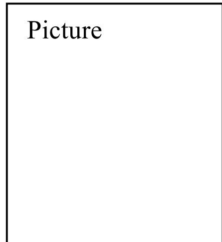

Diabetes Individualized Health Care Plan

Effective Date: ________________ Sent: __________ Returned: _____________

________504 Plan ________Special Education Plan Bus # ____
________Type I Diabetes ________Type II Diabetes

STUDENT INFORMATION NAME: Age at diagnosis:__________

Student:	School Year:	School:	Grade:
Date of birth:	Lives with: ___Both Parents ___Mother___Father ___Other_________________________		
Parent/Guardian:	Phone(s):	Email:	
Parent/Guardian:	Phone(s):	Email:	
Other contact (name):	Phone:		
Physician:	Phone:	FAX:	
Physician:	Phone:	FAX:	
School Nurse:	School Phone:	FAX:	

Blood Glucose Testing

___ Student is independent ___Student needs assistance with testing ___Student needs supervision

Times to test:
___ before lunch ___ before PE ___ before going home ___As needed ____ other___________________________________

Call parent if blood glucose is below _____ mg/dl or above _____ mg/dl

Always test if showing signs/symptoms of low or high blood glucose

Insulin Delivery

Insulin needed during school hours? _____ Yes ______ No

Type of insulin:

Method of insulin delivery if needed at school: _____Syringe _____Insulin pen _____Insulin pump

Person to administer insulin: ___ student (independent) ___student (needs supervision) ___ parent ___ Staff (specify)________________ ___Other___________

Location of medication:*** _____ Office _____ With teacher _____ With student

*****A completed Medication Authorization Form must be signed by both parent and physician and on file in the office before any medication can be given or carried at school**

Meal bolus: Insulin-carbohydrate ratio___________unit(s) of insulin for every___________grams of carbohydrate (CHO)

CHO eaten (or to be eaten)	Units of Insulin

Blood Glucose Correction Dose (bolus):
_____unit(s) of insulin per _____mg/dl over _____ mg/dl

Blood Glucose Level (mg/dl)	Units of Insulin

Note: Insulin dose is a total of meal bolus and correction bolus
If using pump - Type of Insulin Pump:___________________________________

If using insulin pump, enter blood glucose level and carbohydrates eaten or to be eaten. The pump will calculate the prescribed amount of insulin.

Snack

Are snacks needed during school? _____ No _____ Yes (Provided by parent) – if yes what time? As needed for hypoglycemia

Exercise and Sports

Is a snack needed before PE? _____No _____ Yes (Provided by parent)

Student should not exercise if blood glucose level is below _____ mg/dl or above _____ mg/dl.

Low Blood Glucose (Hypoglycemia)

Emergency situations may occur with low blood sugar!

Symptoms: Shaky, feels low, feels hungry, confused, other____

- Student needs treatment when blood glucose is below _____ mg/dl or if symptomatic
- If treated outside the classroom, a responsible person MUST accompany student to the office
- If blood glucose is below _____ mg/dl give____
- After 15 minutes recheck blood sugar
- Repeat until blood glucose is over _____ mg/dl

IF GLUCAGON IS PRESCRIBED AND AVAILABLE, IMMEDIATELY CONTACT DELEGATED STAFF MEMBER TO ADMINISTER!

Only give glucagon if student becomes unconscious

High Blood Glucose (Hyperglycemia)

Symptoms: Increased thirst, increase need for urination, other____

- If blood sugar is over _____ mg/dl contact parent
- Allow unrestricted bathroom privileges
- Encourage student to drink water or sugar-free drinks
- If vomiting call parent ***immediately!***

Call 911 for the following	**Additional information**
• If Glucagon is administered • Student is unable to cooperate to eat or drink anything • Decreasing alertness or loss of consciousness • Seizure	• Student must always be allowed access to fast-acting sugar. • Student is allowed to carry a water bottle and have unrestricted bathroom privileges. • Student is allowed to test his/her blood glucose when/where needed • Substitute teachers must be aware of the student's health situation, but still respecting privacy • Notify parent(s)/guardian when blood sugar is below ________ mg/dl or above _______ mg/dl and for emergencies.

As parent/guardian of the above named student, I give my permission to the school nurse and other designated staff to perform and carry out the diabetes tasks as outlined in this Individualized Health Plan (IHP) and for my child's healthcare provider to share information with the school nurse for the completion of this plan. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the school nurse whenever there is any change in the student's health status or care. Parents/Guardian and student are responsible for maintaining necessary supplies, snack, blood glucose monitor, medications and equipment.

Parent Signature____Date____________________

School Nurse Signature____Dale____________________