**DIABETES – INDIVIDUAL HEALTH CARE PLAN**

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| **Student’s Name**:  |  Date of Birth: | Diabetes: Type 1 🞏 Type 2 🞏 |
| Date of Diagnosis: |  |  |
| School Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  Grade:\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Plan Effective Date(s): |  |  |
| **CONTACT INFORMATION:** |  |  |
| Parent/Guardian #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Numbers: Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent/Guardian #2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Numbers: Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Diabetes Health Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Work #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**EMERGENCY NOTIFICATION:** Notify parents of the following conditions: (If unable to reach parents, call the Diabetes

 Healthcare Provider listed above).

A .Loss of consciousness or seizure (convulsion) immediately after glucose substitute given and 911 called.

B. Blood sugar in excess of \_\_\_\_\_\_\_\_\_\_mg/dl.

C. Positive urine ketones (small, moderate or large).

D. Abdominal pain, nausea/vomiting, diarrhea, fever, altered breathing, or altered level of consciousness.

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| **MEALS/SNACKS:** Students can **🞏** Determine correct portions and number of carbohydrate serving **🞏** Calculate carbohydrate grams accurately  **🞏** Needs adult assistance with calculating dose |
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|  | **Time/Location** | **Food Content/Amount** |  | **Time/Location** | **Food Content/Amount** |
| **🞏**Breakfast | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **🞏**Mid-afternoon | **\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **🞏**Midmorning | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **🞏**Before PE  | **\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **🞏**Lunch | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **🞏**After PE | **\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

If outside food for party or food sampling provided to class:🞏YES 🞏NO count carbohydrates and administer \_\_\_\_\_\_\_\_\_\_(insulin) |

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| **BLOOD GLUCOSE MONITORING AT SCHOOL:** 🞏 YES 🞏 NO Type of Meter: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If yes, can student ordinarily perform own blood glucose checks? 🞏YES 🞏NO // Interpret Results? 🞏YES 🞏NO Needs supervision? 🞏YES 🞏NOTime to be performed: **🞏**Before breakfast **🞏**Before PE/Activity Time **🞏**Before Lunch **🞏**Mid-Afternoon **🞏**Dismissal  **🞏**As needed for signs/symptoms of low/high blood glucosePlace to be performed: **🞏**Classroom **🞏**Nurse’s Office **🞏**Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Optional: Target Range for blood glucose: \_\_\_\_\_\_\_\_\_\_\_(mg/dl to mg/dl) – (Completed by Diabetes Health Care Provider) |

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| **INSULIN INJECTIONS DURING SCHOOL:** 🞏YES 🞏NO Type of Insulin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, can student: Determine correct dose? 🞏YES 🞏NO Draw up correct dose? 🞏YES 🞏NOGive own insulin injection? 🞏YES 🞏NO Needs supervision? 🞏YES 🞏NOInsulin Delivery: 🞏Syringe/Vial 🞏Pen 🞏Pump(“Supplemental Information Sheet for Student Wearing an Insulin Pump”)Correction Dose of Insulin for High Blood Glucose 🞏 YESTime to be given: \_\_\_\_\_\_\_\_\_\_\_\_\_Determine dose per equation plus amount for meal carbohydratesCorrection: \_\_\_\_ Target: \_\_\_\_\_\_\_Example: 1 unit for every 50 (correction) greater than 150 (target)(Blood glucose-target) divided by correction = units to give +meal doseSample:Blood glucose=400 Correction/Target: 1/50Insulin to Carb Ratio = 1:10 Eating 60 grams of carbs(400-150)/50 = 5+6=11 units prior to mealStandard daily insulin at school: 🞏YES 🞏NOType: Dose Time to be given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Calculate insulin dose for carbohydrate intake: 🞏YES 🞏NOIf yes, use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (insulin type)\_\_\_\_\_\_# unit(s) per \_\_\_\_\_ grams of CarbohydratesAdd carbohydrate dose to correction dose? 🞏YES 🞏NO Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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| **OTHER ROUTINE DIABETES MEDICATION AT SCHOOL:** 🞏YES 🞏 NOName of Medication Date Time Route Possible Side Effects\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **EXERCISE, SPORTS AND FIELD TRIPS**Blood glucose monitoring and snacks as above. Quick access to sugar-free liquids, fast-acting carbohydrates, snacks and monitoring equipment. A fast-acting carb such as \_\_\_\_\_\_juice/regular pop/glucose tabs (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) should be available at the site. Child should not exercise if blood glucose is below \_\_\_\_\_\_\_\_\_mg/dl, if child has small, moderate or large ketones in urine or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. |

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| **SUPPLIES TO BE FURNISHED/RESTOCKED BY PARENT/GUARDIAN:** (Agreed-upon locations noted on emergency card/nursing care plan.

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| 🞏Blood glucose meter/ strips/lancets/lancing device | 🞏Fast-acting carbohydrate | 🞏Insulin vials/syringe |
| 🞏Ketone testing strips | 🞏Carbohydrate-containing snacks | 🞏Insulin pen/pen needles/cartridges |
| 🞏Disposal container | 🞏Carbohydrate free beverage/snack | 🞏Glucose-Substitute Emergency Kit |

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| **MANAGEMENT OF HIGH BLOOD GLUCOSE (over \_\_\_\_\_\_mg/dl)**Signs/Symptoms for this Student Indicate treatment choices

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| 🞏Increased thirst, urination, appetite | 🞏Give sugar-free fluids as tol:\_\_\_\_\_\_\_(ounces per hour) |
| 🞏Tiredness/sleepiness | 🞏Check urine ketones if blood glucose over \_\_\_\_\_\_mg/dl |
| 🞏Blurred Vision | 🞏Notify parent is ketones positive=small, moderate or large |
| 🞏Nausea/Vomiting | 🞏If unable to reach parents, call diabetes health care provider |
| 🞏Abdominal Pain | 🞏Frequent bathroom privileges |
| 🞏Headache | 🞏Stay with student, observe status changes |
| 🞏Other | 🞏Other |

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| **MANAGEMENT OF LOW BLOOD GLUCOSE (below \_\_\_mg/dl) –** Treat ASAP/Notify School Nurse of low blood glucose treatment.Signs/Symptoms for this Student Indicate treatment choices

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| 🞏Hunger🞏Weakness/shakiness  | If student is awake and able to swallow, give 15 grams of fast-acting carbohydrate such as: |
| 🞏Tiredness/sleepiness | 🞏4oz of fruit juice or non-diet soda 🞏3-4 glucose tablets |
| 🞏Change in personality/behavior | 🞏Concentrated gel or tube frosting 🞏8oz Milk or |
| 🞏Sweaty/clamminess | 🞏Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 🞏Blurred Vision |  |
| 🞏Nausea/loss of appetite🞏Rapid Heartbeat🞏Slurred Speech🞏Loss of Consciousness🞏Seizure | Retest Blood Sugar 10-15 minutes after treatment.Repeat until blood glucose over\_\_mg/dl.Follow Treatment with 15gram snack if more than 1 hour until next meal/snack or if going to activity. |
| 🞏Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

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| **IMPORTANT!!!*****If student is unconscious or having a seizure***, presume the student is having a low blood glucose and:Call ***911*** immediately and notify parents. 🞏Administer glucose substitute \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Student should be turned on his/her side and maintained in this “recover” position until fully awake |

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| **Parent’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Provider’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |

 **Nurse’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**