# PART I: INDIVIDUALIZED EMERGENCY HEALTHCARE PLAN - DIABETES

**Student's Name:** **Grade:** **School Year:**

| CONTACT INFORMATION | |
|---|---|
| **Date of Birth:**_____ | **Parent/Guardian:** _____<br>**Phone Numbers: Home** _____ **Work** _____ **Cell** _____ |
| **TASK** | **ACTION (S)** |
| **1. Blood Glucose Monitoring** | _____ Target range for blood glucose is □ 70-150 □ 70-180 □ Other_____<br>_____ Usual times to check blood glucose _____<br>_____ Times to do extra blood glucose checks (*check all that apply*)<br>□ Before exercise<br>□ After exercise<br>□ When student exhibits symptoms of hyperglycemia<br>□ When student exhibits symptoms of hypoglycemia<br>□ Other (explain): _____<br>_____ Notify parents immediately for blood glucose < _____ mg/dl and/or > _____ mg/dl.<br>_____ Notify parents (specify) Daily/Weekly/Monthly of any results done at school.<br>_____ Can student perform own blood glucose checks? ___ Health office during school day ___ School related activity |
| **2. Insulin** | _____ Administer _____ units of (specify) Humalog/Novolog SubQ for blood glucose > _____ mg/dl.<br>_____ Above dose may be repeated every _____hours.<br>_____ Not applicable.<br>_____ Other (specify) _____. |
| **3. Insulin Correction Doses** | Glucose Levels _____ YES _____ NO<br>_____ units if blood glucose is _____ to _____ mg/dl _____ units if blood glucose is _____ to _____ mg/dl<br>_____ units if blood glucose is _____ to _____ mg/dl _____ units if blood glucose is _____ to _____ mg/dl<br>_____ units if blood glucose is _____ to _____ mg/dl<br>Can student give own injection _____ YES _____ NO<br>Can student determine correct amount of insulin? _____ YES _____ NO |

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| **4. Students with Insulin Pumps** | Can student draw correct dose of insulin? _____ YES _____ NO<br>Type of Pump: _____<br>Type of insulin in pump: _____<br>Type of infusion set: _____<br>Insulin/carbohydrate ratio: _____ Correction factor: _____<br>Needs Assistance _____ YES _____ NO<br>Count Carbohydrates _____ YES _____ NO<br>Bolus correct amount for carbohydrates consumed _____ YES _____ NO |
| **5. Urine Ketone Testing** | _____ For blood glucose > 240 mg/dl.<br>_____ For acute illness, i.e., vomiting, fever, etc.<br>_____ Student should have unlimited access to restroom and drinking fountain/water bottle.<br>_____ Notify parents immediately for moderate/large ketones (NOTE: if parents can not be reached and the student has moderate/large ketones and is vomiting, contact paramedics for transport to ER).<br>_____ Notify parents (specify) Daily/Weekly/Monthly of results done at school.<br>_____ Other (specify) _____<br>_____ Not Applicable.<br>_____ Restrict gym/sports/etc., for positive ketones. |
| **6. Meal Planning** | _____ Mid-morning snack at _____ a.m. _____ Mid afternoon snack at _____ p.m.<br>_____ Other (specify)<br>_____ Snacks should be taken (specify): Classroom: _____ Nurse's Office: _____ Other:_____<br>_____ Before Exercise<br>_____ After Exercise |
| **7. Activity** | _____ No restrictions<br>_____ Restrict gym/sports etc. for positive ketones.<br>_____ Medical ID should be worn at all times including during gym/sports/etc. |

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| | _____ May attend class/field trips/etc.<br>_____ Possess supplies/equipment necessary to monitor and care for diabetes.<br>_____ Comply with procedures for medical waste disposal. |
| **8. Hypoglycemia/Glucagon**<br><br>**9. Hyperglycemia (High Blood Sugar)** | _____ Treat all blood glucose <70 mg/dl or of symptomatic with 15 grams of rapid-acting carbohydrate i.e., 4 ounces of juice. If more than 1 hour until meal time give snack.<br>_____ For severe hypoglycemia (or suspected severe hypoglycemia) when the student is unconscious or unable to swallow, give _____ mg Gluagon I.M. or SubQ AND _____contact parents - _____contact paramedics immediately.<br>Usual symptoms of hypolycema: _____<br>Usual symptoms of hyperglycemia: _____<br>Treatment of Hyperglycemia: _____<br>Urine should be checked for ketones when blood glucose levels are above _____ mg/dl.<br>Treatment for ketones:_____ |
| **10. Absences** | _____ For diabetes visits approximately every 3 months.<br>_____ Other (specify) _____ |
| **RELEASE OF INFORMATION** | I authorize the sharing of medical information about my child, _____, between my child's physician or advanced practice nurse and other health care providers in the school.<br>I also consent to the release of information contained in this plan to school personnel who have responsibility for or contact with my child, _____, and who may need to know this information to maintain my child's health and safety. _____ Bus Driver _____ Teacher/Staff<br>_____ _____<br>Student's Parent/Guardian Signature Date |

_____ _____ _____

Student's Physician Signature Phone Number Date

_____ _____

School Nurse Signature Date