**STUDENT HEALTH PLAN: DIABETES CLASSROOM DAILY CARE**

Insert Photo

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| **STUDENT:** |  | DOB       | District:       |
| School: |  | Grade/Teacher:       | 504:       |

**NOTE: *A comprehensive Individualized Health Plan is kept in the health offic***

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| **Health Concern:** | [ ] Type 1 Diabetes | [ ] Type 2 Diabetes | Other:  |  | Date of Diagnosis: |  |
| **Mother/Guardian:** |  | Preferred Tel #: |  |
| **Father/Guardian:** |  | Preferred Tel #: |  |
| **School Nurse:** |  | Work#: |  |

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| --- | --- | --- | --- |
| **TARGET RANGE – Blood Glucose:** | **mg/dl** | **TO** | **mg/dl** |
| **Notify Parents if Blood Glucose values below:** | **mg/dl** | **Or above:**  | **mg/dl** |
|  |  |  |
| **When to Check Blood Glucose:** | ****As needed for signs/symptoms of low/high blood glucose and/or does not feel well |  ****Behavior Concern |
| [ ]  Before School Program | [ ]  Before Snack | [ ]  Mid-morning | [ ]  After School Program/Extracurricular Activity |  |
| [ ]  Before Lunch | [ ]  After Lunch | [ ]  Recess | [ ]  Before PE | [ ]  After PE  |
| [ ]  School Dismissal | [ ]  Before riding bus/walking home | [ ]  2 hrs after correction | Other:  |       |
| **Diet Restrictions:** |  | Location of Snacks: |       | Location Snack Eaten: |       |
| **Student Schedule:** Lunch: |       | PE:  |       | Recess: |       | Snack: |      am |      pm |
|  |  |  |  |  |  |  |  |  |
| **Health Concern #1 ✜Low Blood Glucose (Hypoglycemia) <     mg/dl*****Emergency situations may occur with low blood glucose*****Symptoms: shaky, feels low, feels hungry, confused*** Student is treated when blood glucose is below **mg/dl** or if symptomatic.
* If treated outside the classroom, a responsible person should accompany student to the clinic.
* Follow directions on **Hypoglycemia Flow Chart**. - **GIVE FAST ACTING SUGAR** then provide follow-up care by trained school staff/school nurse & notify parents
* **IF UNCONSCIOUS – Trained personnel to give *GLUCAGON* & Call 911**

**Health Concern #2 ✜High Blood Glucose (Hyperglycemia) >     mg/dl****Symptoms: increased thirst, increase in urination, headache, stomachache*** Student is treated when blood glucose is above **mg/dl.**

Follow directions on **Hyperglycemia Flow Chart** then provide follow-up care by trained school staff (may need insulin) & notify parent  |
| **✜ Call 911** **for the following:** | 1. Student is unable to eat or drink anything.
2. Decreasing alertness or loss of consciousness.
3. Seizure–never put anything in mouth of unconscious person. Roll student onto side & protect from injury.
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|  |
| **Medication at School:** **Insulin via:** [ ]  Pump [ ]  Syringe [ ]  Pen [ ]  None **Scheduled Insulin Bolus:** [ ] Yes Times:       **Glucagon:** [ ]  Yes [ ]  No Location in school:       **Equipment at School:** [ ] Pump [ ] Blood Glucose Meter [ ] Continuous Glucose Monitor  |
| **Additional Information:** ***Notify parents & School Nurse of any concerns*** | 1. Student is allowed access to fast-acting glucose, to carry a water bottle, and have unrestricted bathroom privileges.
2. ***Substitute teachers*** must be aware of the student’s health situation and responsibilities
3. **NOTE:** Blood glucose levels can affect ability to concentrate and perform properly on tests. Prior to & during timed tests, standardized tests, etc. have student check their blood glucose. If blood glucose out of range during test, treat per care plan.

Allow for student to continue taking test when student returns to normal range and asymptomatic.1. Always have fast-acting sugar available in each classroom.
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| **FIELD TRIPS AND SPECIAL EVENTS:** Notify parents of all field trips/special events.. Supervising staff will review Health Plans.Trained /delegated staff should accompany student & provide necessary interventions for daily management and emergency care. All necessary supplies will accompany student during the trip. |
| *As parent/guardian of the above named student, I give my permission to the school nurse & other designated staff to perform & carry out the diabetes tasks as outlined in this Student Health Plan & for my child’s health care provider to share information with the school nurse for the completion of this plan. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis.* |
| **Other**:       |
| **Parent Signature:** |       | Date: |       |
| **School Nurse Signature:** |       | Date: |       |