Clayton County Public Schools
Individual Health Plan- Diabetes

School _____

School Year _____ **Date** _____

Student Name: _____Allergies _____ Date of Birth: _____

Teacher: _____ Grade Level: _____

Parents/Guardian: _____Home Phone: _____

Cell Phone (Mother): _____ Work Phone (Mother): _____

Cell Phone (Father): _____ Work Phone (Father): _____

Emergency Contact: _____

Name Relationship Phone

Emergency Contact: _____

Name Relationship Phone

Physician: _____ Phone: _____

Endocrinologist: _____ Phone: _____

I understand that it is my responsibility as the parent/guardian of _____ to notify the school nurse/designee of any changes in my child's health condition and/or medication/treatment regimen. I authorize my child's physician and his/her staff to release the following information regarding my child's health condition. I understand that this health information will **only** be shared with pertinent school staff.

_____ _____

Parent/Guardian Signature Date

Completed by Physician

Type of Diabetes: _____

Has had hospitalization in the past year for Diabetes? _____

If yes, when? _____

How will this illness impact school attendance? _____

_____

Current Insulin Regimen:

A.M. _____

Type – Dose – Time

Lunch _____

Type – Dose – Time

Dinner _____

Type – Dose – Time

Bedtime _____

Type – Dose – Time

Will student require Insulin at school? Yes _____ No _____

Can student give his/her Insulin? Yes _____ No _____

Will student need supervision in giving own Insulin? Yes _____ No _____

Pump Information: _____

_____

_____

_____

Blood Glucose Monitoring:
Target range of blood glucose is _____ mg/dl to _____ mg/dl

Can student test his/her own blood glucose level? Yes _____ No _____
Will student require supervision with blood glucose monitoring? Yes _____ No _____
Routine blood glucose testing times:

Breakfast @ _____ a.m. Lunch @ _____ a.m. /p.m.
Dinner @ _____ p.m. Bedtime @ _____ p.m.

Will student require supplemental testing time?

Before exercise _____ After exercise _____
Before snack(s) _____ With symptoms of high/low _____
Other _____

Dietary Guidelines:
Estimated total calories per day: _____
Meal/Snack Times:

Breakfast @ _____ a.m.
Snack @ _____ a.m.
Lunch @ _____ p.m.
Snack @ _____ p.m.
Dinner @ _____ p.m.
Bedtime @ _____ p.m.

Will student need to be reminded to take a snack? Yes _____ No _____ (Snacks to be provided by parents)
Modifications for parties: _____
_____

Physical Activity:
Does student have restrictions regarding physical activity? Yes _____ No _____
(Exercise/sports limitations)Describe: _____
_____
Is a snack required before physical activity? Yes _____ No_____
Snack given before activity if: _____
Exercise should be delayed or avoided if the blood is higher than _____ mg/dl and lower than _____

Emergency Services for School:

<u>HYPOGLYCEMIA</u> – Insulin Reaction
How often does a hypoglycemic reaction occur? _____
When is the usual time of day hypoglycemic reaction occurs? _____
Student's symptoms: _____
Treatment: _____
_____
_____

<u>HYPERGLYCEMIA</u> – High Blood Glucose
Student's symptoms: _____
Treatment: _____
_____

Individual Considerations:(Please indicate any special diet, physical activity limitations/adaptations, prosthetic devices, special procedures/interventions, and/or impact on school attendance)_____
_____
_____
_____

_____ _____ _____
Physician Printed Name Physician Signature Date