Boone County Schools

School Health Services Department

Diabetes Health Care Plan

Plan Date: _________

Student Name: _______________________________________ **Date of Birth:** ______________ **Grade:** ____

Insulin is delivered through ☐ pump ☐ injections

☐ Humalog ☐ Novalog ☐ Glulisine ☐ Other____________________

Ratios		Correction	Testing times
Breakfast Lunch Snack	1 unit/ _______ 1 unit/ _______ 1 unit/ _______	**Target BG:** ___________ 1 unit for every________ above target BG **Ketone Correction** 1 unit for every________ above target BG	☐ Before meals ☐ 1 hour after eating ☐ Before physical activity ☐ After physical activity
For SEVERE hypoglycemia, unconsciousness or seizure: **Administer ________mg Glucagon intramuscularly.**			☐ With symptoms

Does student need help calculating carbohydrate coverage? ☐ NO ☐ YES

Does student need help calculating corrections? ☐ NO ☐ YES

Does student need assistance with injections? ☐ NO ☐ YES

Does student need to check for ketones? ☐ NO ☐ YES, when ____

Does student have restrictions in physical activity? ☐ NO ☐ YES, when___________________________________

Hypoglycemic (low blood sugar) Reactions		Hyperglycemic (high blood sugar) Reactions	
☐ Mood changes	☐ Dizziness	☐ Mood changes	☐ Thirstiness
☐ Irritability/ anger	☐ Blurred vision	☐ Irritability/ anger	☐ Blurred vision
☐ Crying	☐ Headache	☐ Crying	☐ Headache
☐ Confusion	☐ Shakiness	☐ Confusion	☐ Shakiness
☐ Inappropriate responses	☐ Drowsiness	☐ Inappropriate responses	☐ Hyperactive
☐ Loss of conscious	☐ Numbness	☐ Vomiting	☐ Frequent urination

Other notes: ____

Parent/ Guardian may change coverage ratios as needed (under physician's guidance): ☐ NO ☐ YES

This student: ☐ is self-care ☐ may self-carry insulin ☐ may self-carry Glucagon ☐ supervision only ☐ dependent for diabetic care needs

Physician Signature: ____ Date:_____________________

Parent/Guardian Signature: ____ Date: ____________________

NOTE: Parents are responsible for providing all supplies, including snacks. All medications must be in original containers with prescription label affixed, with student's name. No medication will be sent home unless self- carry permissions have been granted.

Unlicensed School Professional: Boone County Board of Education has adopted a procedure in which a trained staff member may administer: an injection, prescribed medication or other emergency care in the event of a crisis. The above signed understands that the staff member administering the above care may not be a licensed healthcare professional, but that this staff member will undertake to do their best to comply with the procedure as developed by the student's physician in the case of an emergency where in immediate intervention is required.

FOR SCHOOL NURSE USE ONLY	
Potential Complications ☐ Hypoglycemia ☐ Hyperglycemia ☐ Assigned standard reaction response ☐ Individualized care plan	Reviewed on: ___________________________ Delegated or assigned caregivers, names and trained date: ____ ____ Nurse Signature: ______________________________

Revised: Nov. 2018 SLW

Boone County Schools
Student Services Division
School Health Services Department
Transportation/Student Health Concerns

Photo

School Year: ______________________________

Student Name:____

Address: ____

Bus Number: _________ **School:** ____

Date of Birth: ___________________ **Age:** _________________ **Grade:** _________

Health Concern of student: ____

Medication/supplies which will be with student during bus transportation:

____

Is student responsible for medication administration? Yes ☐ No ☐

Comments: ____

Emergency care to be given to student by bus driver: ______________________________

____

Parent / guardian signature: ____

Daytime phone number: ____

Date: _____________________________

This completed form must be returned to your child's school office in order for transportation to be notified.

School nurse is to scan completed form to Transportation: cynthia.buttery@boone.kyschools.us

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