INDIVIDUALIZED HEALTHCARE PLANS
DIABETES

Date:_____

Student:_____ Date of Birth:_____

School:_____ Grade/Homeroom:_____

Parent/Guardian:_____ Home Phone:(___)_____

Mother's Work #: (___)_____ Father's Work #: (___)_____

Emergency Contact:_____

In case of emergency, I authorize school personnel to contact:

Diabetes Care Provider:_____ Diabetes Health Educator:_____

Transport via ambulance to: (hospital) _____

Health History

Age of onset:_____ Related Complications:_____

Allergies:_____ Other medications:_____

Other Health Problems:_____

Blood Sugar Monitoring

Routine Management: Target Blood Sugar Range_____ **to** _____

Test will be performed in_____(location)

Need assistance with testing? Yes_____ No_____ Explain_____

Times to blood sugar:

____ Before lunch

____ After lunch

____ Before P.E.

____ After P.E.

____ As needed for signs/symptoms of low or high blood sugar

Call parent if values are below_____ or above_____

At Home:_____ At School:_____

Needs Routine Assistance:_____ Yes _____ No

Emergency Response/Intervention Plan

Student Name:_____ Grade/HR:_____ Date:_____

Mild Low to Moderate Blood Sugar: (Student to be treated when blood sugar is below_____.)
Symptoms could include (please circle all that apply): hunger, irritability, shakiness, sleepiness, sweating, pallor, uncooperative, crying or other behavioral changes, combative, disoriented or incoherant.
Treatment of Mild Low Blood Sugar; With any level of low blood sugar never leave the student unattended . If treated outside the classroom a responsible person should accompany student to the health office for futher assistance.

_____Test blood sugar. If kit not available treat child immediately for low blood sugar.

_____If blood sugar is between _____ and _____ and lunch is available, escort to lunch and have student eat immediately. If lunch is unavailable, treat immediately as listed below.
If blood sugar is below____, give 4 oz. juice, or 6 oz. (1/2 can) of regular soda or 2-3 glucose tablets. Wait 10 minutes. Re-check blood sugar. Re-treat as above if still below.
Follow with snack or lunch when blood sugar rises above_____ or when symptoms improve.
Notify _____ school nurse _____ and parent.
Comments:_____

Severe Low Blood Sugar Student symptoms include: Seizure or loss of consciousness, unable or unwilling to take gel or juice.

- Stay with the Student.
- Appoint someone to call 911.
- Roll student on side.
- Protect from injury.
- Do not put anything in mouth.

_____Give Glucagon subcutaneously (if ordered).

High Blood Sugar: Student will be accompanied to the health room. The student needs to be treated when blood sugar is above_____. Call parent/guardian when blood sugar s greater than_____.

Symptoms could include (circle all that apply): extreme thirst, headache, abdominal pain, nausea, increased urination. Additional student symptoms

_____

Treatment of High Blood Sugar:

- Drink 8-16 oz. of water every hour.
- Allow free access to bathroom.
- Permission to carry water bottle with them in school.

Check urine for ketones when blood sugar is greater than_____ or when ill. If urine ketones are moderate to large, call parent immediately.
I have reviewed the Intervention Plan.
I will notify the school nurse of any additional information or changes in my student's diabetic management.
Parent Signature_____ Date:_____

School Nurse Signature_____ Date:_____

Daily Management Regimen:

Insulin Type:_____ Insulin Type:_____

Dosage:_____ Dosage:_____

Frequency:_____ Frequency:_____

Insulin being administered by:_____

Insulin administered at school: _____ Yes _____ No

Insulin subcutaneous injection using Humulog/Novolog/Regular (circle type).

_____ Unit (s) if lunch blood sugar is between ____ and ____

_____ Unit (s) if lunch blood sugar is between ____ and ____

_____ Insulin/Carb Ratio____ Unit for every____grams of carbohydrate eaten.

plus____Units for every____mg./dl points above____mg/dl

_____Student can draw up own insulin_____Student cannot draw up own insulin.

_____Student needs assistance checking insulin dosage.

_____Student can draw up but needs and adult to inject insulin.

Diet:

Lunch time _____ Scheduled P.E. time_____ Recess time_____

Snack time_____am_____pm Location snacks are kept_____

Special Lunch Considerations: _____

Parent/Guardian and student are responsible for maintaining necessary supplies, snacks, testing kit, medications and equipment.

Physical Education

Scheduled at:_____

Is snack necessary before physical education? _____Yes_____No

Does child participate in after school sports? _____Yes_____No

P.E. teacher/coach is aware of child's diabetes? _____Yes_____No