**Diabetes Individual Health Care Plan**

Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Review Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_ 504 Plan \_\_\_\_\_\_\_\_\_ IEP

Diagnosis: \_\_\_\_\_\_\_\_\_ Type I Diabetes \_\_\_\_\_\_\_\_\_ Type II Diabetes

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| STUDENT INFORMATION | | | | |
| Student: | School Year: | | | School: |
| Date of Birth: | Age: | | | Grade: |
| Parent/Guardian: | | | | |
| Lives with: \_\_\_\_ Both Parents \_\_\_\_Mother \_\_\_\_ Father \_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Parent/Guardian Phone: | | Parent/Guardian Phone: | | |
| Parent/Guardian Cell: | | Parent/Guardian Cell: | | |
| Other Contact: | |  | | |
| Physician: | | | Phone: | |
| Physician: | | | Phone: | |
| School Nurse: | | | Phone: | |
| BLOOD GLUCOSE TESTING | | | | |
| \_\_\_\_\_\_ Student is independent \_\_\_\_\_\_ Student needs assistance | | | | |
| Times to test:  \_\_\_\_\_\_ in AM ( ) \_\_\_\_\_\_ before PE ( ) \_\_\_\_\_\_ before lunch ( ) \_\_\_\_\_\_ afternoon ( ) \_\_\_\_\_\_ as needed  \_\_\_\_\_\_ other  Call parent if glucose is below \_\_\_\_\_\_\_\_\_\_\_\_ mg/dl    Or above \_\_\_\_\_\_\_\_\_\_\_\_ mg/dl  ***\*\*Always test if showing signs/symptoms of low or high glucose\*\**** | | | | |
| INSULIN DELIVERY | | | | |
| Insulin needed during school hours? \_\_\_\_\_\_\_ yes \_\_\_\_\_\_\_ no | | | | |
| Type of insulin: | | | | |
| Method of Delivery if needed at school: \_\_\_\_\_\_\_\_ Syringe \_\_\_\_\_\_\_\_ Insulin pen \_\_\_\_\_\_\_\_ Insulin pump | | | | |
| Person to administer insulin: \_\_\_\_\_\_\_\_\_student \_\_\_\_\_\_\_\_\_ nurse \_\_\_\_\_\_\_\_\_ staff \_\_\_\_\_\_\_\_\_ other ( )  Staff (specify): | | | | |
| Location of medication: \_\_\_\_\_\_\_ nurse office \_\_\_\_\_\_\_\_ with teacher \_\_\_\_\_\_\_\_ with student \_\_\_\_\_\_\_\_ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (specify)  **\*\*\* A completed Medication Authorization Form must be signed by both parent and physician and on file before any medication can be given or carried at school.** | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Blood Glucose Correction Dose (bolus):  \_\_\_\_\_\_\_\_\_\_\_\_ unit(s) of insulin per \_\_\_\_\_\_\_\_\_\_\_mg/dl over \_\_\_\_\_\_\_\_\_\_\_\_\_ mg/dl   |  |  | | --- | --- | | **Blood Glucose Level (mg/dl)** | **Units of Insulin** | | Less than 100 |  | | 101-150 |  | | 151-200 |  | | 201-250 |  | | 251-300 |  | | 301-350 |  | | 351-400 |  | | 401-450 |  | | 451 and above |  | | Meal Bolus: Insulin-CHO ratio \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  unit(s) of insulin for every \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ grams of carbohydrate (CHO)   |  |  | | --- | --- | | **CHO eaten (or to be eaten)** | **Units of Insulin** | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  | |
| **\*\* NOTE: If using insulin pump, enter blood glucose level and CHO eaten or to be eaten. The pump will calculate the prescribed amount if insulin.** | |

|  |
| --- |
| SNACK |
| Are snacks needed during school? \_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_ Yes If yes what time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  | | --- | | CALL PARENT FOR PERMISSION TO ALLOW STUDENT TO EAT CLASSROOM TREATS (e.g., birthday/holiday treats) | |

|  |
| --- |
| EXERCISE AND SPORTS |
| Is a snack needed before PE? \_\_\_\_\_\_\_\_\_No \_\_\_\_\_\_\_\_\_ Yes |
| Student should not exercise if blood glucose is below \_\_\_\_\_\_\_\_\_\_\_ mg/dl or above \_\_\_\_\_\_\_\_\_\_ mg/dl |

|  |
| --- |
| ALL SCHOOL-SPONSORED ACTIVITES (e.g., field trips, extra curricular activities. etc.) |
| Notify family of activities in order to preplan by: \_\_\_\_\_\_\_\_\_ 1wk \_\_\_\_\_\_\_\_\_ 2wks \_\_\_\_\_\_\_\_\_ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  The following supplies should be available to student during school-sponsored activities:  ☐ A copy of the Student’s Diabetes Health Plan and ☐ Injection/insulin pump supplies with appropriate  section 504 plan. storage.  ☐ Glucometer and test strips ☐ Bag lunch or snacks (optional)  ☐ Fast-acting carbohydrate source ☐ Glucagon Kit  (e.g., fruit juice, glucose gel or tablets) ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| LOW BLOOD GLUCOSE (HYPOGLYCEMIA) |
| **Emergency situations may occur with low blood sugar!!**  Symptoms:  MILD shaky, feels low, feels hungry, confused, blurred vision, lack of concentration, sweaty  MODERATE mood/behavior change, anxious, inattentive, poor coordination  SEVERE extreme confusion, unable to swallow, unconsciousness, seizures **(see Glucagon)**     Student needs treatment when blood glucose is below \_\_\_\_\_\_\_\_\_ mg/dl or if symptomatic   If treated outside classroom, a person MUST accompany student to nurse’s office.   If glucose is below \_\_\_\_\_\_\_\_\_\_ mg/dl give \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   After 15 minutes recheck blood sugar   Repeat until blood glucose is above \_\_\_\_\_\_\_\_\_\_ mg/dl |
| GLUCAGON: Student has glucagon at school (signed authorization must be submitted): NO \_\_\_\_\_\_\_\_\_\_ YES \_\_\_\_\_\_\_\_\_\_  **\*\*Glucagon protocol to be followed\*\***  **\*\*Only trained staff can administer. Given when student is unconscious, unresponsive or having a seizure\*\***  **Trained Staff:**  **(Glucagon)** |

|  |
| --- |
| HIGH BLOOD GLUCOSE (HYPERGLYCEMIA) |
| Symptoms:  MILD extreme thirst, tiredness, blurred vision, flushed skin  MODERATE nausea/vomiting, stomach pain  SEVERE labored breathing, weakness, confusion, unconsciousness   Student needs treatment when blood glucose is over \_\_\_\_\_\_\_\_\_\_\_ mg/dl  If blood glucose is over \_\_\_\_\_\_\_\_\_\_ mg/dl contact parent   Encourage student to water or sugar-free drinks   If vomiting call parents immediately!   Ketones should be checked (equipment provided by parent)  **If ketones are:**  **Trace/Small** **Moderate/Large**  Allow bathroom access Allow bathroom access  Encourage water/sugar-free fluids Encourage water/sugar-free fluids  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Call parents  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| DIABETES SUPPLIES TO BE KEPT AT SCHOOL |
| ☐ Glucometer, glucose test strips, batteries ☐ Fast-acting source of glucose  ☐ Lancets ☐ Carbohydrate snack  ☐ Insulin pump supplies ☐ Glucagon emergency kit  ☐ Insulin vials and syringes ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ☐ Insulin pen, pen needles ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| DIABETES ORAL MEDICATION |
| Name of medication, dose and schedule (list): ☐ not applicable|
| MONITORING |
| Target blood glucose range: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ mg/dl  Can student perform own glucose test? \_\_\_\_\_\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES Exceptions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of Glucose monitor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (maintained by parents)  Other Info: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| IMPORTANT INFORMATION |
|  |
| STAFF TRAINED TO TREAT |
|  |
| EXPECTED OUTCOMES |
|  |

As a parent/guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, I give my permission to the school nurse and other trained designated staff to perform and carry out the diabetes tasks as outlined in this Diabetes Individual Health Plan (IHP). I understand that the information contained in this plan will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the school nurse whenever there is any change in the student’s health status or care. Parent/Guardian are responsible for the maintaining of necessary supplies, blood glucose monitor, medications and equipment.

Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Nurse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Administrator \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_