Child Care Diabetes Care Plan

Public Health
Seattle & King County

This plan should be completed by the child's personal diabetes health care team, including the parents/guardians. It should be reviewed with relevant school staff and copies should be kept in a place that can be accessed easily by the trained diabetes personnel, and other authorized personnel.

Place Photo here

Additional Forms Must be Completed:

- *Medical Information & Treatment Authorization*
- *3-Day Medication Form*

Child's Name: _____ Date of Birth: _____

Diabetes Care Provider Contact Information:

Name:	
Address:	
Phone Number:	

Hospital preference (in case of emergency): _____

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:** Click or tap here to enter text.
☐ Mid- morning	**Time:** Click or tap here to enter text.
☐ Before lunch	**Time:** Click or tap here to enter text.
☐ Mid-afternoon	**Time:** Click or tap here to enter text.
☐ Before dinner	**Time:** Click or tap here to enter text.
☐ Other (i.e. before naps or field trips) _____	**Time:** Click or tap here to enter text.

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	☐ Blurry vision or other vision changes	☐ Headache
☐ Sweaty, clammy skin	☐ Anxious	☐ "Spacing out", quiet
☐ Fussy, irritable, cranky	☐ Hungry	☐ Weak, tired
☐ "Heart beating fast"	☐ Dizzy	☐ 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.

DIABETES BLOOD SUGAR PLAN

WHAT TO DO BASED ON BLOOD SUGAR READINGS

If Blood Glucose is:	Intervention (Food, Juice, Other)	Other Requirements:
Under 60		☐ Notify parent/guardian/ emergency contact
61-80		☐ Notify parent/guardian/ emergency contact
80-100		
101-125		
120-200		
201-240		☐ Notify parent/guardian/ emergency contact
Over 240		☐ Notify parent/guardian/ emergency contact

DIET

Please attach any relevant nutritional information for child while in care. This may include carb counting, meal-planning resources or other needs.

Foods family will supply (please list any special foods): _____

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 his/her blood glucose level is below _____mg/dl or above _____mg/dl

FIELD TRIPS

- The following supplies should accompany child on field trips: _____

  _____

OTHER CONSIDERATIONS

- Does the child carry a sugar source with them? ☐ **Yes** ☐ **No**
- Does the child wear a Medic-Alert bracelet? ☐ **Yes** ☐ **No**
- Are there restrictions of party/celebration foods the child can be offered? ☐ **Yes** ☐ **No**
  - **If yes**, please give examples of foods child can eat at a party/celebration: _____

    _____.
- Does the child ride the bus to school/care? ☐ **Yes** ☐ **No**
  - **If Yes,** should any special supplies (such as food) be kept on the bus or does the child carry food with them?_____

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

_____

_____

EARTHQUAKE and DISASTER INFORMATION

- Child needs to take daily medication for diabetes when at center/school:
  ☐ **Yes** (complete additional Medication Authorization Form) ☐ **No**
- Child has a 3-day emergency supply of diabetes medication at center/school:
  ☐ **Yes** (complete additional 3-Day Critical Medication Form) ☐ **N/A**
- 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 will be replenished/renewed every 6 months.

  Date _____ Date _____ Date _____ Date _____

Supplies

- The supplies for testing blood glucose levels are kept (location) _____
- The supplies for administering insulin are kept (location) _____
- The supplies for testing ketones are kept _____
- Glucagon is kept _____
- The supplies of snack foods are kept _____

Health Care Provider: My signature provides authorization for the above written orders (on Page 1-2 of Diabetes Care Plan Packet). I understand that all procedures will be implemented in accordance with state laws and regulations. (This authorization is active for a maximum of one year from health care provider's signature date.)

_____ _(____)_____
Health Care Provider Name (printed) **Phone Number**

_____ _____
Health Care Provider Signature (required) **Date**

Parent/Guardian: I agree with the above diabetes health care plan and emergency plan. I will provide staff training necessary for implementation and will inform the child care program if child's health status/medication changes.

_____ _(____)_____
Parent/Guardian Name (printed) **Phone Number**

_____ _____
Parent/Guardian Signature **Date**

Child Care Provider: I agree to implement the above diabetes health care plan and emergency plan.

_____ _(____)_____
Child Care Provider Name (printed) **Phone Number**

_____ _____
Child Care Provider Signature **Date**

Emergency Contact Information

Emergency Contact #1	Phone:
Name: _____ Relation: _____	(____)_____
Emergency Contact # 2	**Phone:**
Name: _____ Relation: _____	(____)_____
Emergency Contact # 3	**Phone:**
Name: _____ Relation: _____	(____)_____

For Staff Use Only

Staff Training Information

Staff trained in the symptoms of low and high blood sugar		
Staff Name	**Trainer (parent or guardian)**	**Date**
Staff trained to perform blood glucose testing, insulin administration, and glucagon administration		
Staff Name	**Trainer (parent or guardian)**	**Date**