CORNERSTONE CHRISTIAN ACADEMY

STUDENT WITH DIABETES INDIVIDUAL HEALTH PLAN

MUST BE COMPLETED BY HEALTH CAREPROVIDER

Student's Name	Date of Birth	School/School Year

DAILY MANAGEMENT/SCHEDULE

	AM	Mid-morning	Lunch	Mid-afternoon
Blood Glucose Monitoring				
Insulin Injection (Time/Dosage/Type)				
Insulin Pump (Must be performed independently)				
Snack (Type/Grams)				

Blood Glucose Tests: Equipment and supplies to be provided by family.
Target range for blood glucose: _____mg/dl to _____mg/dl

- ☐ Student tests independently
- ☐ Student tests with verification of number on meter by designated staff
- ☐ Student needs help with testing
- ☐ Test needs to be done by designated staff

Sliding Scale Administration:

Insulin Type	
_____	**____unit if BG>_____mg/dl**
	____unit if BG>_____mg/dl
	____unit if BG>_____mg/dl
	____unit if BG>_____mg/dl
	____unit if BG>_____mg/dl

	Day of Week	Time	Snack (if necessary)	Other Instructions
Physical Education				
Recess				

Name of other medication	Dosage	Time of administration at school

CORNERSTONE CHRISTIAN ACADEMY

STUDENT WITH DIABETES INDIVIDUAL HEALTH PLAN

MUST BE COMPLETED BY HEALTH CAREPROVIDER

Student's Name	Date of Birth	School/School Year

Diabetics can have extremes of high and low blood sugar. Is your child able to recognize symptoms of high and low blood sugar? _____Yes_____No

Hypoglycemia/low blood sugar — your child's usual signs and symptoms:

_____Shakiness, nervousness _____Speech difficulty _____Headache_____Nausea
_____Mood changes; irritability, crying, confusion _____Fatigue _____Dizziness
_____Blurred vision_____Unusual paleness; moist, clammy skin; cold sweats
Other: _____

Hypoglycemia Treatment:

☐ 2-4 glucose tablets

☐ 4 oz. of juice 15 gram snack if no meal or snack within next hour

☐ Glucose gel (using finger lace between cheek and gum in mouth) - 1/2 tube

☐ Glucagon (give mg SQ in the arm or thigh)

☐ **Call 911 for severe hypoglycemia i.e. loss of consciousness/seizure**

☐ **Other:** _____

Hyperglycemia/high blood sugar — your child's usual signs and symptoms:

_____Frequent thirst_____Frequent urination_____Nausea _____Fatigue
_____Mood changes; irritability, crying, confusion, inappropriate responses
Other: _____

Hyperglycemia Treatment:

☐ Provide water and access to bathroom

☐ Test urine ketones if blood glucose is greater than_____, call parent if moderate or large

☐ See sliding scale instructions previous page

PARENT RESPONSIBILITES (please initial next to each line)

_____Will supply all necessary equipment, food andfluids
_____Will notify school nurse of any changes to management plan, dosage or medication changes
_____Will determine follow-up care for symptoms reported by school staff
_____Will communicate necessary medical information between doctors and schoolstaff
_____Will update this plan annually
_____Will provide updated emergency contact numbers as needed

SCHOOL NURSE RESPONSIBILITIES

_____Will follow medical care plan as provided
_____Will maintain daily log
_____Will provide plan to teachers, cafeteria staff, transportation/bus drivers and building administrator
_____Will contact parent if blood glucose is less than 70 or greater than 400
_____Will attach copy of emergency form to this plan

I have read and reviewed this form and agree with its contents.
Parent/guardian's signature: _____Date: _____/
Doctor's signature: _____Date: _____/
Doctor's phone number: _____
Nurse's signature: _____Date: _____/