NOTE: Parents are to provide the physician's medical management plan to the school ***annually.*** The medical orders, along with the health intake below, assist the school nurse in developing an Individual Healthcare Plan for the student.

Student's Name: _____ **DOB:** ___/___/____ **Grade:** _____ **Today's Date:** ___/___/____

Parent/Guardian 1: _____ **Contact Information:** _____

Parent/Guardian 2: _____ **Contact Information:** _____

Name of physician treating student's diabetes: _____ **Phone Number:** _____

Health Insurance: ☐ Private ☐ Medicaid/KanCare ☐ Currently without insurance

Medical alert jewelry worn? ☐ Yes ☐ No **IEP?** ☐ Yes ☐ No **Current 504 Plan?** ☐ Yes ☐ No

Mode of transportation to and from school? _____

Does student participate in before or after school activities? ☐ Yes ☐ No

Date of diagnosis: _____ ☐ **Type 1** ☐ **Type 2**

HYPOGLYCEMIA (LOW blood sugar) – student's usual symptoms (check all that apply):

☐ Shaky or jittery ☐ Sweaty ☐ Hungry ☐ Pale ☐ Headache ☐ Blurry vision ☐ Sleepy ☐ Dizzy
☐ Confused ☐ Disoriented ☐ Uncoordinated ☐ Irritable or nervous ☐ Argumentative ☐ Combative
☐ Changed personality ☐ Changed behavior ☐ Inability to concentrate ☐ Weak ☐ Lethargic
☐ Other: _____

Does student recognize the above signs/symptoms? ☐ Yes ☐ No ☐ Sometimes

In the past year, has student been treated for severe low blood sugar? ☐ Yes ☐ No

If yes: ☐ In a health care provider's office ☐ In the emergency room ☐ Overnight or longer in the hospital

HYPERGLYCEMIA (HIGH blood sugar) – student's usual symptoms (check all that apply):

☐ Increased thirst/dry mouth ☐ Frequent or increased urination ☐ Change in appetite/nausea

☐ Blurry vision ☐ Fatigue ☐ Other: _____

Does student recognize the above signs/symptoms? ☐ Yes ☐ No ☐ Sometimes

In the past year, has student been treated for severe high blood sugar or diabetic ketoacidosis? ☐ Yes ☐ No

If yes: ☐ In a health care provider's office ☐ In the emergency room ☐ Overnight or longer in the hospital

Meal Plan:

Will student participate in breakfast at school? _____

Will student bring lunch, eat school lunch, or both? _____

Does student regularly eat snacks – mid morning, mid-afternoon, etc? _____

Instructions for when food is provided to class (special event/party, etc): _____

_____

Equipment:		**Stays at school**	**Home to school each day**
Blood glucose meter	Brand/model: Testing strips:	☐	☐
Continuous glucose monitor (CGM): **☐ Yes ☐ No**	Brand/model: Alarm parameters:	**N/A**	**N/A**
Ketone testing	Strips:	☐	☐
Insulin delivery device	Syringe:	☐	☐
	Insulin pen:	☐	☐
	Insulin pump – Brand/model:	**N/A**	**N/A**
	Type of infusion set:	**N/A**	**N/A**
Snacks (student preference)	List:	**Parents to provide supply for school**	**N/A**
Short acting glucose (student preference)	List:	**Parents to provide supply for school**	**N/A**
Glucagon ordered	☐ Yes ☐ No	☐	☐

For each self-care task, select the column that best indicates student's current abilities. Leave blank if not applicable.

Student's self-care level at home:	**Does alone**	**Does with help**	**Done by adult**	**Comments**
Checks own blood glucose	○	○	○	
CGM – knows what to do/troubleshoots high/low alarms and malfunctions	○	○	○	
Measures ketones	○	○	○	
Counts carbs for meals/snack	○	○	○	
Calculates insulin	○	○	○	
Measures insulin in syringe (or on insulin pen)	○	○	○	
Primes insulin pen (if applicable)	○	○	○	
Selects insulin injection site	○	○	○	
Administers insulin	○	○	○	
Pump operation Boluses correct insulin	○	○	○	
Calculates and set basal profiles	○	○	○	
Disconnects pump	○	○	○	
Reconnects pump to infusion set	○	○	○	
Prepares reservoir, pod, and/or tubing	○	○	○	
Inserts infusion set	○	○	○	
Troubleshoots alarms	○	○	○	

NOTE: Self-care at school will be determined in consideration of the above information, healthcare provider orders, and school nurse ongoing assessment of student's skills.

Other medications taken by student (name of medication, dosage, reason, side effects):

_____

_____

Does student have family, peer, and community support systems? ☐ Yes ☐ No

Describe student's response and current coping/adaptation to having diabetes: _____

_____

Parent/Guardian Signature: _____ **Date:** _____