Sioux City Community Schools
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DIABETES INDIVIDUAL HEALTH PLAN
Series 504.12-E(iii)

NAME: ____ **Date of Birth:** _________________________

Doctor for Diabetes: ____ Phone:___________________________

BLOOD GLUCOSE (BG) MONITORING: Student can: Perform own BG checks? ___Yes ___No
Interpret results? ___Yes ___No
Needs Supervision? ___Yes ___No

BG target range: _________mg/dl - __________mg/dl. Type of meter: ________________________________
Notify parent if BG out of target range? ____YES ____NO

Time to be performed:
____Midmorning before snack
____Before lunch
____Before PE ____After PE
____Before am recess ____Before pm recess
____Midafternoon ____End of school day
____As needed for low/high blood glucose symptoms/signs

Place to be performed: ____Classroom ____Health office ____Other____________________________

MEALS/SNACKS: Student : ____ Able to calculate carbohydrate grams accurately.
____ Able to calculate insulin dose based on BG & carbs eaten.
____ Unable to do calculations.

Student will eat: ____ Eat cold lunch ____Eat hot lunch

Directions if outside food for party, birthday, & snacks provided to class:

INSULIN INJECTIONS AT SCHOOL: ____Yes ____No

Insulin delivery: ____Syringe/Vial ____Pen ____Pump

Insulin Name: ____________________ Dose ______________ Time to be given ____________________

Calculate insulin dose based on BG & carb intake? ____Yes ____ No
If yes, use _______# unit(s) per ________grams carbohydrate

Calculate insulin dose based on sliding scale?(attached) ____Yes ____ No

Can student:
Calculate correct dose? ____ Yes ____ No
Draw/dial up correct dose? ____ Yes ____ No
Give own injection? ____ Yes ____ No
Operate pump on own? ____ Yes ____ No
Needs supervision ____ Yes ____ No
Use correction dose of insulin for high BG? ____Yes ____No
If yes, provide school with sliding scale of blood glucose, insulin name, insulin dose.

PE, RECESS, OTHER PHYSICAL ACTIVITY AT SCHOOL:
No exercise if BG is below _____mg/dl or above ______mg/dl. Ketone check if BG is ________________________
Notify parent of:

MANAGEMENT OF LOW BLOOD GLUCOSE: **(below ____________mg/dl)**

Usual signs/symptoms for student are:
____Hunger
____Change in behavior
____Paleness
____Shakiness/weakness
____Tiredness/sleepiness
____Headache
____Clamminess/sweating
____Dizziness
____Blurred Vision
____Inattention/confusion
____ Nausea

Indicate treatment choices:
If student is awake and able to swallow, give ________grams fast acting carb such as:

____ 4 oz. Fruit juice
____ Glucose Tabs ____# of tabs to be given
____ Glucose Gel tube
____ Other ________________________________
____

Retest blood glucose 15 minutes after treatment?
_____Yes _____No
Repeat treatment until BG is over

Follow treatment w/snack of ______________________________ if more than 1 hour until next full meal.
Other:

MANAGEMENT OF HIGH BLOOD GLUCOSE: **(over _________mg/dl)**

Usual signs/symptoms for student are:
____ Increased thirst, urination, appetite
____Tiredness/sleepiness
____Blurred vision
____Warm, dry, flushed skin
____Other ______________________________

Indicate treatment choices:
____Sugar free fluids
____Check ketones is BG over _______mg/dl
____No Need to check ketones.
____Notify parent if ketones other than negative.
____May not need snack; call parent.
____Correction insulin dose for high BG/sliding scale

IMPORTANT

If student is unconscious or having a seizure, presume the student is having a low BG:
Call BERT , Call 911, and Call parent.
____Glucagon ½ mg OR 1 mg (circle prescribed dose) should be given by trained personnel.
Turn student on side after Glucagon injection as student may vomit.

PARENT/GUARDIAN WILL PROVIDE:
1) Up-to-date information regarding student's diabetes management.
2) Supplies/snacks /quick sugar items for diabetes management.
3) Signed medication/procedure authorization forms annually.

I have read the above plan and I have made changes that I felt necessary to the plan. I understand that the above plan will remain in place as long as my child is a student in the Sioux City Community School District. I understand that it is my responsibility to notify the school nurse when changes to the plan need to be made. I give permission for the information in this plan to be shared with my child's teachers, Building Emergency Response Team, health office staff and other school staff as deemed necessary.

Parent/Guardian Signature____ **Date**________________________

Physician Signature____ **Date**________________________

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Date plan sent/given to parent/guardian____________ Date plan returned to school____________