INDIVIDUALIZED SCHOOLHEALTH CARE PLAN: DIABETES

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| Date |  | | | | |
| Student |  | | | | | | | | | | | | | | | | | Date of Birth | | | | | |  |
| School |  | | | | | | | | | Grade | | |  | | | Teacher | | |  | | | | | |
| Parent(s)/Guardian(s) | | | |  | | | | | | | | | | | | | | | | | | | | |
| Phone (H) | |  | | | | | (W) | |  | | | | | | | | | (Other) | | | |  | | |
| Additional emergency contact information | | | | | | | |  | | | | | | | | | | | | | | | | |
| Diabetes Care Provider | | | | |  | | | | | | | Phone | |  | | | | | | | Fax | |  | |
| Diabetes Nurse Educator | | | | |  | | | | | | | Phone | |  | | | | | | | Fax | |  | |
| Hospital of choice | | |  | | | | | | | | | | | | | | | | | | | | | |
| Routine Management Target Blood Sugar Range | | | | | | | | | | |  | | | | to | |  | | |

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| **Required blood sugar testing at school:** | | | | **Times to do blood sugar:** | | | |
|  | Trained personnel must perform blood sugar test | | |  | Before lunch | | |
|  | Trained personnel must supervise blood sugar test | | |  | After lunch | | |
|  | Student can perform testing independently | | |  | Before P.E. | | |
|  | | | |  | After P.E. | | |
|  | | | |  | As needed for signs/symptoms of low or high blood sugar | | |
|  | Call parent if values are below |  | or above | | |  |

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| **Medications to be given during school hours:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Oral diabetes medication(s)/dose | | | | | | | |  | | | | | | | | | | | | | Time to be administered: | | | | | | |  | | |
|  | Sliding Scale: | | | |  | | | | | | | | | | | | | | | | | | | To be administered immediately: | | | | | | | |
| Insulin (subcutaneous injection) using Humalog/NovoLog/Regular (circle type) | | | | | | | | | | | | | | | | | | | | | | | | Before Lunch | | | | | After Lunch | | |
|  | | Unit(s) if lunch blood sugar is between | | | | | | | | | | |  | | | | | and | |  | | | |  | |  |  | | |  |
|  | | Unit(s) if lunch blood sugar is between | | | | | | | | | | |  | | | | | and | |  | | | |  | |  |  | | |  |
|  | | Unit(s) if lunch blood sugar is between | | | | | | | | | | |  | | | | | and | |  | | | |  | |  |  | | |  |
|  | | Unit(s) if lunch blood sugar is between | | | | | | | | | | |  | | | | | and | |  | | | |  | |  |  | | |  |
|  | Insulin/Carb Ratio | | | | |  | Unit for every | | | | |  | | | grams of carbohydrate eaten, | | | | | | | | | | | |  | | | | | |
|  | plus | |  | unit(s) for every | | | |  | | mg/dl points above | | | | | | | | |  | | mg/dl | |
|  | Student can draw up and inject own insulin | | | | | | | | | | |  | | Student cannot draw up own insulin but can give own injection | | | | | | | | | | | | | | | | | | |
|  | Trained adult will draw up and administer injection | | | | | | | | | | | | | | |  | Student can draw up but needs adult to inject insulin | | | | | | | | | | | | | | | |
|  | Student is on pump | | | | | | | | | | | | | | |  | Student needs assistance checking insulin dosage | | | | | | | | | | | | | | | |
|  | Glucagon (subcutaneous injection) dosage | | | | | | | | | |  | | | | | | | | | | | | | | dosage = | | |  | | cc | | |

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| **Diet:** | | | | | | | | | | | | | | |
| Lunch time | |  | | | | Scheduled P.E. time | | |  | | Recess time | |  | |
| Snack times(s) | | |  | a.m. |  | | p.m. Location that snacks are kept | | |  | | Location eaten | |  |
|  | Child needs assistance with prescribed meal plan | | | | | | | Parents/Guardian and student are responsible for maintaining | | | | | | |
| necessary supplies, snack, testing kit, medications and equipment. | | | | | | | | | | | | | | |

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| **Field trip information:** |
| 1. Notify parent and school nurse in advance so proper training can be accomplished. |
| 2. Adult staff must be trained and responsible for student’s needs on field trip. |
| 3. Extra snacks, glucose monitoring kit, copy of health plan, glucose gel or other emergency supplies must |
| accompany student on field trip. |
| 4. Adults accompanying student on a field trip will be notified on a need to know basis. |

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| **People trained for blood testing and response:** | | | | |
| Name |  | | Date |  |
| Name |  | | Date |  |
| **Permission signatures:** | | | | |
| As parent/guardian of the above named student, I give permission for use of this health plan in my student’s school and | | | | |
| for the school nurse to contact the below providers regarding the above condition. Orders are valid through the end of the | | | | |
| current school year. | | | | |
| Parent signature | |  | Date |  |
| Nurse signature | |  | Date |  |
| Physician signature | |  | Date |  |