Clarksville-Montgomery Country School System

HEALTH SERVICES

DIABETES INDIVIDUAL HEALTH CARE PLAN

School Year 20____ - 20____

The **student's physician and parent/guardian should complete this plan**. Information provided will serve as a tool to manage the student's diabetes while at school. **Please print** information requested.

Part 1 (*Completed by parent/guardian*)

Student's Name:_____Grade:_____
DOB:_____Age of Diabetes Diagnosis:_____Teacher:_____
Type of diabetes: _____ Type 1 _____ Type 2

Contact Information
Parent(s)/Guardian:_____
Address:_____
_____
Telephone: _____ _____ _____
_____ _____ _____

Other Emergency Contacts
Name:_____ Phone:_____
Name:_____ Phone:_____
Physician:_____Telephone:_____Fax:_____
Address:_____

Part 2 (*Completed by Physician*)

Blood Glucose Monitoring
Target range for blood glucose is ____ 70-150 ____ 70 - 180 ____ Other_____
Usual times to check blood glucose_____
Times to do extra blood glucose checks (*check all that apply*)
____ before exercise
____ after exercise
____ when student exhibits symptoms of hyperglycemia
____ when student exhibits symptoms of hypoglycemia
____ other (explain)_____
Can student perform his/her own blood glucose checks? _____ Yes _____ No
Exceptions_____
Type of blood glucose meter student uses_____
Base dose of Insulin
____ Humalog/Novolog/Regular (circle type) insulin at lunch is _____units.
____ Flexible dosing using _____ units/ _____ grams carbohydrate
____ Intermediate/NPH/Lente/Lantus/Ultralente (circle type) insulin at lunch is _____units.
____ Additional comments_____
_____

Insulin Correction Doses
Parental Authorization should be obtained before administering a correction dose for high blood glucose levels.
_____ Yes _____ No

_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl

Can student give his/her own insulin injections? _____ Yes _____ No
Can student determine correct amount of insulin? _____ Yes _____ No
Can student draw correct dose of insulin? _____ Yes _____ No
_____ (Physician Initials) Parents are authorized to adjust the insulin dosage under the following circumstances:_____
_____

For Students With Insulin Pumps

Type of pump:_____ Basal rates: _____ 12am to _____
_____ _____ to _____
_____ _____ to _____
Type of insulin in pump_____
Type of infusion set_____
Insulin/carbohydrate ratio_____ Correction factor_____

Student Pump Abilities/Skill

Count carbohydrates	_____ Yes	_____ No
Bolus correct amount for carbohydrates consumed	_____ Yes	_____ No
Calculate and administer corrective bolus	_____ Yes	_____ No
Calculate and set temporary basal rate	_____ Yes	_____ No
Disconnect pump	_____ Yes	_____ No
Reconnect pump at infusion set	_____ Yes	_____ No
Prepare reservoir and tubing	_____ Yes	_____ No
Insert infusion set	_____ Yes	_____ No
Troubleshoot alarms and malfunctions	_____ Yes	_____ No

For Students Taking Oral Diabetes Medications

Medication Dose Time of dose
_____
_____

Meals and Snacks Eaten at School

Is student independent in carbohydrate calculations and management? _____ Yes _____ No

Meals/Snack	*Time*	*Food content/amount*
Breakfast	_____	_____
Mid-morning snack	_____	_____
Lunch	_____	_____
Mid-afternoon snack	_____	_____

Snack before exercise? _____ Yes _____ No
Snack after exercise? _____ Yes _____ No
Other times to give snacks and content/amount_____
Preferred snack foods (to be provided by parent/guardian)_____
Instructions for when food is provided to the class (class party or food sampling)
_____
_____

Exercise and Sports

Fast-acting carbohydrates such as _____should be available at the site of exercise or sports. These will be provided by the parent/guardian.
Restrictions on activity, if any:_____
Student should not exercise if blood glucose level is below _____mg/dl or above _____mg/dl or if moderate to large ketones are present.

Hypoglycemia (*Low Blood Sugar*)

Usual symptoms of hypoglycemia_____
Treatment of hypoglycemia_____
_____
_____ Glucagon should be given if the student is unconscious, having a seizure, or unable to swallow.
Route _____ Dosage _____ Site for glucagon injection: _____ arm, _____thigh, _____other.
NOTE: IF GLUCAGON IS ADMINISTERED, EMS (911) IS CALLED.

Hyperglycemia (*High Blood Sugar*)

Usual symptoms of hyperglycemia_____
Treatment of hyperglycemia_____
_____
Urine should be checked for ketones when blood glucose levels are above _____ mg/dl.
Treatment for ketones_____
Supplies provided by parents/guardian for use at school
_____ Blood glucose meter, blood glucose test strips, batteries for meter
_____ Lancet device, lancets, alcohol pads
_____ Urine ketone strips
_____ Insulin vials and syringes
_____ Insulin pump and supplies
_____ Insulin pen, pen needles, insulin cartridges
_____ Fast acting source of glucose_____
_____ Glucagon emergency kits
Other physician orders_____
_____
_____

This Diabetes Individual Healthcare plan has been approved by:

Physician Name:_____Date:_____
Physician Signature:_____

Part 3 (Completed by parent/guardian)

I give permission to the school nurse and/or other designated staff member (Trained Diabetes Personnel) of the CMCSS to perform and carry out the diabetes care tasks or assist student with diabetes care tasks outlined in the Diabetes Individual Health Care Plan. I also consent to the release of the information contained in this Diabetes Individual Health Care Plan to CMCSS employees and emergency contact persons (listed in Part 1) on a need to know basis of this information, to maintain my child's health and safety.

I give permission for school nurse and Health Care Provider to exchange health care information about my child's diabetic condition and the management of the diabetic condition.

I am aware that the nurse will keep me informed (telephone or written communications) of eventful occurrences about my child's medical condition.

I am aware that it is my responsibility to provide all necessary supplies and snacks that my child needs for monitoring and managing his/her medical condition.

_____ _____

Parent(s)/Guardian Signature Date

SPACE BELOW FOR SCHOOL NURSE TO NOTE CHANGES IN PHYSICIAN'S ORDERS

HYPOGLYCEMIA
(Low Blood Sugar)
School year: _____

Student's Name: _____ Date of Plan: _____

School: _____ Teacher: _____ Grade: _____

Emergency Contact Information:

Mother / Guardian: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Father / Guardian: _____

Home phone: _____ Work phone: _____ Cell phone: _____

NEVER SEND OR LEAVE A STUDENT WITH SUSPECTED LOW BLOOD SUGAR ANYWHERE ALONE

Causes of Hypoglycemia:

- o Too much insulin
- o Delayed food
- o Missed food
- o Unscheduled exercise
- o Too much or too intense exercise

Onset:

- o Sudden

Symptoms:

Mild	***Moderate***	***Severe***
___Irritability ___Sweating	___Blurry Vision ___Headache	___Loss of consciousness
___Shakiness ___Paleness	___Confusion ___Weakness	___Seizure
___Weakness ___Anxiety	___Behavior change	___Inability to swallow
___Drowsiness ___Hunger	___Slurred speech	
___Dizziness ___Personality chang	___Poor coordination	
___Inability to concentrate	___Other_____	
___Other_____		
(check student's USUAL symptoms)	***(check student's USUAL symptoms)***	***(check student's USUAL symptoms)***

What to do:

Notify School Nurse or Trained Diabetic Personnel

Check Blood Sugar

When in doubt, always TREAT FOR HYPOGLYCEMIA

Mild / Moderate

- o Student ____ **MAY** / ____ **MAY NOT** treat self
- o Provide quick sugar source
  (3 - 4 glucose tablets OR 4 oz. juice OR 6 oz regular, non-diet, soda OR 3 tsp glucose gel)
- o Wait 10-15 minutes then recheck blood sugar
- o Repeat food if symptoms persist or if blood sugar is less than _____
- o Follow with a snack of protein and carbohydrate
  (cheese crackers OR peanut butter crackers)

Severe

- o Do **NOT** attempt to give anything by mouth
- o Contact School Nurse or Trained Diabetic Personnel
- o Administer glucagon
- **Location:** _____
- o Position student on side
- o Call 911
- o Contact parents / guardian.

HYPERGLYCEMIA
(High Blood Sugar)
School year: _____

Student's Name: _____ Date of Plan: _____

School: _____ Teacher: _____ Grade: _____

Emergency Contact Information:

Mother / Guardian: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Father / Guardian: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Causes of Hyperglycemia:		***Onset:***
o Too much food	o Illness	o Over time - several hours or days
o Too little insulin	o Infection	
o Decreased activity	o Stress	

Symptoms:

Mild	***Moderate***	***Severe***
___Thirst	MILD SYMPTOMS PLUS:	MILD and MODERATE SYMPTOMS PLUS:
___Frequent urination	___Dry mouth	___Labored breathing
___Fatigue/sleepiness	___Stomach cramps	___Very weak
___Increased hunger	___Nausea	___Confused
___Blurred vision	___Vomiting	___Unconscious
___Weight loss	___ Other_____	
___Stomach pains		
___Flushed skin		
___Lack of concentration		
___Sweet, fruity breath		
___Other_____		
(check student's USUAL symptoms)	***(check student's USUAL symptoms)***	***(check student's USUAL symptoms)***

What to do:

o Allow student free use of the bathroom	o Administer insulin per Diabetic IHP
o Encourage student to drink water	o If student has nausea, vomiting or is lethargic
o Contact School Nurse or Trained Diabetic Personnel	contact parent/guardian
o Check urine for ketones, if indicated	o If parent/guardian not available, call **911**

PLEASE NOTE:

____ Student is permitted, per IHP, to carry testing supplies and check blood sugar anywhere but **CANNOT treat high blood sugar per self. REQUIRES DIRECT ADULT SUPERVISION.**

____ Student is permitted, per IHP, to carry testing supplies as well as insulin; **MAY** test and treat self anywhere without direct adult supervision.