LEBANON
COMMUNITY SCHOOL CORPORATION

LCSC Diabetes Care Plan

Student's Name: _____Date:___/____/___ DOB: ___/____/___ Age: _____

Parent/Guardian:_____ Email:_____

Phone: _____ (W) _____ (H) _____ (C)

Emergency Contacts:

1._____Phone: _____

2._____Phone: _____

3._____Phone: _____

Family MD: _____Phone: _____

Diabetes Physician: Dr._____ Phone: _____

Significant Medical History or
Condition_____

Allergies_____ When was student diagnosed with diabetes_____

Is it Okay to Notify the Staff of Your Child's Condition? Yes_____ No_____

THIS WILL HELP DECREASE TIME WHEN THERE COULD BE A PROBLEM. WE WILL ONLY NOTIFY THAT THEY ARE DIABETIC AND TREATMENT COULD BE NEEDED AT ANY TIME.

Do We Have Permission to Call 911 if Needed? Yes ☐ No ☐

Current Medications and Insulin (Please list ALL medications the student is currently taking.)

Name	Dose	Time	Possible Side Effects

PLEASE PROVIDE DOCTOR ORDERS FOR THE FOLLOWING:

Current insulin treatment/current glucose range
Snacks
Treatment for hypoglycemia/hyperglycemia
To carry glucose tablets/have glucagon injection
Glucose monitoring
Exercise/sport activities

If the student needs to carry water, snacks and/or have increased bathroom privileges, a note from the physician is required.

PLEASE CALL ASAP IF THERE ARE ANY CHANGES IN THE PHONE NUMBERS OR CONTACTS. ALSO, CALL IF THERE ARE ANY CONCERNS OR CHANGES IN CARE. WE WILL NEED UPDATES ORDERS FROM THE DOCTOR IF ANY THING CHANGES.

Parent Consent: _____ DATE_____

Health Services Reviewed: _____DATE_____
(SIGNATURE OF CLINIC STAFF)

Revised 8/21/2017