

DIABETES MANAGEMENT PLAN

This plan should be completed by both the child's health care provider (diabetes nurse educator, endocrinologist, or primary care provider/physician) and the child's parent/guardian.

It should be immediately updated with any new information, as necessary.

Effective Dates: _____

Child's Name: _____

Date of Birth: _____

Physical Condition (Identify and Explain): _____

Date of Diagnosis: _____

Grade: _____

Contact Information: *Circle the primary contact person and phone number*

Parent/Guardian: _____

Home Address: _____

Employer: _____

Employer's Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Parent/Guardian (2): _____

Home Address: _____

Employer: _____

Employer's Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Who has custody of the child? _____

Child's Health Care Provider:

Name: _____

Address: _____

Telephone: _____

Emergency Number: _____

Other Emergency Contacts:

Names: _____

Relationship: _____

Telephone: Home: _____ Work: _____ Cell: _____

Notify parent/guardian or emergency contact in the following situations: _____

Recommended Monitoring of Child: _____

Specify any medical time requirements: _____

Can child perform own monitoring: Yes No

Exceptions: _____

Identify the type of any meter, monitor, nebulizer, applicator, needle, pump, or any other devices necessary for the child's Diabetes Management Plan (include model and instruction booklet):

What signs does the child demonstrate when child is symptomatic?

Foods to avoid, if any: _____

Instructions for when food is provided to the child (e.g., as part of a party or food sampling event): _____

Exercise and Sports Limitations

List, identify, and explain any restrictions to exercise, sports, or any other activities:

Treatment Supplies to be kept at the site and provided by parent/guardian are as follows (please provide specific instructions regarding the storage and treatment of all supplies): _____

For children with medical concerns, please complete the supplemental form.

This Diabetes Management Plan has been approved by:

Child's Physician/Health Care Provider

Date

I give permission to the Town to perform and carry out the care tasks as outlined in the Diabetes Management Plan. I also consent to the release of the information contained in this Diabetes Management Plan to all staff members and other adults who have custodial care of my child, such as those persons on the emergency list and who may need to know this information to maintain my child's health and safety. A written revocation or amendment to this document must be delivered to the camp director by the child's Parent/Guardian in order to effectuate a revocation of the same.

The Town reserves the right to request additional documentation after review of the information contained in this document.

Acknowledged and received by:

Child's Parent/Legal Guardian

Date

Child's Parent/Legal Guardian

Date