

DIABETES Individualized Healthcare Plan			School Year: _____	Picture
STUDENT INFORMATION				
Student:	School:	DOB:	Grade:	
Parent:	Phone:	Email:		
Physician:	Phone:	Fax:		DMMO <input type="checkbox"/> Yes <input type="checkbox"/> No
School Nurse:	School Phone:	Fax:		
<input type="checkbox"/> Type I	<input type="checkbox"/> Type II	Age at diagnosis:		
Parent: complete the above section, read and sign below, obtain signature from Health Care Provider and return to school nurse.				
As parent/guardian of the above named student, I give permission for my child's healthcare provider to share information with the school nurse for the completion of this plan. I understand 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 of any change in the student's health status, care or medication order. If medication is ordered I authorize school staff to administer medication described below to my child. If prescription is changed a new prescriber order must be completed before the school staff can administer the medication. Parents/Guardian are responsible for maintaining necessary supplies, medications and equipment.				
Parent Signature: _____			Date: _____	
BLOOD GLUCOSE MONITORING				
<input type="checkbox"/> Student is independent <input type="checkbox"/> Student needs assistance <input type="checkbox"/> Student needs supervision <input type="checkbox"/> Student has a Continuous Glucose Monitoring System (CGMS) (CGMS readings are for trends only, ALWAYS verify with blood glucose before treating, including any dosing) Always test if student is showing signs/symptoms of high or low blood glucose!				
INSULIN DELIVERY (Per instruction from PCH, correction doses can be given at mealtime only, unless on a pump)				
Method of insulin delivery: <input type="checkbox"/> Pump <input type="checkbox"/> Insulin Pen <input type="checkbox"/> Syringe/vial		<input type="checkbox"/> Student is independent <input type="checkbox"/> Student needs supervision <input type="checkbox"/> Student needs assistance (attach training documentation if applicable)		
High Blood Glucose Correction Dose for PUMP only: If BG over _____ mg/dl, give correction per pump calculation				
Lunch: Student will typically eat <input type="checkbox"/> School Lunch (staff can help with carb counts) <input type="checkbox"/> Home Lunch (parent must provide carb counts)				
If blood glucose is below _____ at lunch do this: <input type="checkbox"/> decrease insulin dose by ___ units <input type="checkbox"/> other: _____				
LOW BLOOD GLUCOSE - HYPOGLYCEMIA		HIGH BLOOD GLUCOSE - HYPERGLYCEMIA		ADDITIONAL INFORMATION
Emergency situations may occur with low blood sugar! Symptoms: shaky, feels low, feels hungry, confused, other _____ <input type="checkbox"/> Student needs treatment when blood glucose is below _____ mg/dl or if symptomatic <input type="checkbox"/> If treated outside the classroom, a responsible person MUST accompany student to the office <input type="checkbox"/> If blood glucose is below _____ mg/dl give _____ <input type="checkbox"/> After 15 minutes recheck blood sugar <input type="checkbox"/> Repeat until blood glucose is over _____ mg/dl <input type="checkbox"/> Disconnect or suspend pump		Symptoms: Increased thirst, increase need for urination, other _____ <input type="checkbox"/> Student needs treatment when blood glucose is over _____ mg/dl <input type="checkbox"/> If blood sugar is over _____ mg/dl contact parent <input type="checkbox"/> Allow unrestricted bathroom privileges <input type="checkbox"/> Encourage student to drink water or sugar-free drinks If vomiting call parent immediately!		<ul style="list-style-type: none"> • 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 CALL 911 IF: <ul style="list-style-type: none"> • Glucagon is administered • Student is unable to cooperate to eat or drink anything • Decreasing alertness or loss of consciousness • Seizure
Notify parent(s)/guardian when blood glucose is below _____ mg/dl or above _____ mg/dl				
SPECIAL CONSIDERATIONS (Academic testing, Snacks, PE, School Parties, Field Trips)				
PE: <input type="checkbox"/> 15 gram carb (free) snack before PE <input type="checkbox"/> Check BG before PE <input type="checkbox"/> Do not exercise if BG is below _____ mg/dl or above _____ mg/dl				
SPECIAL CONSIDERATIONS AND PRECAUTIONS: School Parties: <input type="checkbox"/> No coverage for parties <input type="checkbox"/> I:C Ratio <input type="checkbox"/> Student to take snack home <input type="checkbox"/> parent will provide alternate snack <input type="checkbox"/> Other: Field Trips:				
ACADEMIC TESTING: <input type="checkbox"/> Student may reschedule academic testing with teacher, as needed, if blood glucose is below _____ or over _____				
EMERGENCY MEDICATION (See DMMO)				
Person to give Glucagon : <input type="checkbox"/> School Nurse <input type="checkbox"/> Parent <input type="checkbox"/> EMS <input type="checkbox"/> Volunteer(s) (Specify): _____				
Attach volunteer(s) training documentation				
Location of Glucagon: _____				
SIGNATURES				
The above named student is under my care. <u>The above reflects my plan of care for the above named student.</u>				
Prescriber Signature (if no DMMO): _____			Date: _____	
School Nurse Signature: _____			Date: _____	

Please try to plan all class/school parties right before lunch, or later in the afternoon so that parents can dose at home with their next meal.