

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	1 unit/ _____	Target BG: _____	<input type="checkbox"/> Before meals
Lunch	1 unit/ _____	1 unit for every _____ above target BG	<input type="checkbox"/> 1 hour after eating
Snack	1 unit/ _____	Ketone Correction	<input type="checkbox"/> Before physical activity
			<input type="checkbox"/> After physical activity
For SEVERE hypoglycemia, unconsciousness or seizure: Administer _____ mg Glucagon intramuscularly.			<input type="checkbox"/> 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	
<input type="checkbox"/> Mood changes	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Mood changes	<input type="checkbox"/> Thirstiness
<input type="checkbox"/> Irritability/ anger	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Irritability/ anger	<input type="checkbox"/> Blurred vision
<input type="checkbox"/> Crying	<input type="checkbox"/> Headache	<input type="checkbox"/> Crying	<input type="checkbox"/> Headache
<input type="checkbox"/> Confusion	<input type="checkbox"/> Shakiness	<input type="checkbox"/> Confusion	<input type="checkbox"/> Shakiness
<input type="checkbox"/> Inappropriate responses	<input type="checkbox"/> Drowsiness	<input type="checkbox"/> Inappropriate responses	<input type="checkbox"/> Hyperactive
<input type="checkbox"/> Loss of conscious	<input type="checkbox"/> Numbness	<input type="checkbox"/> Vomiting	<input type="checkbox"/> 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 <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hyperglycemia <input type="checkbox"/> Assigned standard reaction response <input type="checkbox"/> Individualized care plan	Reviewed on: _____ Delegated or assigned caregivers, names and trained date: _____ _____ Nurse Signature: _____

Student's Emergency Medication Location

First Aid Room

Self-carries; Location: _____

**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

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

Comments: _____

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
