

**TOWNSHIP OF UNION PUBLIC SCHOOLS
INDIVIDUALIZED HEALTH CARE PLAN
DIABETES**

Effective Date(s): _____

This plan should be completed by the student's personal health care team and parents/guardian.

Student's Name: _____

Date of Birth: _____ Date of Diabetes Diagnosis: _____

Grade: _____ Homeroom Teacher: _____

Physical Condition: Diabetes type 1 Diabetes type 2

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: _____

Other Emergency Contacts:

Name: _____

Relationship: _____

Telephone: Home _____ Work _____ Cell _____

Notify parent/guardian or emergency contact in the following situations: _____

Diabetes Health Care Plan *Continued*

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

Exceptions: _____

Type of blood glucose meter student uses: _____

Insulin

Usual Lunchtime Dose

Base dose of Humalog/Novolog/Regular insulin at lunch (circle type of rapid-/short-acting insulin used is _____ units or does flexible dosing using _____ units/ _____ grams carbohydrate. Use of other insulin at lunch: (circle type of insulin used): intermediate/NPH/lente _____ units or basal/Lantus/Ultralente _____ units.

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

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

_____ Parents are authorized to adjust the insulin dosage under the following circumstances: _____

For students with Insulin Pumps

Type of pump: _____ Basal rates: _____ 12 am to _____
_____ to _____
_____ to _____

Type of insulin in pump: _____

Type of infusion set: _____

Insulin/carbohydrate ratio: _____ Correction factor: _____

Diabetes Health Care Plan *Continued*

Student Pump Abilities/Skills

Needs Assistance

- Count carbohydrates Yes No
- Bolus correct amount for carbohydrates consumed Yes No
- Calculate and administer corrective bolus Yes No
- Calculate and set basal profiles 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

Type of medication: _____ Timing: _____

Other medications: _____ Timing: _____

Meals and Snacks Eaten at School

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 and content/amount: _____

Preferred snack foods: _____

Foods to avoid, if any: _____

Instruction for when food is provided to the class (e.g., as part of a class party or food sampling event):

Exercise and Sport

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.

Diabetes Health Care Plan *Continued*

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 9-1-1 (or other emergency assistance) and the parents/guardian.

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 to be Kept at School

- | | |
|---|--|
| _____ Blood glucose meter, blood glucose test | _____ Insulin pump and supplies |
| _____ Strips, batteries for meter | _____ Insulin pen, pen needles, cartridges |
| _____ Lancet device, lancets, gloves, etc. | _____ Fast-acting source of glucose |
| _____ Urine ketone strips | _____ Carbohydrate containing snack |
| _____ Insulin vials and syringes | _____ Glucagon emergency kit |

Signatures

This diabetes Medical Management Plan has been approved by:

Student's Physician/Health Care Provider Date

I give permission to the school nurse, trained diabetes personnel, and other designated staff members of _____ school to perform and carry out the diabetes care tasks outlined by _____'s Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical management 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.

Acknowledged and received by:

Student's Parent/Guardian Date

Student's Parent/Guardian Date

**TOWNSHIP OF UNION BOARD OF EDUCATION
UNION, NJ 07083**

Pupil's Name _____ School _____

Address _____ Teacher _____

Telephone No. _____ Grade _____

Description of medication provided by physician _____

Diagnosis: _____

School nurse is instructed to administer _____ in
the following manner _____

Medication to be administered from _____ to _____

Consideration for Field Trips:

The above named student may skip the dose of prescribed medication on a field day trip.

The above named student may take the prescribed medication upon returning to school from a field trip.

Date _____
(Physician's Signature & Stamp Required)

The school nurse is requested to administer to _____
(Child's Name)
the medication prescribed by the above-named physician.

Signature of Parent/Guardian _____

The completion of this form is the responsibility of the parent. Upon its completion, it is to be given to the school nurse who will give the medication prescribed. This form will be filed in the office of the school nurse.

**MEDICATION MUST BE BROUGHT TO SCHOOL BY PARENT IN THE
PRESCRIPTION CONTAINER AND HANDED TO THE NURSE.**

For School Nurses Use Only:

Date Received	# of Received	Received From/Print Name	Signature	Given to/Print Name	Signature

MEDICATION RECORD: ADMINISTRATION – PHYSICIAN'S ORDER

School Year: _____ School: _____

Student: _____ DOB: ____/____/____ Teacher: _____ Room: _____

MONTHS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
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