

COLLINGDALE NAZARENE CHRISTIAN SCHOOL (CNCS)

INDIVIDUALIZED HEALTHCARE PLANS
DIABETES

Date: _____

Student: _____ Date of Birth: _____

School: _____ Grade/Homeroom: _____

Parent/Guardian: _____ Home Phone: (____) _____

Mother's Work #: (____) _____ Father's Work #: (____) _____

Emergency Contact: _____

In case of emergency, I authorize school personnel to contact:

Diabetes Care Provider: _____ Diabetes Health Educator: _____

Transport via ambulance to: (hospital) _____

Health History

Age of onset: _____ Related Complications: _____

Allergies: _____ Other medications: _____

Other Health Problems: _____

Blood Sugar Monitoring

Routine Management: Target Blood Sugar Range _____ to _____

Test will be performed in _____ (location)

Need assistance with testing? Yes _____ No _____ Explain _____

Times to blood sugar:

____ Before lunch

____ After lunch

____ Before P.E.

____ After P.E.

____ As needed for signs/symptoms of low or high blood sugar

Call parent if values are below _____ or above _____

At Home: _____ At School: _____

Needs Routine Assistance: _____ Yes _____ No

Diabetes Action Plan
Collingdale Nazarene Christian School (CNCS)

Emergency Response/Intervention Plan

Place Child's
Photo Here

Student Name: _____ Grade/HR: _____ Date: _____

Mild Low to Moderate Blood Sugar: (Student to be treated when blood sugar is below ____.)
Symptoms could include (please circle all that apply): hunger, irritability, shakiness, sleepiness, sweating, pallor, uncooperative, crying or other behavioral changes, combative, disoriented or incoherent.

Treatment of Mild Low Blood Sugar; With any level of low blood sugar never leave the student unattended . If treated outside the classroom a responsible person should accompany student to the health office for futher assistance.

_____ Test blood sugar. If kit not available treat child immediately for low blood sugar.

_____ If blood sugar is between _____ and _____ and lunch is available, escort to lunch and have student eat immediately. If lunch is unavailable, treat immediately as listed below.

If blood sugar is below _____, give 4 oz. juice, or 6 oz. (1/2 can) of regular soda or 2-3 glucose tablets. Wait 10 minutes. Re-check blood sugar. Re-treat as above if still below.

Follow with snack or lunch when blood sugar rises above _____ or when symptoms improve.

Notify _____ school Principal _____ and Parent _____

Comments: _____

Severe Low Blood Sugar Student symptoms include: Seizure or loss of consciousness, unable or unwilling to take gel or juice.

- Stay with the Student.
- Appoint someone to call 911.
- Roll student on side.
- Protect from injury.
- Do not put anything in mouth.

_____ Give Glucagon subcutaneously (if ordered).

High Blood Sugar: Student will be accompanied to the health room. The student needs to be treated when blood sugar is above _____. Call parent/guardian when blood sugar s greater than _____.

Symptoms could include (circle all that apply): extreme thirst, headache, abdominal pain, nausea, increased urination. Additional student symptoms

Treatment of High Blood Sugar:

- Drink 8-16 oz. of water every hour.
- Allow free access to bathroom.
- Permission to carry water bottle with them in school.

Check urine for ketones when blood sugar is greater than _____ or when ill. If urine ketones are moderate to large, call parent immediately.

I have reviewed the Intervention Plan.

I will notify the school Principal of any additional information or changes in my student's diabetic management.

Parent Signature _____

Date: _____

CNCS Principal Signature _____

Date: _____

Daily Management Regimen:

Insulin Type: _____ Insulin Type: _____

Dosage: _____ Dosage: _____

Frequency: _____ Frequency: _____

Insulin being administered by: _____

Insulin administered at school: _____ Yes _____ No

Insulin subcutaneous injection using Humalog/Novolog/Regular (circle type).

_____ Unit (s) if lunch blood sugar is between ____ and ____

_____ Unit (s) if lunch blood sugar is between ____ and ____

_____ Insulin/Carb Ratio _____ Unit for every _____ grams of carbohydrate eaten.

plus _____ Units for every _____ mg./dl points above _____ mg/dl

_____ Student can draw up own insulin _____ Student cannot draw up own insulin.

_____ Student needs assistance checking insulin dosage.

_____ Student can draw up but needs and adult to inject insulin.

Diet:

Lunch time _____ Scheduled P.E. time _____ Recess time _____

Snack time _____ am _____ pm Location snacks are kept _____

Special Lunch Considerations: _____

Parent/Guardian and student are responsible for maintaining necessary supplies, snacks, testing kit, medications and equipment.

Physical Education

Scheduled at: _____

Is snack necessary before physical education? _____ Yes _____ No

Does child participate in after school sports? _____ Yes _____ No

P.E. teacher/coach is aware of child's diabetes? _____ Yes _____ No