Individualized Health Plan: Diabetes

CONROE INDEPENDENT SCHOOL DISTRICT
Committed to Excellence

Date: _____

Student's name: _____ Grade: _____ Homeroom teacher: _____

Date of Birth: _____ Date/age diagnosed: _____ Diabetes diagnosis: ☐ type 1 ☐ type 2

Parent/Guardian #1: Name _____

Home _____ Work _____ Cell _____

Parent/Guardian #2: Name _____

Home _____ Work _____ Cell _____

Other Contact: Name _____ Phone # _____

Physician _____ Phone # _____

Blood Glucose Usual times to test glucose at school _____

BG testing *(check any that apply)* ☐ before exercise ☐ after exercise

☐ other *(explain)*: _____

Can student perform own test? ☐ Yes ☐ No

Hypoglycemia Symptoms: _____

Glucose level mandating treatment if no symptoms _____

Treatment _____

Glucagon *(dose)* _____ Expiration _____

Activity restriction *(if applicable)* _____

Hyperglycemia Symptoms: _____

Blood glucose to test for ketones _____

Treatment _____

Sliding scale correction dose: _____ units if BG is _____ to _____ mg/dl _____ units if BG is _____ to _____ mg/dl

_____ units if BG is _____ to _____ mg/dl _____ units if BG is _____ to _____ mg/dl

Activity restriction *(if applicable)* _____

Insulin Time: _____ ☐ a.m. ☐ p.m. Dose _____ by *(check one)* ☐ syringe ☐ pen ☐ pump

Can student give own injections? ☐ Yes ☐ No Supervision required? ☐ Yes ☐ No

Flex insulin dosage: *Insulin type* _____, _____ *units to* _____ *gms carbohydrates*

Insulin pump: *type* _____ *Basal rates* _____ *time* _____ *to* _____ *insulin type* _____

Insulin/carbohydrate ratio _____ Correction factor _____

Insulin type _____ Infusion set _____

Type II Diabetes Medication: _____ Daily calories _____

Meals and snacks Times in school: _____

Circumstances requiring parent notification: _____

I give permission to the school nurse, trained diabetes personnel, and other designated staff members of _____ school to perform and carry out the diabetes care tasks as outlined by _____'s Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

_____ *School nurse*

_____ *Parent/guardian*

_____ *Administrator*

_____ *Faculty representative*