Diabetes (Type I or II)

School Year: ____________ Grade: ______

INDIVIDUAL HEALTH PLAN

Student Name: ______________________________ DOB: ______________
Parent/Guardian: ______________________________ Phone: ______________
Emergency Contact: ______________________________ Phone: ______________
Treating Physician: ______________________________ Phone: ______________

LOCATION OF DIABETIC SNACKS: ______________________________

SNACK TIMES DURING SCHOOL DAY: ❒ Mid Morning ❒Mid Afternoon ❒ Other ______________________________

SPECIAL EVENT/PARTY FOODS: ❒ Parent/Guardian Discretion ❒ Student Discretion ❒ Other ______________________________

LOCATION OF GLUCOSE METER: ______________________________ IS GLUCAGON ORDERED? ❒ YES ❒ NO

LOCATION OF GLUCAGON: ______________________________

OTHER DIABETES MEDICATION(s) AT SCHOOL or TAKEN AT HOME

Name:______________________________Dose:______________Route: __________ Time(s) ________

Name:______________________________Dose:______________Route: __________ Time(s) ________

During an overnight field trip, '<u>at home'</u> medication: ❒ requires a trained staff member to administer medication

❒ is authorized to carry and self-administer medication

DIABETES MANAGEMENT: HEALTHCARE PROVIDER must provide a signed diabetes management plan from your facility. It must specify the following: Blood Glucose Monitoring, Insulin type and route of administration, Approved treatment of hypo and hyperglycemia, Approved Sports plan (if applicable), Parental Authorization to adjust Insulin dose and a Disaster Plan.

INSULIN THERAPY **Insulin delivery device:** ❒ **syringe** ❒ **insulin pen** ❒ **insulin pump**

Student's self-care carbohydrate counting and insulin administration skills:			**Student's self-care carbohydrate counting and insulin pump skills:**		
Carbohydrate Calculation	❒ Student	❒ Student requires assistance	Carbohydrate Calculation	❒ Student	❒ Student requires assistance
Calculate Insulin Dosage	❒ Student	❒ Student requires assistance	Calculate Insulin Dosage	❒ Student	❒ Student requires assistance
Insulin Administration	❒ Student	❒ Student requires assistance	Insulin Administration	❒ Student	❒ Student requires assistance
			Alarms or Malfunctions	❒ Student	❒ Contact Parent/Guardian

Blood Glucose/Sugar Monitoring During School Hours: ❒ Classroom ❒ Health Unit ❒Other______________

❒ Student checks blood sugar level independently and must keep testing supplies with them at all times.

❒ Student checks blood sugar level independently in the health unit ❒ Student checks blood sugar level with assistance/supervision

If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions

Administer: Glucagon as prescribed: ______________________________

Call 911 (Emergency Medical Services) & Contact the student's parents/guardian.

Being the parent/guardian of the above named student, I give consent for the information on this form—and the diabetes management plan-- to be shared with school personnel having direct contact with my child for the current school year. I understand that a trained staff member may administer prescribed medication and/or assist my child to comply with his/her physician's prescribed medications or treatments if needed. If my child's physician gives authorization for my child to carry and self-administer his/her medication, I consent and understand that medication independently self-administered is not monitored by school staff. I agree to provide the necessary prescribed medication or treatment supplies and agree to notify the school nurse immediately of any changes.

The school nurse shall contact the student's Parent/Guardian to discuss any concerns regarding the student's care which might require medical follow-up and/or shall contact the health care provider to obtain current information verbally when necessary to manage the student's condition at school. I understand that the Rockcastle County Board of Education Medication Policy and Procedures) are readily available for me to read. I hereby agree to release and hold Rockcastle County Schools free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from such treatment described by me or prescribed by my child's physician. I have read and understand this consent. I sign it voluntarily and with full knowledge of its significance.

X ______________________________ ______________
Parent/Guardian Signature ***Date Signed***