

AUSTIN PUBLIC SCHOOLS
INDIVIDUAL HEALTH CARE PLAN 2022-2023

Name:	DOB:	Grade:
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DIAGNOSIS/CONDITION: DIABETES MELLITUS Age of onset:					
Hunger or "butterfly feelings"		Headache		Blurred vision	Dizzy
Stomachache, nausea, or		Shaky/trembling		Sweaty or pale	Irritable
Rapid heart rate		Unconsciousness		Weak/drowsy	Anxious
Dry mouth- thirsty		Sleepy or fainting		Inappropriate	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

Syringe/Pen	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 is lancet changed				
Reads monitor				
Records results				
Able to calculate amount of insulin based on results				
If student uses syringe , able to prepare syringe and draw up correct amount of insulin. If student uses pen , able to prime and dial correct amount of insulin. If using pen is student able to change the insulin cartridge? Yes ___ or No				
Selects insulin injection site Does student clean site with alcohol? Yes ___ or No				
Injects insulin				
If needed measures for Ketones				

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

Person to Contact	Relationship	Home Phone	Work/Alt. Phone
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.