

Diabetes Individual Health Plan

**Attach the Diabetes Management and Treatment Plan from licensed health care practitioner responsible for the student's diabetes treatment.

Date of Plan: _____ Original Revision
Student's Name: _____ STN: _____
Date of Birth: _____ Date of Diabetes Diagnosis: _____
Grade: _____ Homeroom Teacher: _____
Diabetes: Type 1 Type 2 Other: _____

Contact Information

Mother/Guardian: _____
Address: _____
Telephone: Home _____ Work _____ Cell _____

Father/Guardian: _____
Address: _____
Telephone: Home _____ Work _____ Cell _____

Student's Doctor/Health Care Provider:

Name: _____
Address: _____
Telephone: _____ Emergency Number: _____

1. 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 own blood glucose checks? Yes No

2. Insulin

Type and time administered: _____

Can student give own injections? Yes No

Can student determine correct amount of insulin? Yes No

Can student draw correct dose of insulin? Yes No

Student has insulin pump: Yes No (Refer to Diabetes Management and Treatment Plan)

Student takes oral medications: Yes No (Refer to Diabetes Management and Treatment Plan)

Supplies kept at school: _____ Location _____

- | | |
|---|---|
| <input type="checkbox"/> Glucometer, glucose test strips | <input type="checkbox"/> Insulin pen, pen needles, insulin cartridges |
| <input type="checkbox"/> Lancet device, lancets, gloves, etc. | <input type="checkbox"/> Fast-acting source of glucose |
| <input type="checkbox"/> Urine ketone strips | <input type="checkbox"/> Carbohydrate containing snack |
| <input type="checkbox"/> Insulin pump and supplies | <input type="checkbox"/> Glucagon emergency kit |

Student carries supplies: Yes No

3. Meals and Snacks

Is student independent in carbohydrate calculations and management? Yes No

<i>Meal/Snack</i>	<i>Time</i>	<i>Food content/amount</i>
Breakfast	_____	_____
Mid-morning snack	_____	_____
Lunch	_____	_____
Mid-afternoon snack	_____	_____
Dinner	_____	_____

Snack before exercise: Yes No

Snack after exercise: Yes No

Other times to give snacks/amounts: _____

Preferred snack foods: _____

Foods to avoid, if any: _____

4. Exercise and Sports

A fast-acting carbohydrate such as _____ should be available at the site of exercise or sports.

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 urine ketones are present.

5. Hypoglycemia (Low Blood Sugar)

Usual symptoms of hypoglycemia: _____

Treatment of hypoglycemia: _____

Glucagon should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow.

Route _____ Dosage _____, site for glucagons injection: arm thigh
 other _____

If glucagon is required, administer it promptly. Then, call 911 (or other emergency assistance) and the parents/guardian.

6. 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: _____

7. Field Trips and Extracurricular Activities

The student's diabetes supplies such as blood glucose monitor and fast acting sugar sources and snack MUST accompany the teacher on all field trips and extracurricular activities on or away from school premises.

A diabetes trained staff member should be available on field trips or at the site of the extracurricular activity on or away from the school premises unless the parent is able and wishes to attend.

Signatures

Participants:

Physician/Health Care Provider

Principal/Designee

Parent/Guardian

Teacher

School Nurse

Other

I give permission to the school nurse, trained diabetes personnel, and other designated staff members, including volunteer health aide(s), to perform and carry out the diabetes care tasks as outlined by my student's Diabetes Individual Health Plan. I understand that, as provided under Indiana Code 34-30-14, the volunteer health aide(s) are not liable for civil damages for assisting in my student's care. I also consent to the release of the information contained in this Diabetes Individual Health Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

Parent/Guardian

Date

This plan should be reviewed with relevant school staff and copies should be kept in the student's cumulative record and the school clinic.