



NOTE: Parents are to provide the physician’s medical management plan to the school **annually**. The medical orders, along with the health intake below, assist the school nurse in developing an Individual Healthcare Plan for the student.

Student’s Name: _____ DOB: ___/___/___ Grade: _____ Today’s Date: ___/___/___

Parent/Guardian 1: _____ Contact Information: _____

Parent/Guardian 2: _____ Contact Information: _____

Name of physician treating student’s diabetes: _____ Phone Number: _____

Health Insurance: Private Medicaid/KanCare Currently without insurance

Medical alert jewelry worn? Yes No IEP? Yes No Current 504 Plan? Yes No

Mode of transportation to and from school? _____

Does student participate in before or after school activities? Yes No

Date of diagnosis: _____ Type 1 Type 2

HYPOGLYCEMIA (LOW blood sugar) – student’s usual symptoms (check all that apply):

- Shaky or jittery Sweaty Hungry Pale Headache Blurry vision Sleepy Dizzy
- Confused Disoriented Uncoordinated Irritable or nervous Argumentative Combative
- Changed personality Changed behavior Inability to concentrate Weak Lethargic
- Other: _____

Does student recognize the above signs/symptoms? Yes No Sometimes

In the past year, has student been treated for severe low blood sugar? Yes No

If yes: In a health care provider’s office In the emergency room Overnight or longer in the hospital

HYPERGLYCEMIA (HIGH blood sugar) – student’s usual symptoms (check all that apply):

- Increased thirst/dry mouth Frequent or increased urination Change in appetite/nausea
- Blurry vision Fatigue Other: _____

Does student recognize the above signs/symptoms? Yes No Sometimes

In the past year, has student been treated for severe high blood sugar or diabetic ketoacidosis? Yes No

If yes: In a health care provider’s office In the emergency room Overnight or longer in the hospital

Meal Plan:

Will student participate in breakfast at school? _____

Will student bring lunch, eat school lunch, or both? _____

Does student regularly eat snacks – mid morning, mid-afternoon, etc? _____

Instructions for when food is provided to class (special event/party, etc): _____



| Equipment: | | Stays at school | Home to school each day |
|---|--|--------------------------------------|-------------------------|
| Blood glucose meter | Brand/model: Testing strips: | | |
| Continuous glucose monitor (CGM): <input type="checkbox"/> Yes <input type="checkbox"/> No | Brand/model: Alarm parameters: | N/A | N/A |
| Ketone testing | Strips: | | |
| Insulin delivery device | Syringe: | | |
| | Insulin pen: | | |
| | Insulin pump – Brand/model: | N/A | N/A |
| | Type of infusion set: | N/A | N/A |
| Snacks (student preference) | List: | Parents to provide supply for school | N/A |
| Short acting glucose (student preference) | List: | Parents to provide supply for school | N/A |
| Glucagon ordered | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

For each self-care task, select the column that best indicates student’s current abilities. Leave blank if not applicable.

| Student’s self-care level at home: | Does alone | Does with help | Done by adult | Comments |
|---|------------|----------------|---------------|----------|
| Checks own blood glucose | | | | |
| CGM – knows what to do/troubleshoots high/low alarms and malfunctions | | | | |
| Measures ketones | | | | |
| Counts carbs for meals/snack | | | | |
| Calculates insulin | | | | |
| Measures insulin in syringe (or on insulin pen) | | | | |
| Primes insulin pen (if applicable) | | | | |
| Selects insulin injection site | | | | |
| Administers insulin | | | | |
| Pump operation | | | | |
| Boluses correct insulin | | | | |
| Calculates and set basal profiles | | | | |
| Disconnects pump | | | | |
| Reconnects pump to infusion set | | | | |
| Prepares reservoir, pod, and/or tubing | | | | |
| Inserts infusion set | | | | |
| Troubleshoots alarms | | | | |

NOTE: Self-care at school will be determined in consideration of the above information, healthcare provider orders, and school nurse ongoing assessment of student’s skills.

Other medications taken by student (name of medication, dosage, reason, side effects):

Does student have family, peer, and community support systems? Yes No

Describe student’s response and current coping/adaptation to having diabetes: _____

Parent/Guardian Signature: _____ Date: _____