# Individualized Health Plan: *Diabetes*

Date: ______________________________

Student's name: ______________________________ Grade: ______ Homeroom teacher: ______________________________

Date of Birth: ______________________ Date/age diagnosed: ______________________ Diabetes diagnosis: ☐ type 1 ☐ type 2

**Parent/Guardian #1:** Name ______________________________

Home ______________ Work ______________ Cell ______________

**Parent/Guardian #2:** Name ______________________________

Home ______________ Work ______________ Cell ______________

**Other Contact:** Name ______________________________ Phone # ______________

Physician ______________________________ Phone # ______________

**Blood Glucose** Usual times to test glucose at school ______________________________

BG testing *(check any that apply)* ☐ before exercise ☐ after exercise

☐ other *(explain)*: ______________________________

Can student perform own test? ☐ Yes ☐ No

**Hypoglycemia** Symptoms: ______________________________

Glucagon level mandating treatment if no symptoms ______________________________

Treatment ______________________________

Glucagon *(dose)* ______________________________ Expiration ______________

Activity restriction *(if applicable)* ______________________________

**Hyperglycemia** Symptoms: ______________________________

Blood glucose to test for ketones ______________________________

Treatment ______________________________

Sliding scale correction dose: _____ units if BG is _____ to _____ mg/dl _____ units if BG is _____ to _____ mg/dl

_____ units if BG is _____ to _____ mg/dl _____ units if BG is _____ to _____ mg/dl

Activity restriction *(if applicable)* ______________________________

**Insulin** Time: ______________ ☐ a.m. ☐ p.m. Dose ______________ by *(check one)* ☐ syringe ☐ pen ☐ pump

Can student give own injections? ☐ Yes ☐ No Supervision required? ☐ Yes ☐ No

Flex insulin dosage: *Insulin type* ______________________, ____________ *units to* ________ *gms carbohydrates*

Insulin pump: *type* ______________________ *Basal rates* ______ *time* ______ *to* ______ *insulin type* ______________

Insulin/carbohydrate ratio ______________________ Correction factor ______________________

Insulin type ______________________ Infusion set ______________________

**Type II Diabetes** Medication: ______________________ Daily calories ______________

**Meals and snacks** Times in school: ______________________________

**Circumstances requiring parent notification** ______________________________

**Additional recommendations** ______________________________

**Emergency health-care plan** ______________________________

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______________________________
*School nurse*

______________________________
*Parent/guardian*

______________________________
*Administrator*

______________________________
*Faculty representative*