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:** ___________	☐ Before meals
Lunch	1 unit/ _______	1 unit for every________ above target BG	☐ 1 hour after eating
Snack	1 unit/ _______	**Ketone Correction**	☐ Before physical activity
		1 unit for every________ above target BG	☐ 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

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: _________________

*****In response to the COVID-19 pandemic; under the guidance of CDC, Kentucky Department of Education and local health department, small modification will be made during the school day to accommodate the needs and safety of the student. It is Boone County's policy to keep the privacy and integrate of the student's health while providing a safe environment; all proper health checks and laws still apply during the modification.*****

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.

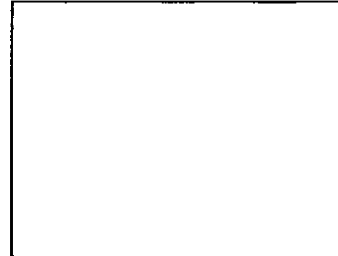
FOR SCHOOL NURSE USE ONLY	
Potential Complications	Reviewed on: ___________________________
☐ Hypoglycemia	Delegated or assigned caregivers, names and trained date:
☐ Hyperglycemia	____
☐ Assigned standard reaction response	____
☐ Individualized care plan	Nurse Signature: ______________________________

Revised Nov. 2015 SW

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

Revised Sep 2019 SLW