Educational Service Center of Medina County
"Stepping Up to Excellence"

Student Photo ID

Confidential

DIABETIC HEALTHCARE PLAN

Student's Name:	**School/Grade:**
Date of Birth:	**Contact Teacher:**
Parent/Guardian Name:	**Phone (Family):**
Address:	
Physician: **Endocrinologist:**	**RN:**
Emergency Number:	
Emergency Number:	
Emergency Number:	

Health Condition: Type I Diabetic with Insulin Injection or Insulin Pump **Date:** _____

Medications: Glucagon, Glucose Tablets, Insulin, _____

Goals: Student will participate daily in normal activities, foster independence, and maintain target blood glucose.

Target Blood Glucose: _____ **MUST CALL PARENT IF BG IS UNDER _____ OR OVER _____.**

1. **Supplies**:

   ____ Glucometer ____ Glucose test strips ____ Lancets ____ Glucagon ____ Insulin syringes

   ____ Insulin ____ Glucose tablets/liquid ____ Juice ____ Crackers/snack

   Because of lockdown procedures, all lecture classes will maintain a supply of juice and crackers for emergency use. These will be supplied by the parent at all times.

2. **Self-Care**:

   ____ Checks own blood sugar ____ Needs help checking blood sugar ____ Self-injects insulin

   ____ Needs help with injections ____ Has an insulin pump ____ Brings equipment daily

   ____ Determines correct dose of insulin ____ Draws correct dose ____ Equipment is stored in clinic

3. **Blood Sugar Testing Time**:

   ____ Before breakfast ____ After breakfast ____ Before exercise ____ After exercise

   ____ Before lunch ____ After lunch ____ As needed ____ Document on log sheet

4. **Dosage**:

   _____ Units/_____ Grams of carbohydrates

   Correction dose: _____ Unit per _____ mg/dl over _____ mg/dl

5. **Carbohydrate Count:**

Breakfast: Time _____ Carb. Total _____

Mid-morning snack: Time _____ Carb. Total _____

Lunch: Time _____ Carb. Total _____

Mid-afternoon snack: Time _____ Carb. Total _____

Other times: _____

6. **School:**

a. The cafeteria will supply a carbohydrate count menu to the student, RN, and/or parent.
b. When student states "not feeling well" or "feeling low" or does not seem himself, student is **ALWAYS** to be accompanied by another student or staff to his supplies or office (whichever is closest). Office staff, clinic staff, or RN needs to stay with student until the situation is resolved and student is safe.
c. All teachers will have a signed copy of student's healthcare plan along with signs and symptoms of hyper/hypoglycemia.

7. **Parents:**

a. This student may have an increase in absences due to doctor appointments and illness. A medical excuse will be required for each doctor's visit/illness as stated by school policy.
b. At any time during the school year, the parents are responsible for updating medical information to include any change in insulin dosage (orders must be signed by physician) or contact information.

I am in agreement with this plan of care and understand it will be shared as needed with members of the school staff to safeguard and promote the health of the student listed above while at school. I will notify the school immediately if: 1) the health status of the student listed above changes, 2) we change physicians, or 3) there is a change or cancellation of the physician's orders.

Parent/Legal Guardian _____ Date _____

Parent/Legal Guardian _____ Date _____

Registered Nurse _____ Date _____

MEDICAL REVIEW

I have reviewed the attached Diabetic Healthcare Plan (DHP) for _____ AND:

_____ I approve the DHP as written.
_____ I approve the DHP with the attached amendments.
_____ I do not approve of the DHP as written, and substitute orders are attached.

Physician _____ Date _____

Other Recommendations: _____

_____

_____

_____

_____

Copies to:
☐ Board Office ☐ Bus Garage ☐ Teacher ☐ Other _____