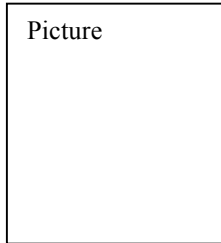


Diabetes Individualized Health Care Plan

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: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> 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)

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

CHO eaten (or to be eaten)	Units of Insulin

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

- If Glucagon is administered
- Student is unable to cooperate to eat or drink anything
- Decreasing alertness or loss of consciousness
- Seizure

Additional information

- 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 _____