School Year _____ □ Regular HCP □ IEP HCP

DIABETIC HEALTH CARE PLAN

Name: _____ Date: _____

School: _____ Grade: _____

Student number: _____ Birthdate: _____

Health Action Plan:

□ Daily snacks

Snack times: _____

Student carries with him/her □ yes □ no

Location of snacks at school _____

□ Blood sugar test

Time: _____ Location: _____

□ Insulin Injection

Insulin injections at school □ yes □ no Location: _____

Student carries supplies □ yes □ no

□ Other Plan Items: _____

_____

Daily Time Schedule:

□ Concurrent illness or disability: _____

□ Social/emotional factors: _____

□ Concurrent medications: _____

□ Allergies: _____

□ Dietary Concerns/Restrictions: _____

_____

Contact Information:

Parent/Guardian: _____ Home phone: _____

Address: _____ Cell phone: _____

_____ Work phone: _____

Parent/Guardian: _____ Home phone: _____

Address: _____ Cell phone: _____

_____ Work phone: _____

Emergency contact: _____ Phone: _____

Relationship to student: _____

Primary care physician: _____ Phone: _____

Specialty care physician: _____ Phone: _____

School Nurse: _____ Phone: _____

Contingency plan when unable to contact parent in emergency: (i.e. call numbers listed above)

_____

Disaster kit at school □ yes □ no Location: _____

_____ _____

(parent signature) (date)

_____ _____

(physician signature) (date)

Copies disseminated:

□ parent
□ PE
□ library
□ recess
□ Health Care Plan Book master
□ classroom teacher
□ music
□ computer
□ transportation
□ clinic