**INDIVIDUALIZED HEALTHCARE PLAN – DIABETES WITH INJECTION HEALTHCARE PROVIDER ORDERS**

**Monitor Blood Glucose – test...**
- If student has symptoms of high or, **without moving student**, low blood glucose
  - Before breakfast
  - Before mid-morning snack
  - Before lunch
- After lunch
- Before afternoon snack
- Before leaving school
- Other: ____________

Where to test: □ Classroom □ Health office □ Other: ____________

**Check ketones** if nausea, vomiting or abdominal pain or blood glucose >300 twice when tested 2 hours apart.
- Give _____________ of rapid-acting insulin for moderate ketones, or _____________ for large.

Repeat ketone test in 2 hours, and repeat additional insulin as above if moderate or large ketones are still present.

**Routine Daily Insulin Injection:**
- Insulin Delivery: □ Syringe/vial □ Pen
- Type: □ rapid acting (Humalog / NovoLog / Apidra) □ regular or □ other: ____________

Calculate insulin dose for carbohydrate intake:
- Give ____ unit(s) of rapid-acting insulin for ___ grams of carbohydrate.
- Give at: □ breakfast □ AM snack □ lunch □ PM snack □ parties.

**Correction insulin dose for high blood glucose:**
- Time to be given: □ Before lunch □ Other: ____________

Do not give insulin correction dose more than once every 2 to 3 hours.
- □ Use correction scale

**Check ketones** if nausea, vomiting or abdominal pain OR if blood glucose >300 twice when tested 2 hours apart.
- Give _____________ of rapid-acting insulin for moderate ketones, or _____________ for large.
- Repeat ketone test in 2 hours, and repeat additional insulin as above if moderate or large ketones are still present.

**Exercise and Sports**
- □ Student should monitor blood glucose hourly.

**Parent/Guardian Authority to Adjust Insulin Dose**
- Dose adjustment allowed up to 20% higher or lower □ Yes □ No

**Other Health Concerns and Medications**
- Other health concerns: Allergies:
  - □ Glucagon Dose: _____________ IM or SC per thigh or arm
  - □ Oral diabetes medication(s)/dose: ___________________________ Times to be given: ___________________________
  - □ Other medication(s)/dose: ___________________________ Times to be given: ___________________________

**HCP Assessment of Student’s Diabetes Management Skills:**

<table>
<thead>
<tr>
<th>Skill</th>
<th>Independent</th>
<th>Needs supervision</th>
<th>Cannot do</th>
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</thead>
<tbody>
<tr>
<td>Check blood glucose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count carbohydrates</td>
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<td></td>
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<tr>
<td>Calculate insulin dose</td>
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<tr>
<td>Injection</td>
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**HEALTHCARE PROVIDER SIGNATURE/STAMP:**

**UPDATED** Change Date Initials

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Created by the Alaska Division of Public Health and the American Diabetes Association, Alaska Area

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