INDIVIDUALIZED HEALTH CARE PLAN

Livonia Public Schools

Confidential

Name:	School Year:
Health Concern: **DIABETES** ☐ Type I ☐ Type 2	
Date of Birth:	Student ID:
Case Manager:	Ext:

Blood Glucose Monitoring

Target blood glucose range _____ mg/dl to _____ mg/dl

Usual times to check blood glucose _____

Times to do extra blood glucose checks (check all that apply) ☐ before exercise ☐ after exercise

☐ when student exhibits symptoms of hyperglycemia ☐ when student exhibits symptoms of hypoglycemia

☐ other (explain) _____

Can student perform own blood glucose checks? ☐ Yes ☐ No Exceptions _____

Type of blood glucose meter student uses _____

Insulin

Times, types and dosages of insulin injections to be given during school:

Time	Type(s)	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____

Can student . . .

- give own injections? ☐ Yes ☐ No
- determine correct amount of insulin? ☐ Yes ☐ No
- draw correct dose of insulin? ☐ Yes ☐ No

For Students with Insulin Pumps

Type of pump _____

Insulin/carbohydrate ratio _____

Correction factor _____

_____

Is student competent regarding pump? ☐ Yes ☐ No

Can student effectively troubleshoot problems (i.e. ketosis, pump malfunction, etc.)? ☐ Yes ☐ No

Comments _____

_____

_____

Meals and Snacks Eaten at School (The carbohydrate content of the food is important in maintaining a stable blood glucose level)

	Time	Food Content/Amount
Breakfast	_____	_____
A.M. snack	_____	_____
Lunch	_____	_____
P.M. snack	_____	_____

Snack before exercise? ☐ Yes ☐ No

Snack after exercise? ☐ Yes ☐ No

A source of glucose, such as _____ should be readily available at all times.

Preferred snack foods _____

Foods to avoid (if any) _____

Instructions for when food is provided to the class (i.e. class party or food sampling) _____

_____

Other times to give snacks and content/amount _____

Exercise and Sports

A snack such as _____ should be available at the site of exercise or sports.

Restrictions on activity (if any) _____

Student should not exercise if blood glucose is below _____ mg/dl

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Location of Supplies

Blood glucose monitoring equipment _____

Insulin administration supplies _____

Glucagon emergency kit _____

Ketone testing supplies _____

Other _____

_____

Hypoglycemia – Low Blood Sugar

Common Causes
Too much insulin
Missed or delayed food
Too much or too intense exercise
Unscheduled exercise

SYMPTOMS

MILD

Hunger
Weakness
Dizziness
Paleness
Shakiness
Confusion
Sweating
Lack of concentration
Poor coordination
Personality or behavior change

Other _____

SEVERE

Loss of consciousness
Seizure
Inability to swallow

Other _____

ACTION PLAN

MILD BLOOD GLUCOSE < 70

- Provide 15 grams of carbohydrate OR 4 oz. of juice OR 3-4 glucose tablets
- Wait 15 minutes
- Recheck blood glucose
- Repeat treatment if blood glucose is < _____
- If > 1 hour before a meal, give a snack of carbohydrate and protein

SEVERE

- Call 911
- DO NOT give anything by mouth
- Contact trained medical personnel
- Administer Glucagon as prescribed
- Position on side, if possible
- Stay with student
- Contact parents

Hyperglycemia – High Blood Sugar

Common Causes
Too little insulin
Too much food
Decreased activity
Illness / infection or stress

SYMPTOMS

MILD

Increased hunger / thirst
Frequent urination
Fatigue / sleepiness
Blurred vision
Stomach pains
Lack of concentration

Other _____

SEVERE

Nausea / vomiting
Moderate or large ketones
Sweet, fruity breath
Labored breathing
Confused
Unconscious

Other _____

ACTION PLAN

NEGATIVE KETONES

- Give extra water or sugar free drinks
- Allow use of bathroom as needed
- Encourage exercise
- Inform parents of frequent high readings

TRACE TO SMALL

- Give at least 8 oz. water every hour
- Recheck ketones at next urination

MODERATE TO LARGE

- Call parent
- Encourage water until parent is contacted
- If student has abdominal pain or is nauseous, vomiting, or lethargic, call for medical assistance if parent can't be reached

Emergency Contact Information

Contact # 1 _____ Relationship _____

Home _____ Cell _____ Work _____

Contact # 2 _____ Relationship _____

Home _____ Cell _____ Work _____

Student's Doctor _____ Work _____

Address _____ Fax _____

The following individuals have reviewed this Health Care Plan and support its implementation.

_____ _____ _____

Parent / Guardian Signature Date | Administrator Signature Date | Doctor Signature (required) Date

Revised 2017