Diabetes Individual Healthcare Plan

Date of Plan:_____ Effective for the_____school year

Student's Name:_____Date of Birth_____

Grade:_____Date of Diabetes Diagnosis:_____Type 1_____Type 2_____(check one)

Contact Information

Mother/Guardian:_____

Address:_____

Telephone:Home_____Work_____Cell_____

Father/Guardian:_____

Address:_____

Telephone:Home_____Work_____Cell_____

Student's Physician/Healthcare Provider:_____

Address:_____

Telephone:_____Emergency Number:_____

Other Emergency Contacts:

Name:_____Relationship_____

Telephone:Home_____Work_____Cell_____

Name:_____Relationship:_____

Telephone:Home_____Work_____Cell_____

Notify parents/guardian or emergency contact in the following situations (i.e.; blood glucose number low):

_____

_____

_____

_____

_____

*****************Please Complete Both Sides*****************

Blood Glucose Monitoring

Target range for blood glucose is □ 70-150 □ 70-180 □ Other_____

Usual times to check blood glucose_____

Times to do extra blood glucose checks (*check all that apply*)

□ before exercise □ when student exhibits symptoms of hyperglycemia

□ after exercise □ when student exhibits symptoms of hypoglycemia

□ Other (explain):_____

Can student perform own glucose checks? □ Yes □ No Is nurse supervision needed? □ Yes □ No

Exceptions:_____

Type of blood glucose meter student uses:_____

Insulin
Usual Lunchtime Dose

Base dose of Humalog/Novolog/Regular insulin at lunch (circle type of rapid-/short-acting insulin used) is

_____units OR does flexible dosing using_____units/_____grams carbohydrate.

Use of other insulin at lunch: (circle type of insulin used): intermediate/NPH/lente _____units OR

Basal/Lantus/Ultralente_____units.

Insulin Correction Doses
Parental authorization should be obtained before administering a correction dose for high blood glucose levels**:** □ Yes □ No

_____units if blood glucose is _____to_____mg/dl

_____units if blood glucose is _____to_____mg/dl

_____units if blood glucose is _____to_____mg/dl

_____units if blood glucose is _____to_____mg/dl

Can student give own injections? □ Yes □ No

Can student determine correct amount of insulin? □ Yes □ No

Can student draw correct dose of insulin? □ Yes □ No

Is nurse supervision needed? □ Yes □ No

For Students With Insulin Pumps
Type of pump: _____

Basal rates:_____units /hr at_____12am to_____; _____units at _____to_____; units at _____to_____

Type of insulin in pump:_____Type of infusion set:_____

Insulin /carbohydrate ratio:_____Correction factor:_____

Student Pump Abilities/Skills:	*Needs Assistance(check one)*	
Count carbohydrates	☐ Yes	☐ No
Bolus correct amount for carbs consumed	☐ Yes	☐ No
Calculate and administer corrective bolus	☐ Yes	☐ No
Calculate and set basal profiles	☐ Yes	☐ No
Calculate and set temporary basal rate	☐ Yes	☐ No
Disconnect pump	☐ Yes	☐ No
Reconnect pump at infusion site	☐ Yes	☐ No
Prepare reservoir and tubing	☐ Yes	☐ No
Insert infusion set	☐ Yes	☐ No
Troubleshoot alarms and malfunctions	☐ Yes	☐ No

For Students Taking Oral Medications

Type of medication:_____Timing:_____

Other medications:_____Timing:_____

Meals and Snacks Eaten at School
Is student independent in carbohydrate calculations and management? ☐ Yes ☐ No

Mid- morning:time_____content_____

Lunch:time_____content_____

Mid-afternoon:time_____content_____

Snack before exercise? ☐ Yes ☐ No Snack after exercise? ☐ Yes ☐ No

Other?_____

Exercise and Sports
Type of fast-acting carbohydrate to be available at site:_____

Activity restrictions?_____
Student ***should not*** exercise if blood glucose level is below_____mg/dl or above_____mg/dl,
Or if moderate to large urine ketones are present.

**********Please Complete Both Sides**********

Hypoglycemia (Low Blood Sugar)
Usual symptoms:_____

What glucose level mandates treatment if no symptoms?_____

Treatment of hypoglycemia_____

Glucagon to be given if student is unconscious, having a seizure (convulsion), or unable to swallow.

Dose:_____Route:_____site:_____
If glucagon is required, administer promptly. Then call 911 and the parents/guardian.

Hyperglycemia (High Blood Sugar)
Usual symptoms:_____

Treatment of hyperglycemia:_____

Urine should be checked for ketones when blood glucose levels are above_____mg/dl.
Supplies to be Kept at School

_____Blood glucose meter, blood glucose test strips, batteries for meter
_____Lancet device, lancets, gloves, etc
_____urine ketone strips
_____Insulin vials and syringes
_____Insulin pump and supplies
_____Insulin pen, pen needles, cartridges
_____Fast-acting source of glucose
_____carbohydrate containing snack
_____**Glucagon emergency kit**

This Diabetes Individual Healthcare Plan Has Been Approved By:

Signature of Physician/Healthcare Provider_____Date_____

Physician/Healthcare Provider Stamp:

Signature of Parent/Guardian_____Date_____

Permission to Release and Exchange of Confidential Information

I hereby authorize an exchange of medical information to occur between the School Nurse and the appropriate staff involved in my student's education, health, and safety. (i.e.; class teachers, counselors, bus driver). I also permit the exchange of medical information between the School Nurse and my student's Physician/Healthcare Provider. I agree to provide the necessary equipment and supplies, including snacks, glucose tabs, or glucagon that may be needed by my student in school or at school activities. I also understand that this authorization is in effect for the school year, and must be renewed on an annual basis. As the parent/guardian, I am responsible for updating the school nurse of any changes in my student's condition or orders.

Signature of Parent/Guardian:_____Date:_____