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

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| **STUDENT:** |  | **DOB:** |  | **DISTRICT:** |  |
| **SCHOOL:** |  | **GRADE/TEACHER:** |  | **504:** |  |

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

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| Health Concern: | [ ]  | Type 1 Diabetes | [ ]  | Type 2 Diabetes | Other: |       | Date of Diagnosis: |       |
| School Nurse: |       | Work#: |       |

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| **TARGET RANGE – Blood Glucose/Sensor Glucose:** | **mg/dl** | **TO** | **mg/dl** |
| **Notify Parents and School Nurse if Blood Glucose/Sensor Glucose values below:** | **mg/dl** | **Or above:**  | **mg/dl** |
| [ ]  Continuous Glucose Monitor  | **(see CGM addendum)** |  |
| **When to Check Blood Glucose/Sensor Glucose:** | [ ]  As needed for signs/symptoms of low/high BG/SG 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: |        a.m. |       p.m. |
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| **Health Concern #1 ✜Low Blood Glucose/Sensor Glucose (Hypoglycemia)<     mg/dl*****Emergency situations may occur with low blood glucose/sensor glucose*****Symptoms: shaky, feels low, feels hungry, confused*** Student is treated when blood glucose/sensor 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**
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| **Health Concern #2✜High Blood Glucose/Sensor Glucose (Hyperglycemia)>     mg/dl****Symptoms: increased thirst, increase in urination, headache, stomachache*** Student is treated when blood glucose/sensor 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:** | [ ]  No | [ ]  Yes | [ ]  InPen | 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/sensor 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/sensor glucose. If blood/sensor 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.
4. 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: |       |