



Clarksville-Montgomery Country School System
HEALTH SERVICES
DIABETES INDIVIDUAL HEALTH CARE PLAN
School Year 20 ____ - 20 ____

The **student's physician and parent/guardian should complete this plan**. Information provided will serve as a tool to manage the student's diabetes while at school. **Please print** information requested.

Part 1 (*Completed by parent/guardian*)

Student's Name: _____ Grade: _____
 DOB: _____ Age of Diabetes Diagnosis: _____ Teacher: _____
 Type of diabetes: _____ Diabetes type 1 _____ Diabetes type 2 _____

Contact Information

Parent(s)/Guardian: _____
 Address: _____
 Telephone: _____

Other Emergency Contacts

Name: _____ Phone: _____
 Name: _____ Phone: _____
 Physician: _____ Telephone: _____ Fax: _____
 Address: _____

Part 2 (*Completed by Physician*)

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 _____
 Base dose of Insulin
 _____ Humalog/Novolog/Regular (circle type) insulin at lunch is _____ units.
 _____ Flexible dosing using _____ units/ _____ grams carbohydrate
 _____ Intermediate/NPH/Lente/Lantus/Ultralente (circle type) insulin at lunch is _____ units.
 Additional comments _____

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
 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

(Physician Initials) Parents are authorized to adjust the insulin dosage under the following circumstances: _____

For Students With Insulin Pumps

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

Type of insulin in pump _____

Type of infusion set _____

Insulin/carbohydrate ratio _____ Correction factor _____

Student Pump Abilities/Skill

Count carbohydrates	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bolus correct amount for carbohydrates consumed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculate and administer corrective bolus	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculate and set temporary basal rate	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Disconnect pump	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reconnect pump at infusion set	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prepare reservoir and tubing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Insert infusion set	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Troubleshoot alarms and malfunctions	<input type="checkbox"/> Yes	<input type="checkbox"/> No

For Students Taking Oral Diabetes Medications

Medication	Dose	Time of dose
_____	_____	_____
_____	_____	_____

Meals and Snacks Eaten at School

Is student independent in carbohydrate calculations and management? Yes No

<i>Meals/Snack</i>	<i>Time</i>	<i>Food content/amount</i>
Breakfast	_____	_____
Mid-morning snack	_____	_____
Lunch	_____	_____
Mid-afternoon snack	_____	_____

Snack before exercise? _____ Yes _____ No

Snack after exercise? _____ Yes _____ No

Other times to give snacks and content/amount _____

Preferred snack foods (to be provided by parent/guardian) _____

Instructions for when food is provided to the class (class party or food sampling) _____

Exercise and Sports

Fast-acting carbohydrates such as _____ should be available at the site of exercise or sports. These will be provided by the parent/guardian.

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 ketones are present.

Hypoglycemia (*Low Blood Sugar*)

Usual symptoms of hypoglycemia _____

Treatment of hypoglycemia _____

_____ Glucagon should be given if the student is unconscious, having a seizure, or unable to swallow.

Route _____ Dosage _____ Site for glucagon injection: _____ arm, _____ thigh, _____ other.

NOTE: IF GLUCAGON IS ADMINISTERED, EMS (911) IS CALLED.

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 provided by parents/guardian for use at school

_____ Blood glucose meter, blood glucose test strips, batteries for meter

_____ Lancet device, lancets, alcohol pads,

_____ Urine ketone strips

_____ Insulin vials and syringes

_____ Insulin pump and supplies

_____ Insulin pen, pen needles, insulin cartridges

_____ Fast acting source of glucose _____

_____ Glucagon emergency kits

Other physician orders _____

This Diabetes Individual Healthcare plan has been approved by:

Physician Name: _____ Date: _____

Physician Signature: _____

Part 3 (Completed by parent/guardian)

I give permission to the school nurse and/or other designated staff member (Trained Diabetes Personnel) of the CMCSS to perform and carry out the diabetes care tasks or assist student with diabetes care tasks outlined in the Diabetes Individual Health Care Plan. I also consent to the release of the information contained in this Diabetes Individual Health Care Plan to CMCSS employees and emergency contact persons (listed in Part 1) on a need to know basis of this information, to maintain my child's health and safety.

I give permission for school nurse and Health Care Provider to exchange health care information about student's diabetic condition and the management of the diabetic condition.

I am aware that the nurse will keep me informed (telephone or written communications) of eventful occurrences about my child's medical condition.

I am aware that it is my responsibly to provide all necessary supplies and snacks that my child needs for monitoring and managing his/her medical condition.

Parent(s)/Guardian Signature

Date

SPACE BELOW FOR SCHOOL NURSE TO NOTE CHANGES IN PHYSICIAN'S ORDERS

Clarksville-Montgomery County School System
HEALTH SERVICES
QUICK REFERENCE EMERGENCY PLAN FOR
HYPOGLYCEMIA (Low Blood Sugar)

Student's Name _____

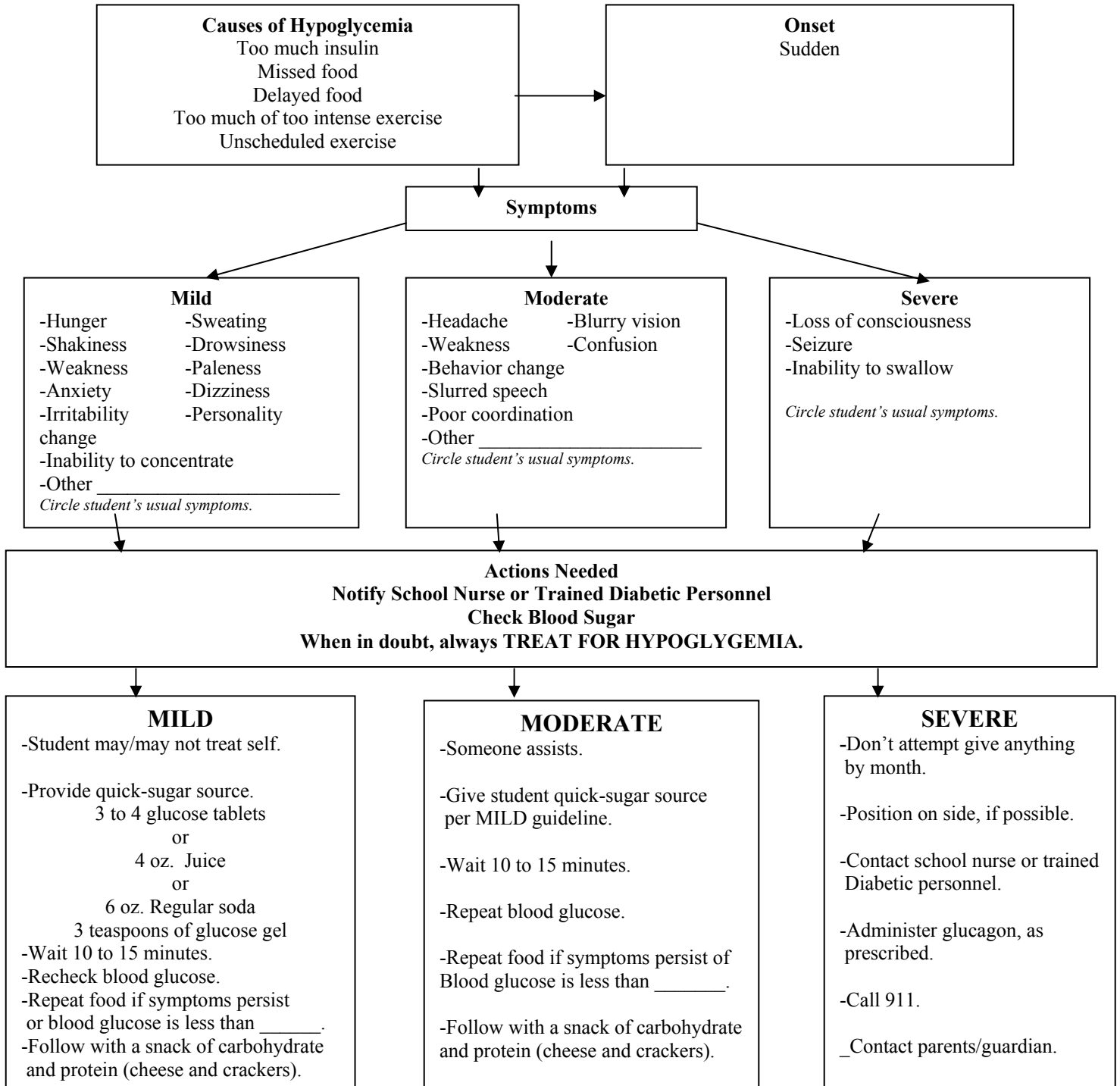
Grade _____

Teacher _____

Date _____

Refer to Student's Diabetes Individual Health Care Plan for information on management of medical condition and for contact information.

Never Send A Child With Suspected Low Blood Sugar Anywhere Alone



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HYPERGLYCEMIA (High Blood Sugar)

Student's Name _____

Grade _____

Teacher _____

Date _____

Refer to Student's Diabetes Individual Health Care Plan for information on management of medical condition and for contact information.

