

AUSTIN PUBLIC SCHOOLS INDIVIDUAL HEALTH CARE PLAN 2020-2021

Name:		DOB:		Grade:	
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DIAGNOSIS/CONDITION: DIABETES MELLITUS Age of onset:					
	Hunger or “butterfly feelings”		Headache		Blurred vision
	Stomach ache, nausea or		Shaky/trembling		Sweaty or pale
	Rapid heart rate		Unconsciousness		Weak/drowsy
	Dry mouth- thirsty		Sleepy or fainting		Inappropriate
					Dizzy
					Irritable
					Anxious
					Seizure
Severity of symptoms can change quickly, and rapidly progress to a life-threatening situation! NEVER SEND STUDENT WITH ANY OF THE ABOVE SYMPTOMS ANYWHERE ALONE!					

Low Blood Sugar: less than _____, but conscious	Low Blood Sugar: unconscious
<ul style="list-style-type: none"> ▪ Give 15 grams of carbohydrates (1/2 cup juice, 1/2 can regular pop or 3-4 glucose tabs) ▪ Wait 10 minutes ▪ Recheck blood sugar ▪ If still less than _____ give 15 more grams of carbs ▪ Wait 10 more minutes ▪ Recheck blood sugar ▪ Repeat until blood sugar is _____ or more and student is alert, student may need a snack if their next meal is over an hour away. ▪ Return student to class 	<ul style="list-style-type: none"> ▪ Give instant glucose – please circle preferred choice Glucose Gel or Glucagon (only LSN/RN/LPN may give glucagon and there must be a physician’s order at school) ▪ Turn student on side ▪ Call 911 ▪ Call parent ▪ Stay with student ▪ Other:
High Blood Sugar: more than:	
Check ketones	
Offer drinks that do not contain carbohydrates (water, sugar free soda, crystal light)	
Call parent	
Other:	

Insulin Type: _____ Dose at mealtime: _____ Date Issued: _____		
Correction Scale (Provide indications for use)		
BS	=	
BS	=	
BS	=	
BS	=	
BS	=	
BS	=	
BS	=	
BS	=	
BS	=	
Daily school routines/Classroom information/Accommodations (to be filled out by health office staff):		
Lunch time:		
Recess times (Elementary only): AM _____ PM		
Physical Education Elementary -- Time: _____ Days of the week:		
Physical Education Secondary-- All year: ___ 1 st Semester: ___ 2 nd Semester: _____ Time of day:		
Unlimited access to drinking water (if a container is needed it will be provided by the parent)		
Bathroom privileges when medically necessary		
Blood sugar testing as needed Set testing times:		
Regularly scheduled snacks, if applicable: AM _____ PM		
Re-take tests as needed for blood sugar imbalances		
Other:		

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Please put an X in the box that best describes your child's role in management of their diabetes (If an activity is marked as independent an RN or LSN from the Austin Public Schools will verify competency with the student.)

In order for activity to be marked as independent student must be able to perform task without reminders or assistance

For Students Wearing a Pump	Does it independently	Does it with supervision	Health Staff needs to assist	Health staff performs
Washes hands				
Puts strip in monitor				
Pricks finger: How often should lancet be changed?				
Reads monitor				
Records results/enters amount into pump				
Able to determine amount of carbs				
Give correct bolus for carbs				
Calculate and administer correction bolus				
Calculate and set temporary basal rate				
Recognize signs/symptoms of site infection				
Disconnect pump if necessary				
Reconnect pump infusion set				
Prepare reservoir and tubing				
Insert new infusion set				
Give injection with syringe or pen, if needed				
Troubleshoot alarms and malfunctions				

Health Care Provider:	Clinic:	Phone:
Hospital:	Phone:	

<i>Person to Contact</i>	<i>Relationship</i>	<i>Home Phone</i>	<i>Work/Alt. Phone</i>
1.			
2.			
3.			

Parent Signature:	Date:
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OFFICE USE ONLY

Plan Initiated by:	Date:	
Plan Reviewed/Updated by:	Date:	
	Date:	

If 911 is needed – get a phone line, dial 9-911 (from a school phone) – Notify office when 911 is called.