

## INDIVIDUAL HEALTH PLAN DIABETES

Student:	School:
Birthdate:	Grade:
Address:	Phone:
Physician:	Mother:
Contact number:	Home:
	Work:
	Pager/Cell Phone:
Effective date:	Father:
Parent-designated adult:	Home:
Home phone:	Work:
Cell phone:	Pager/Cell Phone:

Brief History:

Age of onset:
Date(s) of recent hospitalizations:
Concurrent illness or disability:
Related social/emotional factors:

Level of Independence (attach copy of "HCP Orders for Children with Diabetes in Washington State Schools")

**PURPOSE:** To promote student self-management of diabetes, recognize signs of high and low blood sugar, and provide appropriate assistance and/or emergency care.

**PLAN:** Daily Diabetes Routines

- **Daily snacks at school (time):** \_\_\_\_\_
- **Recess times:** \_\_\_\_\_ a.m. \_\_\_\_\_ p.m.
- **Blood sugar monitoring:**  
Time: \_\_\_\_\_ Location: \_\_\_\_\_  
Additional tests: as needed when having symptoms of low blood sugar.
- **Insulin injection:**  
Time: \_\_\_\_\_ Location: \_\_\_\_\_
- **Lunch eaten at (time):** \_\_\_\_\_
- **PE days and times:** \_\_\_\_\_

**BLOOD SUGAR** normal range from \_\_\_\_\_ to \_\_\_\_\_      **CALL PARENT IF** below \_\_\_\_\_  
above \_\_\_\_\_

**1) In event of field trips, all diabetes supplies are taken and care is provided:**

- By accompanying parent or parent-designated adult.
- According to procedure developed prior to field trip.
- According to low/high blood sugar school plans.
- Notify parent prior to planned field trip.

**2) In event of classroom/school parties, food treats will be handled as follows:**

- Student will eat treat.
- Replace with parent supplied alternative.
- Modify the treat as follows:
- Schedule extra insulin per prearranged plan.

**3) Scheduled after school activities:**

- List:
- Low/high blood sugar after school plan to:
  - Supervisor with instruction.
  - Parent-designated adult.

**4) Attach copies of High Blood Sugar School Plan and Low Blood Sugar School Plan\*.**

**\*NEVER SEND A CHILD WITH LOW OR HIGH BLOOD SUGAR ANYWHERE ALONE.**

**5) Activities student can self manage:**

- Totally independent management.

**OR**

**A. Blood sugar monitoring:**

- Student monitors independently.
- Student monitors with verification of number on meter by designated staff.
- Student needs help with monitoring → to be done by parent-designated adult.
- Monitoring needs to be done by → parent-designated adult.

**B. Insulin injection:**

- Administers independently.
- Student self injects with verification of number on insulin pen by designated staff.
- Student self injects (syringe or pen) with → supervision and/or administration by → parent-designated adult.
- Administration by → parent-designated adult.

**C.  Self treats mild hypoglycemia.**

**D.  Monitors own snacks and meals.**

**E.  Monitors and interprets own ketones.**

**F.  Student implements universal precautions when lancing finger and disposing of lancets/syringes.**

**6) Equipment and Supplies:**

<b>EQUIPMENT AND</b>	<b>Blood Sugar Meter Kit</b> (includes	<b>Disaster Supplies (check x):</b>
----------------------	--	-------------------------------------

<b>SUPPLIES PROVIDED BY PARENT.</b>	<p>all blood monitoring supplies for school).</p> <p><b>Low Blood Sugar Supplies:</b></p> <p>_____</p> <p>_____</p> <p><b>For Example:</b></p> <ul style="list-style-type: none"> <li>• Fast-acting carbohydrate drinks: apple juice and/or orange juice and soda pop (regular, not diet)–6 pack.</li> <li>• Glucose tablets.</li> <li>• Glucose gel product.</li> <li>• Gel Cakemate (not frosting) (19gm. Mini-purse size).</li> <li>• Pre-packaged snacks (such as cracker/cheese; crackers/peanut butter, etc.) times 5–6.</li> </ul> <p><b>Daily Snacks:</b> (for a.m./p.m. snack times): _____</p> <p>_____</p>	<p><input type="checkbox"/> Food supply for 3 days stored in: _____</p> <p><input type="checkbox"/> Low blood sugar supplies.</p> <p><input type="checkbox"/> Medication and medical supplies stored in: _____</p> <p>_____</p> <p><input type="checkbox"/> Insulin pen and needles.</p> <p><input type="checkbox"/> Insulin and syringes.</p> <p><b>Other Supplies</b> (specify): _____</p> <p>_____</p> <p>_____</p> <p><b>Disaster Plan attached.</b></p>
-------------------------------------	---	--

**Date of next plan review:** \_\_\_\_\_

Must be reviewed before the next school year unless there is a change requiring earlier revision.

<b>Parent</b>	<b>Date</b>	<b>School Nurse</b>	<b>Date</b>
<b>Student</b>	<b>Date</b>	<b>Physician (optional) MD/DO/PA/ARNP</b>	<b>Date</b>
<b>Parent-designated adult (if one has been assigned)</b>			<b>Date</b>