

PART B: DIABETES INDIVIDUAL HEALTHCARE PLAN

Parents and School Nurse to Complete Annually Together

NAME: _____ DOB: _____ SCHOOL: _____ GRADE: _____
 Start Date _____ End Date: _____ Last day of school Other: _____

Brief History:

| | |
|---|--|
| Age of onset: | Results and date of Hemoglobin A1C test: |
| Date(s) of recent hospitalizations: | Related social/emotional factors: |
| Concurrent illness or disability (including medications): | |

Substantial limitation in major life activities:

All students with diabetes are substantially limited in the function of the endocrine system. Additional major life activities affected:

Eating Caring for oneself Thinking Communicating Learning
 Other: _____

ACCOMMODATIONS:

Daily Diabetes Routine:

| | |
|---|--------------------------------------|
| Daily Snacks (time): _____ | Recess Times: _____ |
| Blood Glucose testing: Time/s: _____ | Insulin Injections: Time/s: _____ |
| Location/s: _____ | Location/s: _____ |
| Breakfast eaten at (time): _____ | PE days/times: _____ |
| Lunch eaten at (time): _____ | |

- **District food services department** will provide carbohydrate content information for meals provided by the district.
- **Student will be allowed** unrestricted access to water, meal/snack, and use of restroom. Meals will never be withheld because of nonpayment of fees or disciplinary action.
- 504 team will assess student's ability to take standardized tests, and provide accommodations as necessary.
- The classroom teacher/physical education teacher/coach will be informed if the student has a blood glucose reading that could affect his/her functioning, i.e., blood glucose less than ____ or over ____ by:

Student verbally Written note from the office Other (specify) _____

When the student experiences either a low blood glucose reaction or a high blood glucose reaction, his/her thought processes are likely to be adversely affected. Therefore, accommodations will need to be made for performance expectations during the time immediately before and for at least one hour after the reaction is treated.

- Classroom Parties:** Food treats will be handled as follows: Student will eat treat Replace with parent/guardian supplied alternative Modify the treat _____
 Schedule extra insulin per prearranged plan.
- After school activities/school sponsored events:** _____
 Note: Student will be permitted to participate in all school-sponsored activities without restriction and with all of the accommodations and modification indicated in this plan.
- Field Trips:** All diabetes supplies are taken and care is provided by: Licensed nurse PDA Other _____
 Note: In the event that none of these options are (unexpectedly) unavailable, student may remain at school and be provided a comparable experience or stay home when applicable.
- Transportation:** Student: Takes the bus (Bus # _____) Walks Is transported by parent
 On bus care is provided by: Licensed nurse PDA Other _____
 Note: In the event that the above options are unexpectedly unavailable, parent may transport the student to and from school or the student may remain at home when applicable.
 Parent may choose for student to not be transported on school bus with BG < ____ or > ____ within 30 minutes of testing. Call parent to pick up student.
- Parent Designated Adult:** Is a PDA present for your child? Yes No (If Yes, PDA Documentation Required)
- Additional accommodations:**

EXTRA SUPPLIES (PROVIDED BY PARENT/GUARDIAN), INCLUDING LOCATION (including disaster supplies):

| |
|----|
| 1. |
| 2. |
| 3. |
| 4. |

EMERGENCY CONTACTS:

Mother/Guardian

Father/Guardian

| | |
|-------------|-------------|
| Name: | Name: |
| Home Phone: | Home Phone: |
| Work Phone: | Work Phone: |
| Other: | Other: |

ADDITIONAL EMERGENCY CONTACTS:

| | | |
|----|---------------|--------|
| 1. | Relationship: | Phone: |
| 2. | Relationship: | Phone: |

LICENSED HEALTHCARE PROVIDER:

| | | |
|-------------------|--------|------|
| Name: | Phone: | Fax: |
| Location/Address: | | |

SIGNATURES:

| | |
|------------------|-------|
| Parent/Guardian: | Date: |
| School Nurse: | Date: |