LETTER TO PARENTS

DIABETES

TO: Parents

FROM: School Health Clinic

DATE: _______________

Subject: Diabetes

You have told us that your child has diabetes.

The American Diabetes Association recommends that all students with diabetes have a Diabetic Health Care Plan at school. This plan needs to be completed by your health care provider each school year. The Diabetic Health Care Plan must be signed by the health care provider and the student’s parent/guardian. Some health care providers may have their own forms. These are acceptable as long as the requested information is provided and it is signed by the health care provider and the parent/guardian.

In order to provide the best care, please update us with any changes in the management of your child’s diabetes. This plan will be shared with the appropriate school personnel such as the classroom teacher(s) and principal.

It is the responsibility of the parent/guardian to provide the school with all the information, materials and supplies necessary for school personnel to care for their student’s diabetes at school.

Please return the Diabetic Health Care Plan to your child’s school. Thank you.

...where the schools and the communities are one...
Please use the numbers below to fax forms to the appropriate school.

<table>
<thead>
<tr>
<th>SCHOOL BUILDING</th>
<th>GRADES</th>
<th>FAX NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Twinsburg High School</td>
<td>9-12</td>
<td>330-405-7406</td>
</tr>
<tr>
<td>R.B. Chamberlin Middle School</td>
<td>7-8</td>
<td>330-963-8313</td>
</tr>
<tr>
<td>George G. Dodge Intermediate School</td>
<td>4-6</td>
<td>330-963-8323</td>
</tr>
<tr>
<td>Samuel Bissell Intermediate School</td>
<td>2-3</td>
<td>330-963-8333</td>
</tr>
<tr>
<td>Wilcox Primary School</td>
<td>PreK, K-1</td>
<td>330-963-8332</td>
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</table>

"... where the schools and the communities are one. "
DIABETES HEALTH CARE PLAN

Student____________________________________
DOB____________________________________
Teacher/Grade__________________________________________
Transportation:  ☐ Bus  ☐ Car (Parent/Guardian)

EMERGENCY CONTACTS – Please complete the Emergency Contacts below:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Telephone Number</th>
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<tbody>
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Prescriber Name________________________________________________________ Phone __________________

Blood Glucose Monitoring: Location

Is student permitted to carry meter:  ☐ Yes      ☐ No
☐ before lunch   ☐ 1-2 hours after lunch  ☐ before snacks   ☐ before getting on the bus
☐ after snacks   ☐ before exercise   ☐ when he/she feels low or ill

Snack: Please allow a _______ gm snack at __________________ or ☐ before exercise.

Treatment for Low Blood Glucose (Hypoglycemia)

☐ Student may treat “low” with food according to schedule below. Retest blood glucose 15 minutes after treating “low”.
☐ If blood glucose is less than 70, give______________________________
☐ If blood glucose is less than 50, give__________________________________________

Call Parent when blood glucose is less than______________________________
☐ Notify parent and record blood glucose value and treatment.
☐ Snacks are provided by parent and located______________________________
Comments_____________________________________________________________
Will glucagon be provided?  ☐ Yes      ☐ No
If YES, describe the circumstances when it should be administered__________________________________________

Amount to be administered ________________________________ mg(s) IM and call 9-1-1

Treatment for High Blood Glucose (Hyperglycemia)

☐ Provide water and access to bathroom   ☐ See next page for insulin instructions (if applicable)
Comments_____________________________________________________________
☐ Always call parent for dosage
☐ Call parent and/or prescriber when blood glucose is greater than______________________________
My child’s insulin is administered via:  ☐ vial/syringe  ☐ insulin pen  ☐ insulin pump
Can student draw correct dose, determine correct amount, and give own injection?  ☐ Yes      ☐ No

CONTINUED ON NEXT PAGE
Insulin   □ student is taking insulin at school □ student is NOT taking insulin at school

Insulin is located__________________________________________________________________________________

Daily lunchtime dose_________________________________ Type of insulin__________________________
Correction/Adjustment Scale__________________________  Type of insulin___________________________

_______ units if blood glucose is __________to __________ mg/dl
_______ units if blood glucose is __________to __________ mg/dl
_______ units if blood glucose is __________to __________ mg/dl
_______ units if blood glucose is __________to __________ mg/dl

Parental authorization should be obtained before administering a correction dose for high blood glucose levels
(excluding lunchtime) □ Yes □ No

For students using Insulin Pumps:
Type of pump___________________________________ Type of insulin in pump_________________________
Insulin/carbohydrate ratio__________________________ Correction factor__________________________

□ Parents are authorized to adjust the insulin dosage under the following circumstances-

__________________________________________________________________________________________

The checklist below indicates the activities that are self-managed, those needing assistance from school personnel, and
those requiring parental involvement that must be performed during the school day in order for your child maintain
glucose control.

<table>
<thead>
<tr>
<th>ACTIVITY/ SKILL LEVEL</th>
<th>INDEPENDENT STUDENT</th>
<th>SCHOOL ASSISTANCE</th>
<th>PARENTAL INVOLVEMENT</th>
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</thead>
<tbody>
<tr>
<td>Blood glucose monitoring</td>
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<tr>
<td>Insulin dose calculation</td>
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<td>Carbohydrate counting</td>
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<tr>
<td>Insulin injection administration</td>
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<td>Treatment for mild hypoglycemia</td>
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<td>Selection of snacks and meals</td>
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<tr>
<td>Management of Insulin Pump</td>
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<tr>
<td>Testing of Urine Ketones</td>
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Authorization for the Release of Information:
I hereby give permission for ___________________________________________ (school) to exchange
specific, confidential medical information with ___________________________________________ (diabetes healthcare provider) for my child ___________________________________________ to develop more effective ways
to providing for the healthcare needs of my child at school.

Prescriber Signature__________________________ Date__________________________
Parent Signature____________________________ Date__________________________