Return completed form to:
Jefferson County Public Schools,
Health Services Department, LAM Building
4309 Bishop Lane, Louisville, KY 40218
Telephone # (502) 485-3387
Fax # (502) 485-3670

JEFFERSON COUNTY PUBLIC SCHOOL
SCHOOL HEALTH PLAN
DIABETES

School Year:

DO NOT WRITE IN THIS AREA
1719111214

Please print neatly. Por favor, escriba legible

PART A Parent / Guardian: Complete Items 1 - 11 *(Padre/madre/tutor: complete la información en los espacios 1 al 11)*

1) Student ID# *(Numero de estudiante)* | **2) Student's Last Name** *(Apellido)* | **3) Student's First Name** *(Nombre del estudiante)* | **4) Date of Birth** *(Fecha de nacimiento)*

5) School *(Escuela)* | **6) Grade** *(Grado)*

Parent/Guardian Name & Contact Information ***(Nombre & Información del contacto)***

7) Name *(Nombre)* | **8)** Phone Number *(Teléfono)* ( ) - | **9)** Mailing Address, City, State, Zip *(Dirección posta, ciudad, estado, código postal)*

10) Emergency Contact (Contacto de emergencia y Teléfono) ( ) -

11) Note to parent/guardian: Signing this form shall release the Jefferson County Board of Education and its employees from liability of any nature that might result from this plan of action. This form shall not relieve the liability of the school or its employees for their own negligence. Also, I hereby give permission for the healthcare provider completing and signing this form to exchange information with JCPS staff regarding this health condition. I acknowledge and agree when I authorize my child to attend a school sponsored field trip these medications and/or health services may also be provided by a licensed volunteer.

Parents please note: A prescription authorization form must be on file at school for medications to be given at school

PARENT/GUARDIAN Signature X | **TELEPHONE NUMBER** ( ) - | **DATE**

PART B COMPLETED BY THE HEALTHCARE PROVIDER ONLY: Complete Items 12 – 19
(12 al 19 - Esta sección para ser completada por el médico solamente.)

12) Diabetes diagnosis ☐ Type 1 ☐ Type 2

13) Insulin Administration
* Type of Insulin ☐ Fast-Acting (Humalog, Novolog, Aprida) ☐ Long-Acting (Lantus/Basaglar, Levemir) ☐ Other_____
* Insulin Delivery ☐ Syringe ☐ Pen ☐ Pump ☐ Other_____

14) Use of CGM: ☐ YES ☐ NO

15) Low Blood Glucose Below: 70 / 80 mg/dL
* Symptoms ☐ Hungry ☐ Weak/Shaky/Pale ☐ Headache ☐ Inattention/confusion ☐ Dizziness ☐ Nausea/Loss of Appetite ☐ Slurred Speech ☐ Seizure ☐ Clamminess ☐ Unresponsive ☐ Blurred Vision ☐ Other (Specify):

16) High Blood Glucose Above: _____ mg/dL
* Symptoms ☐ Increased thirst/urination ☐ Tired/Drowsy ☐ Warm/Dry/flushed skin ☐ Blurred Vision ☐ Abdominal Pain/Nausea/vomiting ☐ Fruity Breath ☐ Weakness/muscle aches ☐ Other (Specify):

17) LEVEL of INDEPENDENCE: ☐ Independent ☐ Supervision Only ☐ Assistance

18) INSULIN DOSE:
* Target Blood Glucose: _____ to _____

CORRECTION DOSE FORMULA:
If BG > _____ mg/dL, give _____ unit per _____ mg/dL > _____ mg/dL

KETONE SUPPLEMENTATION FORMULA
*Check for ketones when blood glucose is >200mg/dL x2 episodes or student is ill, DO NOT correct for ketones more often than every 4 hours)
Give additional insulin as follows: SMALL= _____ units, MODERATE= _____, Large = _____

CARBOHYDRATE DOSAGE: ☐ Before meals ☐ After meals

Breakfast	1 Unit per _____ grams of Carbs
Morning Snack	1 Unit per _____ grams of Carbs
Lunch	1 Unit per _____ grams of Carbs
Afternoon Snack	1 Unit per _____ grams of Carbs
PE/Activity	1 Unit per _____ grams of Carbs
Dismissal	1 Unit per _____ grams of Carbs
Other / As Needed	1 Unit per _____ grams of Carbs

* Round to: ☐ WHOLE unit ☐ HALF Unit

* Correct for High Blood Glucose if >3 hours since last Bolus

19) **Healthcare Provider Information** Form **must** be signed by a Healthcare Provider **and** parent/guardian

Healthcare Provider Signature X | Date

Healthcare Provider Printed Name

Medical Office Stamp (required for processing)

This institution is an equal opportunity provider and employer.