BISHOP HEELAN CATHOLIC SCHOOLS

DIABETES INDIVIDUAL HEALTH PLAN

NAME: _____ **Date of Birth:** _____

Doctor for Diabetes: _____ Phone:_____

BLOOD GLUCOSE (BG) MONITORING: Student can: Perform own BG checks? ☐ Yes ☐ No
Interpret results? ☐ Yes ☐ No
Needs Supervision? ☐ Yes ☐ No

BG target range: _____mg/dl - _____mg/dl. Type of meter: _____
Notify parent if BG out of target range? ____ YES ____ NO

Time to be performed:
☐ Midmorning before snack
☐ Before lunch
☐ Before PE ____ After PE
☐ Before am recess ____ Before pm recess
☐ Midafternoon ____ End of school day
☐ As needed for low/high blood glucose symptoms/signs

Place to be performed: ☐ Classroom ☐ Health office ☐ Other_____

MEALS/SNACKS: Student : ____ Able to calculate carbohydrate grams accurately.
____ Able to calculate insulin dose based on BG & carbs eaten.
____ Unable to do calculations.

Student will eat: ____ Eat cold lunch ____ Eat hot lunch

Directions if outside food for party, birthday, & snacks provided to class:

INSULIN INJECTIONS AT SCHOOL: ____ Yes ____ No

Insulin delivery: ____ Syringe/Vial ____ Pen ____ Pump

Insulin Name: _____ Dose _____ Time to be given _____

Calculate insulin dose based on BG & carb intake? ____ Yes ____ No
If yes, use _____ # unit(s) per _____ grams carbohydrate

Calculate insulin dose based on sliding scale?(attached) ____ Yes ____ No

Can student:
Calculate correct dose? ____ Yes ____ No
Draw/dial up correct dose? ____ Yes ____ No
Give own injection? ____ Yes ____ No
Operate pump on own? ____ Yes ____ No
Needs supervision ____ Yes ____ No
Use correction dose of insulin for high BG? ____ Yes ____ No
If yes, provide school with sliding scale of blood glucose, insulin name, insulin dose.

PE, RECESS, OTHER PHYSICAL ACTIVITY AT SCHOOL:
No exercise if BG is below _____ mg/dl or above _____mg/dl. Ketone check if BG is _____
Notify parent of:

MANAGEMENT OF LOW BLOOD GLUCOSE: **(below _____ mg/dl)**

Usual signs/symptoms for student are:

____ Hunger
____ Change in behavior
____ Paleness
____ Shakiness/weakness
____ Tiredness/sleepiness
____ Headache
____ Clamminess/sweating
____ Dizziness
____ Blurred Vision
____ Inattention/confusion
____ Nausea

Follow treatment w/snack of _____ if more than 1 hour until next full meal.

Other:

Indicate treatment choices:

If student is awake and able to swallow, give
_____ *grams fast acting carb such as:*

____ 4 oz. Fruit juice
____ Glucose Tabs ____ # of tabs to be given
____ Glucose Gel tube
____ Other _____
_____

Retest blood glucose 15 minutes after treatment?
_____ Yes _____ No

Repeat treatment until BG is over _____

MANAGEMENT OF HIGH BLOOD GLUCOSE: **(over _____ mg/dl)**

Usual signs/symptoms for student are:

____ Increased thirst, urination, appetite
____ Tiredness/sleepiness
____ Blurred vision
____ Warm, dry, flushed skin
____ Other _____

Indicate treatment choices:

____ Sugar free fluids
____ Check ketones is BG over _____ mg/dl
____ No Need to check ketones.
____ Notify parent if ketones other than negative.
____ May not need snack; call parent.
____ Correction insulin dose for high BG/sliding scale

IMPORTANT

If student is unconscious or having a seizure, presume the student is having a low BG:
Call 911, and Call parent at_____
____ Glucagon ½ mg OR 1 mg (circle prescribed dose) should be given by trained personnel.
Turn student on side after Glucagon injection as student may vomit.

PARENT/GUARDIAN WILL PROVIDE:

1) Up-to-date information regarding student's diabetes management.
2) Supplies/snacks /quick sugar items for diabetes management.
3) Signed medication/procedure authorization forms annually.

I have read the above plan and I have made changes that I felt necessary to the plan. I understand that the above plan will remain in place as long as my child is a student in the Bishop Heelan Catholic School District. I understand that it is my responsibility to notify the designated school staff when changes to the plan need to be made. I give permission for the information in this plan to be shared with my child's teachers, health staff and other school staff as deemed necessary.

Parent/Guardian Signature_____ **Date**_____

Physician Signature_____ **Date**_____

Staff Use Only----------

Date plan sent/given to parent/guardian_____Date plan returned to school_____

Names of designated school staff who are competent per school and family to administer care to student:

Name_____Date_____

Name_____Date_____

Name_____Date_____

Name_____Date_____

(July 2011)