District one91
Future Ready. Community Strong.

DIABETIC HEALTH PLAN

STUDENT_____ **DOB** _____**GRADE**_____

DIAGONOSIS/CONDITION: DIABETES

Person to Contact	*Relationship*	*Work Phone*	*Home Phone*	*Cell Phone*
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

SIGNS AND SYMPTOMS OF LOW BLOOD SUGAR (Check if applicable):

___shaking ___sweating ___hunger ___weakness ___headache ___tingling sensation

___dizziness ___pallor ___fatigue ___confusion ___anxious ___rapid heart beat

___irritability ___yawning ___blurred vision

other:_____

INTERVENTIONS:

BLOOD GLUCOSE MONITORING:

Time(s):_____ Target Range:_____

Self-test: Yes_____ No_____

If < _____ do this:_____

If > _____ do this:_____

Other special instructions:_____

INSULIN TO BE GIVEN AT SCHOOL:

Type_____ Time(s):_____

Type_____ Time(s):_____

Sliding Scale: Yes_____ No_____

Self-administers: Yes_____ No_____

Insulin pump: Yes_____ No_____ Type of pump:_____

SNACKS:

Time(s):_____ Type(s):_____ # of Carbs:_____

LUNCH:

Time:_____

PE CLASS : Day(s) and time scheduled:_____

Snack before: Yes_____ No_____

Test before: Yes_____ No____

Field Trip Plan:_____

EMERGENCY PLAN OF CARE

GLUCAGON: Yes_____ No_____

ORAL GLUCOSE GEL: Yes_____ No_____

EMERGENCY PLAN OF ACTION:

1. If student is conscious:
   - Needs to be accompanied to the health office.
   - Give their snack, 4 ounces of juice, 6 ounces of pop (not diet), or 3-4 glucose tablets.

If unable to give snack or glucose tablets, give 15 grams of glucose gel.

   - Call 911 if student does not respond to treatment.
   - Notify parent.
   - After treatment and rest, the student should resume his/her usual schedule unless parents or medical provider indicate otherwise.

2. If student is unresponsive or is unable to swallow:
   - Call 911 immediately
   - Call Health Office at x_____
   - DO NOT give anything to eat or drink.
   - Administer glucagon if ordered (LSN only)

Health Care Provider_____ Clinic_____ Phone_____

Hospital of Choice_____

	NURSING DIAGNOSIS	**GOALS**
1.	Potential for less than optimal school achievement due to diabetes mellitus.	To coordinate diabetes management with school activities/schedule.
2.	Potential for future complications related to diabetes.	To coordinate optimal blood sugar levels.

	Plan Initiated	***Reviewed/ Updated***	
Parent/Guardian(s) Signature _____	**Date _____**	**Date _____**	**Date _____**
School Nurse _____	**Date _____**	**Date _____**	**Date _____**
Health Assistant _____	**Date _____**	**Date _____**	**Date _____**

*Please contact the Licensed School Nurse if you have questions regarding this health plan or if you would like to meet to discuss other accommodations that may be needed.

Co-curricular and Extra-curricular Activities: If your child is involved in co-curricular / extra-curricular or other school-sponsored activities or programs that take place during or outside of the school day, please contact the program coordinator, teacher, or coach to discuss accommodations that may be needed as it relates to your child's medical condition. Please provide needed emergency medications directly to the program coordinator, teacher, or coach.

I give permission for the Licensed School Nurse to consult (both verbally and in writing) with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the medical condition and/or medication(s), treatment(s), or procedure(s) being used to treat the condition.

LSN signature_____ Date copy sent to Parent_____