

## INDIVIDUAL HEALTH PLAN DIABETES INDEPENDENT MANAGEMENT

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

Brief History:

Age of onset:
Date(s) of recent hospitalizations:
Concurrent illness or disability:

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

- **Blood sugar monitoring:**  
Time: \_\_\_\_\_ Location: \_\_\_\_\_  
Additional tests: as needed when having symptoms of low blood sugar.
- **Insulin injection:**  
Time: \_\_\_\_\_ Location: \_\_\_\_\_
- **Lunch eaten at (time):** \_\_\_\_\_

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

**1) Scheduled after school activities:**

List: \_\_\_\_\_

**2) 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.**

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**3) Student is:**

Totally independent in management of their diabetes.

**4) Equipment and Supplies:**

<p><b>EQUIPMENT AND SUPPLIES PROVIDED BY PARENT.</b></p>	<p><b>Blood Sugar Meter Kit</b> (includes 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><b>Disaster Supplies (check x):</b></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><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>
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**Date of next plan review:** \_\_\_\_\_

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

\_\_\_\_\_  
**Parent** **Date** **School Nurse** **Date**

\_\_\_\_\_  
**Student** **Date** **Physician (optional)** **Date**  
**MD/DO/PA/ARNP**

\_\_\_\_\_  
**Parent-designated adult (if one has been assigned)** **Date**