**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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| **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 🞏NO  Time to be performed: **🞏**Before breakfast **🞏**Before PE/Activity Time **🞏**Before Lunch **🞏**Mid-Afternoon **🞏**Dismissal  **🞏**As needed for signs/symptoms of low/high blood glucose  Place 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 🞏NO  Give own insulin injection? 🞏YES 🞏NO Needs supervision? 🞏YES 🞏NO  Insulin Delivery: 🞏Syringe/Vial 🞏Pen 🞏Pump(“Supplemental Information Sheet for Student Wearing an Insulin Pump”)  Correction Dose of Insulin for High Blood Glucose 🞏 YES  Time to be given: \_\_\_\_\_\_\_\_\_\_\_\_\_  Determine dose per equation plus amount for meal carbohydrates  Correction: \_\_\_\_ Target: \_\_\_\_\_\_\_  Example: 1 unit for every 50 (correction) greater than 150 (target)  (Blood glucose-target) divided by correction = units to give +meal dose  Sample:  Blood glucose=400 Correction/Target: 1/50  Insulin to Carb Ratio = 1:10 Eating 60 grams of carbs  (400-150)/50 = 5+6=11 units prior to meal  Standard daily insulin at school: 🞏YES 🞏NO  Type: Dose Time to be given:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Calculate insulin dose for carbohydrate intake: 🞏YES 🞏NO  If yes, use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (insulin type)  \_\_\_\_\_\_# unit(s) per \_\_\_\_\_ grams of Carbohydrates  Add carbohydrate dose to correction dose? 🞏YES 🞏NO  Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **OTHER ROUTINE DIABETES MEDICATION AT SCHOOL:** 🞏YES 🞏 NO  Name 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.   |  |  |  | | --- | --- | --- | | 🞏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   |  |  | | --- | --- | | 🞏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   |  |  | | --- | --- | | 🞏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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**