INDIVIDUALIZED SCHOOLHEALTH CARE PLAN: DIABETES

|  |  |
| --- | --- |
| 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 |  |

|  |  |
| --- | --- |
| **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 |  |

|  |
| --- |
| **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 |

|  |
| --- |
| **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. |

|  |
| --- |
| **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. |

|  |
| --- |
| **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 |  |