

**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.**

3) Student is:

Totally independent in management of their diabetes.

4) Equipment and Supplies:

<p>EQUIPMENT AND SUPPLIES PROVIDED BY PARENT.</p>	<p>Blood Sugar Meter Kit (includes all blood monitoring supplies for school). Low Blood Sugar Supplies: _____ _____</p> <p>For Example:</p> <ul style="list-style-type: none"> • Fast-acting carbohydrate drinks: apple juice and/or orange juice and soda pop (regular, not diet)–6 pack. • Glucose tablets. • Glucose gel product. • Gel Cakemate (not frosting) (19gm. Mini-purse size). • Pre-packaged snacks (such as cracker/cheese; crackers/peanut butter, etc.) times 5–6. <p>Daily Snacks: (for a.m./p.m. snack times): _____ _____</p>	<p>Disaster Supplies (check x):</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>Other Supplies (specify): _____ _____ _____</p> <p>Disaster Plan attached.</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
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Student	Date	Physician (optional) MD/DO/PA/ARNP	Date
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Parent-designated adult (if one has been assigned)	Date
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