DIABETES
Individualized Healthcare Plan

School Year:

Picture

STUDENT INFORMATION

Student:	**School:**	**DOB:**	**Grade:**
Parent:	**Phone:**	**Email:**	
Physician:	**Phone:**	**Fax:**	**DMMO** □**Yes** □**No**
School Nurse:	**School Phone:**	**Fax:**	
☐ **Type I** ☐ **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

☐ Student is independent ☐ Student needs assistance ☐ Student needs supervision ☐ 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: ☐Pump ☐Insulin Pen ☐Syringe/vial ☐Student is independent ☐Student needs supervision ☐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 ☐ School Lunch (staff can help with carb counts) ☐ Home Lunch (parent must provide carb counts)

If blood glucose is below _____ at lunch do this: ☐ decrease insulin dose by ____ units ☐ other:_____

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
☐ Disconnect or suspend pump

HIGH BLOOD GLUCOSE - HYPERGLYCEMIA

Symptoms: Increased thirst, increase need for urination, other_____

☐ Student needs treatment when blood glucose is over ____ mg/dl
☐ 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!***

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

CALL 911 IF:

- 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: ☐ 15 gram carb (free) snack before PE ☐ Check BG before PE ☐ Do not exercise if BG is below ____mg/dl or above ____mg/dl

SPECIAL CONSIDERATIONS AND PRECAUTIONS:
School Parties: ☐ No coverage for parties ☐ I:C Ratio ☐ Student to take snack home ☐ parent will provide alternate snack ☐ Other:
Field Trips:

ACADEMIC TESTING: ☐ Student may reschedule academic testing with teacher, as needed, if blood glucose is below _____ or over _____

EMERGENCY MEDICATION (See DMMO)

Person to give **Glucagon**: ☐ School Nurse ☐ Parent ☐ EMS ☐ Volunteer(s) (Specify:)_____
Attach volunteer(s) training documentation

Location of Glucagon:

SIGNATURES

The above named student is under my care. The above reflects my plan of care for the above named student.

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.