BOYS & GIRLS CLUBS
OF THE RED RIVER VALLEY

Individual Child Care Plan (ICCP): Type 1 Diabetes

Child's Name: _____   **DOB:** _____

Site Location: _____

What symptoms and behaviors does your child experience?

     Before and during LOW blood sugar:

     Before and during HIGH blood sugar:

List any program restrictions we should be aware of:

What medication and treatment plan is your child following?

- o **Insulin Pump**

- o **Insulin Injections (If your child will take medication while in our care, a medication permission form must be completed with dosing instructions.)**

- o **Internal Glucose Monitor (If your child is using <u>Dexcom</u>, would you like our site staff to follow and monitor blood glucose levels?)**

     Yes _____ (Please fill out Dexcom follow form.)   No _____

What would you like our staff to do for the following?

     How and when should we check blood sugar levels:

     LOW blood sugar:

     If your child does not respond to above treatment:

     HIGH blood sugar:

     If your child does not respond to above treatment:

Can your child administer the medication and treatment themselves?   Yes _____   No _____

If assistance is needed, what does the staff need to do? Please note; if staff need to help your child you will need to train them in specifics.

Where is the medication and treatment supply stored?

Is there any additional information staff must know in order to best serve your child?

OFFICE USE ONLY

Received by:_____   Date:_____

Copy to Site:_____   Copy to Director:_____   File:_____

Dexcom Follow App

Parent will be responsible to send invite to Childs BGC site location.

BGC Site supervisor will accept the invite and set the Dexcom follow settings to those specified below:

- **Urgent Low Notification**

  Urgent Low Notification: _____ (OFF or ON)

  Notify me below: _____mg/dL

  Sound: Urgent Low Attentive

  (click Save- top right side)

- **Low Notification**

  Low Notification: _____ (OFF or ON)

  Notify me below: _____mg/dL

  For more than: _____Minutes

  Repeat: _____Minutes

  Sound: Low

  (click Save- top right side)

- **High Notification**

  High Notification: _____ (OFF or ON)

  Notify me above: _____mg/dL

  For more than: _____ (Minutes or Hours)

  Repeat every: _____ (Minutes or Hours)

  Sound: High

  (click Save- top right side)

- **No Data notification:**

  No Data Notification: _____ (OFF or ON)

  For more than: _____ (Minutes or Hours)

  Sound: No Data

  (click Save- top right side)

Parent signature: _____

Date: _____