Clarksville-Montgomery Country School System
DIABETES INDIVIDUAL HEALTH CARE PLAN

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** below.

Student's Name:_____DOB:_____School Year: 20___ - 20 ___
School: _____Teacher:_____Grade:_____

Age of Diabetes Diagnosis:_____Diabetes: Type 1 [ ] Type 2 [ ]
Emergency Contact Information
Parent(s)/Guardian: _____ Phone: _____
Name:_____ Phone:_____

Physician:_____Telephone:_____Fax:_____
Address:_____

Part 1 (*Completed by Physician*)

__ Student requires *Direct Adult Supervision*. Student is permitted to carry testing supplies and check blood sugar anywhere but cannot administer insulin per self.

__ Student may *Independently* test blood glucose, administer insulin, and keep all diabetes supplies with them anywhere on school property.

Insulin Correction Doses
_____Humalog/Novolog/Regular (circle type) insulin is _____units for every _____ grams of carbohydrates.
_____ Flexible dosing using _____ units for every _____ grams carbohydrate.
_____ Intermediate/NPH/Lente/Lantus/Ultralente (circle type) insulin is _____units.

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
Parent/Guardian may modify doses and sliding scale within 1-2 units. [ ] 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
_____ units if blood glucose monitor reads HIGH

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_____

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For Students Taking Oral Diabetes Medications
Medication Dose Time of dose

Blood Glucose Monitoring
Target range for blood glucose is ____ 70-150 ____ 70 - 180 ____ Other: _____

Hypoglycemia (*Low Blood Sugar*)
Usual symptoms of hypoglycemia_____
Treatment of hypoglycemia: If student is awake and able to swallow, give 15 grams of fast acting carbohydrates. Retest glucose 15 minutes after treatment and repeat until glucose is over 70 mg/dl.
_____ 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_____

This Diabetes Individual Healthcare plan has been approved by:

Physician Name:_____ Date:_____
Physician Signature:_____

Part 2 (*Completed by parent/guardian*)

Blood Glucose Monitoring:

[ ] Before breakfast	[ ] Before PE/ Activity Time
[ ] Midmorning, before snack	[ ] After PE/ Activity Time
[ ] Before Lunch	[ ] Mid afternoon
[ ] Dismissal	[ ] As needed for signs/symptoms of low/high blood glucose

Can student perform his/her own blood glucose checks? _____ Yes _____ No
Type of blood glucose meter: _____

Meals and Snacks Eaten at School
Can student independently determine correct portions and number of carbohydrate servings: [ ] Yes [ ] No
Can student independently calculate carbohydrate grams accurately: [ ] Yes [ ] No

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)

Student Pump Abilities/Skills

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

Exercise and Sports

- Quick access to sugar-free liquids, fast-acting carbohydrates, and snacks should be available at the site. 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.
- Activity mode will be initiated on pump 30 minutes prior to start of activity and discontinue after activity has ended. [ ] Yes [ ] No

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
Additional comments_____
_____

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