# DIABETES
## Individualized Healthcare Plan

Confidential

**For:** _____ **DOB:** _____

**RIDES BUS: yes no Ext. Care: yes no**

Originally Written on: _____ By: _____ RN IEP or 504 plan? _____

**Grade:**_____ **School Year:** _____

Parents: _____

Daytime Phone #'s _____ (Cell) _____(Work)

Daytime Phone #'s _____(Cell) _____ (Work)

Emergency Contact name/phone #: _____

Physician Name: _____

Physician Phone #: _____

**I. Diabetes Mellitus Type 1; insulin: _____; diagnosed: _____**

A. Normal blood sugar range for this student is between 80 & 180 mg/dL.
B. Blood sugar testing:
   1. Blood sugar will be tested at school routinely and as needed: **yes no**
   2. Student is capable/responsible for testing self: **yes, independently yes, with supervision no.**
   3. Times of routine testing: **before lunch,** _____, _____, _____.
   4. Place blood sugar testing will be performed: **health room classroom student preference**
C. Insulin injections:
   1. Insulin injections given at school: **yes no N/A**
   2. Who is giving injections: **student parent school staff**
   3. Can student determine correct amount of insulin: **yes no**
   4. Can student draw correct dose of insulin: **yes no**
   5. Insulin injections given via: **syringe insulin pen insulin pump**
   6. Times insulin injections are given at school: _____
D. Insulin pump:
   1. Type of pump: _____.

**E. LOW BLOOD SUGAR** (hypoglycemia) for this student is below **80** mg/dL.

1. **Symptoms of LOW BLOOD SUGAR:**
   Shaking Irritability Change in consciousness Paleness Confusion Sweating Dizziness
   Hunger Headache Character change Weakness Other:_____

2. **If student is UNCONSCIOUS or UNABLE TO SWALLOW, DO:**
   - **Delegate CALL to 911**, parent, and district nurse. Have **AED** brought to student.
   - **If on insulin pump, crimp or cut pump tubing going from pump to student's skin.**
   - **ADMINISTER GLUCAGON** if prescribed by physician and provided by parent.
   - Glucagon provided for school, stored in: **health room student backpack not provided**
   - Place student on side, do not put anything in student's mouth.

3. If student is CONSCIOUS and ABLE TO SWALLOW,
   DO:
   - Treat immediately with 15 grams fast-acting carbohydrate, such as: 4-6-8 oz. juice/regular soda OR 4 round glucose tabs OR 3 square glucose tabs OR 1 tube glucose gel.
   - After 15 minutes, check blood sugar again. If less than 80mg/mL, repeat treatment.
   - If still less than 80 mg/mL after 2 treatments, have student suspend pump (if on insulin pump), call parent and district nurse, continue to treat.
   - When greater than 80 mg/mL, if more than 1 hour until next meal/snack, give snack provided by parent (e.g. 6 saltine crackers with cheese OR 15 grams carbohydrate). If on insulin pump, student to adjust insulin, as needed.

F. HIGH BLOOD SUGAR (hyperglycemia) for this student is above **300** mg/dL.

1. Symptoms of HIGH BLOOD SUGAR:
   Increased thirst  Nausea/vomiting  Rapid/labored breathing  Loss of appetite
   Dry/flushed skin  Frequent urination  Fruity breath odor  Complaints of not feeling well
   Other: _____

2. For HIGH BLOOD SUGAR,
   DO:
   - Allow free access to non-calorie fluids/water and bathroom.
   - Contact parent.
   - If on insulin pump, student to administer insulin via pump to treat high blood sugar and/or troubleshoot pump.
   - Allow student to check urine ketones, if applicable.
   - If ketones are present or student is lethargic, vomiting or has abdominal pain, contact parent. If unable to reach parent, contact district nurse. If nurse not available, call EMS/911.

G. Meals/Snacks:
1. Student requires lunch at (time): _____.
2. Student will require a snack at school at (time): _____, _____.
3. Extra snack required before PE/sports: **yes** **no** **student discretion**
4. Place snack kept: **health room** **classroom** **student backpack** **student locker** **with student**
5. Place snack will be eaten: **health room** **classroom** **student preference**
6. Typical number of grams of carbohydrates in snack: _____

H. Academics:
1. If the student is affected by high or low blood glucose levels at the time of regular testing, the student will be permitted to take the test at another time without penalty.
2. If the student needs to take breaks to use the water fountain or bathroom, check blood glucose, or to treat hypoglycemia or hyperglycemia during a test or classroom work, the student will be given extra time to finish the test/work without penalty.

I. Parent will provide:
1. Necessary equipment for blood sugar testing.
2. Snacks and treatment for low and high blood sugar.
3. Insulin and equipment if ordered by physician to be administered at school.
4. Glucagon to be administered at school in an emergency.

**I HAVE READ AND AGREE WITH THIS PLAN:**
I will notify the district nurse as soon as possible if the health status of my child changes or becomes unstable; and/or there is a cancellation of any of the procedures listed. I authorize the exchange of educational/protected health information between my child's healthcare team and school personnel.

Parent Name (printed)  Parent signature  Date

PSD Nurse name (printed)  PSD nurse signature  Date