1/2 Cup mashed potatoes * 1 Small baked potato * 1/2 Cup corn or peas * 1 Cup winter squash * 1/3 Cup cooked beans or lentils * 4-6 Crackers * 3 Cups popped corn * 1 Muffin * 1 Cup soup 	VEGGIES 5 Grams Carbo	<ul style="list-style-type: none"> * 1 Cup raw * 1/2 Cup cooked Carrots Broccoli Tomatoes Cauliflower Beets
MEAT	<ul style="list-style-type: none"> * 1 Ounce beef, turkey, chicken, ham, pork, veal or fish * 1 Ounce cheese * 1/3 Cup cooked beans or lentils * 1/4 Cup cottage cheese * 1 Tablespoon peanut butter * 1 Egg * 1/2 Cup tuna or salmon 	CHO 15 Grams Carbo	<ul style="list-style-type: none"> * 1 Tablespoon sugar, honey or syrup * 2 Teaspoons jam or jelly * 1 Cookie * 1/2 Cup ice cream * 2" square cake * 1 Granola bar
FREEBIES	<ul style="list-style-type: none"> * Sugar-free soda pop * Sugar-free jello * Sugar-free popsicles * Broth * Other veggies not listed above * Mustard 	FATS	<ul style="list-style-type: none"> * 1 Teaspoon margarine or oil * 1 Ounce nuts * 1 Tbs. mayonnaise, salad dressing * 1/8 Avocado * 5 Olives * 1 Tablespoon cream cheese * 1 Slice bacon
		2 - 3 Servings per day	<ul style="list-style-type: none"> * Ketchup * Non-fat cream cheese * Salsa * Non-fat sour cream * Low-sugar jam or jelly * Whipped topping