REQUIREMENTS FOR DEVELOPING AN INDIVIDUALIZED HEALTHCARE PLAN FOR STUDENTS WITH DIABETES

Parent/ Guardian will:

- ☐ Notify the appropriate school personnel of student diagnosed with diabetes.
- ☐ Educate and review diabetes treatment with student.
- ☐ Provide school with all completed forms prior to student starting the first day of school:

  1. INDIVIDUALIZED HEALTHCARE PLAN FOR DIABETES
  2. SELF-CARRY AND SELF-ADMINISTER DIABETES MEDICATION AGREEMENT-if authorized by physician in student's Individualized Healthcare Plan

- ☐ Provide the school with all prescribed medication with proper pharmacy label prior to starting school. Replace the medication after use or upon expiring.

Student will:

- ☐ Need to know his/her diabetes signs, symptoms, care they need, restriction(s), and treatment.
- ☐ If ordered by the physician, may carry his/her own diabetes medication/supplies. It must be labeled appropriately, including the expiration date. It must be stated in the *Self-Carry and Self-Administer Diabetes Medication Agreement* where the student will carry the diabetes medication/supplies and the school location for back up.
- ☐ If authorized by physician in the student's Individualized Healthcare Plan, the parent and student will sign the ***Self-Carry and Self-Administer Diabetes Medication Agreement.***
- ☐ Notify an adult immediately if he/she is having difficulty with his/her diabetes.

School:

- ☐ For a student with diabetes, the school will setup a meeting with the parent and appropriate school personnel to review the student's Individualized Healthcare Plan.
- ☐ School personnel are notified of the following:
  - Student(s) who have diabetes, any signs and symptoms to, instruction of care, and proper treatment.
  - The location of medication if carried by the student and the school location of the backup medication.
  - School will contact the Catholic Schools Office (CSO) if their school does not have a full-time licensed nurse. CSO will review diabetes documents for unlicensed personnel.

INDIVIDUALIZED HEALTH CARE PLAN FOR STUDENTS WITH DIABETES
2021-2022 SCHOOL YEAR

To be completed by the Parent:

Students Name: _____ D.O.B.: _____

School: _____

FATHER/GUARDIAN NAME: _____ MOTHER/GUARDIAN NAME: _____

ADDRESS: _____ ADDRESS: _____

EMAIL: _____ EMAIL: _____

CELL PHONE: _____ CELL PHONE: _____

FATHER'S EMPLOYER: _____ MOTHER'S EMPLOYER: _____

WORK PHONE: _____ WORK PHONE: _____

LIST PERSONS TO BE CONTACTED IN CASE OF EMERGENCY WHEN PARENT/GUARDIAN CANNOT BE REACHED

EMERGENCY CONTACTS	
NAME: _____	NAME: _____
PHONE: _____	PHONE: _____
EMAIL: _____	EMAIL: _____
RELATIONSHIP: _____	RELATIONSHIP: _____

Trained unlicensed school personnel: (filled in by school)

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Parent/Guardian Signature: _____ Date: _____

To be completed by the School:

This Diabetes Medical Management Plan has been reviewed by:

School Nurse/Health Coordinator Signature: _____ Date: _____

Principal Signature: _____ Date: _____

Before & After Program Coordinator Signature: _____ Date: _____
(If applicable)

Teacher notification provided by:

School Personnel Signature: _____ Date: _____