MCS-240
5/2026

Mason City Schools
Independent Health Plan (IHP) -Diabetes Management

Student Information

Date of IHP_____

Student Name:	Date of Birth:	Student ID#:
Grade: Teacher/Team:	Bus#	Car Rider:
Age at Diagnosis:	Date of Diagnosis	

Diabetes Information/Management

Insulin Delivery: Pump_____Pen_____Syringe_____	Continuous Glucose Monitor (CGM): Y_____N_____
Baqsimi Provided? Yes_____No_____Date of EXP_____ Location(s) Baqsimi_____	
Ketostix Provided? Y_____No_____EXP date_____Recommendation for Ketone check **BG >300x2 in 3 hr intervals** and/or stomach ache and vomiting	

Causes of Hypoglycemia (Low Blood Sugar)	**Causes of Hyperglycemia HIgh blood Sugar)**
Too much Insulin Delayed Food Missed food Exercise	Not enough insulin Too much food Illness Infection Stress Decreased Activity

Symptoms of Hypoglycemia	**Symptoms of Hyperglycemia**
Shaky Sweaty Headache Anxious Hungry Weakness Dizzy Irritability Blurred Vision ***Parent to circle symptoms***	Extreme Thirst Drowsy Dry mouth/Dry skin Stomach ache Nausea Frequent Urination ***Parent to circle symptoms***

Action for Hypoglycemia	**Action for Hyperglycemia**
Never send a student with suspected low glucose anywhere alone • Notify School Nurse or trained personnel • If possible, test glucose. CGM not always correct • Treat if BG 70 or less. If unable to test BG, and student is symptomatic, **TREAT** • ***If unconscious, treat with Baqsimi Nasal Spray. Call 911***	• Notify school nurse of High BG. Nurse will test Blood glucose and urine for ketones • If glucose is high and the student is able to return to class, allow him/her to drink water or carbohydrate free fluids and use bathroom as needed • Call parent if high BG persists or Positive ketones

Student Management of Diabetic Care

Blood Sugar Monitoring: Independent_____Needs Assistance_____CGM_____
Carbohydrate Calculation: Independent_____Needs Assistance_____Parent provided_____
Insulin Dosage Calculation Independent_____Needs Assistance_____
Insulin Administration: Independent_____Needs Assistance_____
Insulin Pmmp Site Change: Student_____Parent_____Site Change Supplies in clinic: Y____N___
Student Manages Diabetes: Clinic Only_____Clinic& Classroom_____Classroom Only_____

As Parent/Guardian,

- ☐ **I am aware my child is Eligible for 504**
- ☐ **I have submitted a self management form request from Cincinnati Diabetes Center**

Parent Signature_____Date_____

CLINIC USE ONLY

☐ **IHP Shared: Transportation____/____/____**	☐ **Physician Orders Received___/____/____**
☐ **IHP Shared Teacher/Staff ___ /____/____**	☐ **Supplies/Glucagon Received___/____/____**
☐ **IHP Shared Nutrition Dept____/___/_____**	☐ **Location(s)of supplies_____**