



**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 his/her 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 his/her own insulin 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 \_\_\_\_\_ Yes \_\_\_\_\_ No
- Bolus correct amount for carbohydrates consumed \_\_\_\_\_ Yes \_\_\_\_\_ No
- Calculate and administer corrective bolus \_\_\_\_\_ 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**

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 my child'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 responsibility to provide all necessary supplies and snacks that my child needs for monitoring and managing his/her medical condition.

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Parent(s)/Guardian Signature

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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 \_\_\_\_\_

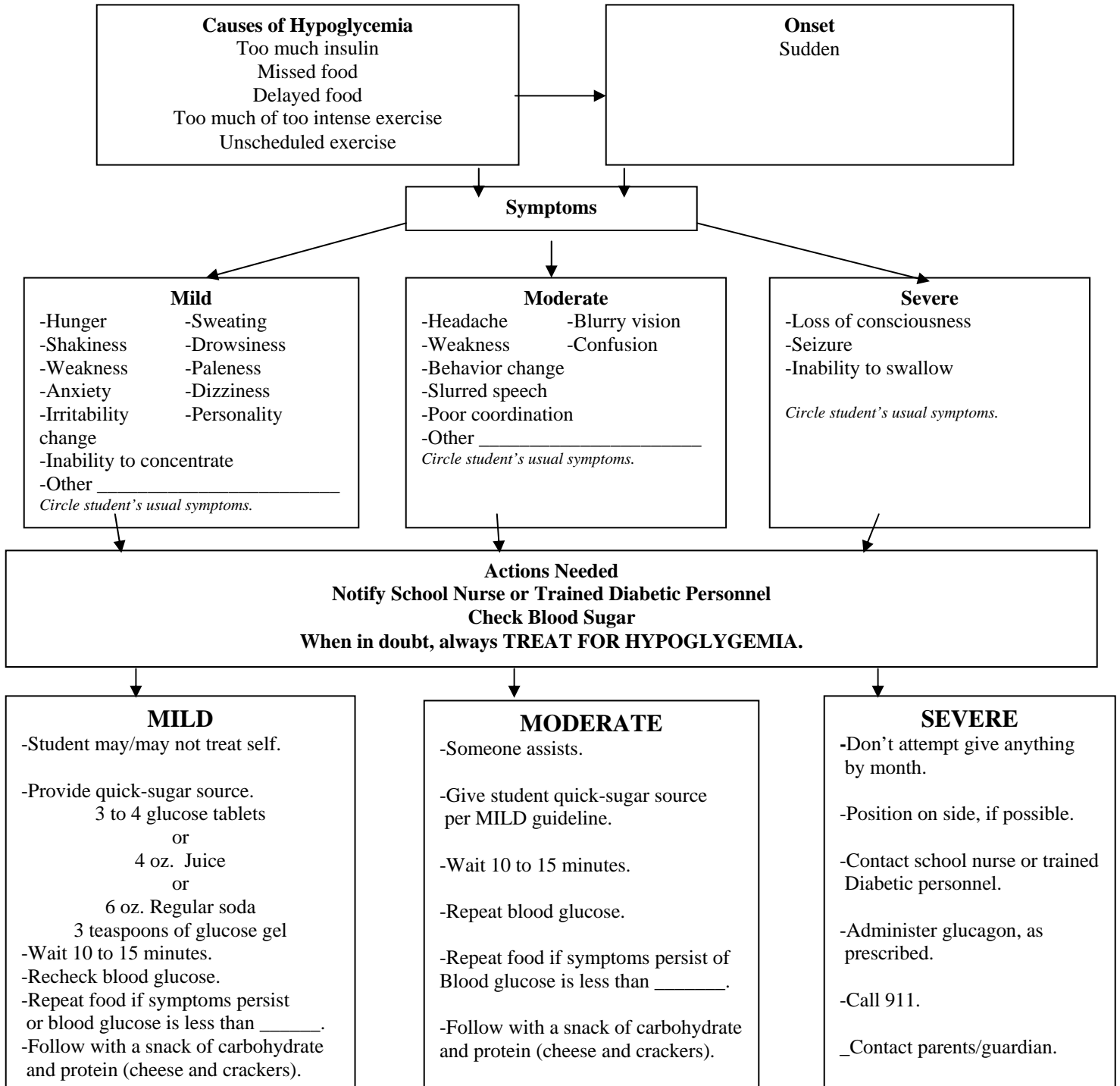
Grade \_\_\_\_\_

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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**HEALTH SERVICES**  
**QUICK REFERENCE EMERGENCY PLAN FOR**  
***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.

