Diabetes Individualized Healthcare Plan

Student:			**ID:**
Grade:	**D.O.B.**	**Educational Placement:**	
School:		**Teacher/Room:**	
District:			
School Nurse:	**Clinic#:**		**Fax #:**

PARENT'S SIGNATURE: _____ **Consent Date:** _____

PHYSICIAN'S SIGNATURE: _____ **Authorization Date:** _____

Parent	**Home #**	**Work #**	**Cell #**
Parent	**Home #**	**Work #**	**Cell #**
Guardian	**Home #**	**Work #**	**Cell #**
Home Address		**City**	**Zip**
Other Contact (Relationship):		**Home #**	**Work #**
Physician		**Phone #**	**Fax #**
Physician Address		**City**	**Zip**

Healthcare Service Needed at School	**Management of Diabetes at School and School Sponsored Events:**
Purpose of an ISHP	1. **The purpose** of an Individualized School Healthcare Plan (ISHP) is to provide safe management of healthcare needs and services for students at school and during school-related activities. 2. **The school nurse**, in collaboration with the student and the student's parent/guardian, healthcare providers, and school team, is responsible for: a) Development, implementation, and revisions of the ISHP. b) The training and supervision of all designated personnel who will provide healthcare according to the ISHP and standard procedures. 3. **ISHP revisions** must be directed to the school nurse prior to implementation. All physician changes must have a written physician authorization and written parent consent. Revisions, not requiring physician authorization, may be made with written parent consent. 4. **ISHP review** must occur annually and whenever necessary to ensure provision of safe care.

Individualized Healthcare Plan for Management of Diabetes at School
Completed with Parent and Student

Student:	**School:**	**Grade:**	**ID:**

Diabetic Routines At School Per Parent Request/Consent

Daily Snacks: Time(s) _____
Place specified_____
☐ Done independently
☐ Needs reminder
☐ Needs daily compliance verification

- **Extra Snacks:** ☐ Before exercise
  ☐ After exercise
  ☐ 10 gms. CHO every 30 minutes during vigorous exercise
  ☐ Needs daily compliance verification
- **Daily Blood Test:** ☐ Before Meals ☐ Prior to Exercise ☐ As Needed
  Location for testing ☐Classroom ☐ Health Office
  Student is to be tested where they are at if Hypoglycemic
  ☐ By student independently
  ☐ Adult verifies results
  ☐ Needs assistance (specify)_____
  ☐ **Refer to Algorithms for Blood Glucose Results, (attached sheet).**
- **Exercise:** ☐ None if blood glucose test results are below _____ mg/dl
- **Lunch Eaten At** (time) _____ Regardless of schedule changes, field trips, disaster, etc.
  ☐ Needs daily verification of meal eaten
  ☐ Written consent with schedule changes with snack and meal times.
- **Field Trips:** all diabetic supplies are taken and care is provided according to this ISHP (a copy is taken on trip)

NOTIFY SCHOOL NURSE TWO WEEKS BEFORE FIELD TRIP TO PREPARE QUALIFIED PERSONNEL

- **In Event of Classroom/School Parties**, food treats will be handled as follows:
  ☐ Student will eat the treat.
  ☐ Replace with parent supplied alternative
  ☐ Place in baggie and take home with teacher note.
  ☐ Modify the treat as follows: _____
  ☐ Do not eat snack.
- **In Event of Bus Transportation:**
  ☐ Blood test given 10 to 20 minutes before boarding. If 70 or less, provide care per **Procedure for Mild to Moderate Low Blood Glucose**
  ☐ Blood test not required.
- **Scheduled After-School Activities:** _____
  _____
  _____

Training and Notification of School Employees of Diabetes Basic Training Program

The following personnel will be notified of my child's medical condition and participate in Diabetes Basic Training Program:
☐All School Personnel ☐ School Personnel that have contact with my child ☐ Cafeteria Staff ☐ Other _____

Other

(Specify):_____
Student has unrestricted use of the bathroom and water.

Individualized Healthcare Plan
For Management of Diabetes at School (Continued)
Completed with Parent and Student

Student:	**School:**	**Grade:** **ID:**

Equipment and supplies

Provided By Parent

Daily Snacks (for AM/PM snack times) Specify:

_____

Extra Snacks (for before, after, and/or during exercise) Specify:

_____

Blood Glucose Meter Kit
(Includes meter, testing strips, lancing device with lancets, cotton balls)

Brand/Model:_____

Low Blood Glucose Supplies, (5 day supply)

- ☐ **Fast-Acting Carbohydrate Drinks:** (Apple juice and/or orange juice, sugared soda -NOT diet), at least 6 containers.
- ☐ **Glucose Tablets**, 1 package or more.
- ☐ **Glucose Gel Products** (Insta-Glucose, Glucose/25--31 gms.), 2 or more.
- ☐ **Gel Cakemate** (not frosting), (19 gm, mini-purse size), 2 or more.
  Note: Not used in Emergency Procedure for Severe Low Blood Sugar**.**
- ☐ **Prepackaged Snacks** (such as crackers with cheese or peanut butter, yogurt, etc.), 5-6 servings or more.

High Blood Glucose Supplies

- ☐ Ketone Test Strips/Bottle
- ☐ Urine cup
- ☐ Water bottle

Note: Timing device may be wall clock or watch worn by student or personnel.

Provided By Parent (Continued)

Insulin Supplies

- ☐ Insulin pen
- ☐ Pre-filled syringes (labeled per dose)
- ☐ Insulin and syringes
- ☐ Extra pump supplies such as:
  - ☐ Vial of insulin, syringes
  - ☐ Pump syringe
  - ☐ Pump tubing/needle
  - ☐ Batteries
  - ☐ Pump cannula inserter

Insulin supplies stored:

_____

Emergency Supplies

- ☐ **Glucagon kit stored:**

_____

- ☐ **3-day disaster food supply stored**:

_____

3 Day Disaster Diabetes Supplies

- ☐ Vial of insulin; 6 syringes
- ☐ Insulin pen with cartridge and pen needles
- ☐ Blood glucose testing kit (testing strips lancing device with lancets
- ☐ Glucose gel product and glucose tablets
- ☐ Glucagon kit
- ☐ Food supply (include daily meal plan) stored as follows:_____
- ☐ Ketone strips/plastic cup

School will include a copy of the ISHP for Diabetes Management with the Disaster Supplies. Stored as follows:

_____

_____

Other Supplies, Specify:

Signs of Low Blood Sugar:
Fatigue, excessive sweating, trembling, clammy, dizziness, headache, hunger pangs, visual impairment, accelerated heart beat, anxiety, difficulty concentration, blackouts, confusion, crying, irritability, poor coordination, nausea, inappropriate behavior.

Algorithms for Blood Glucose Results

Signs of high Blood sugar:
Early Symptoms:
Thirsty /dry mouth, frequent urination, fatigue/sleepiness, increased hunger, blurred vision, lack of concentration.
Symptoms progressively become worse:
Sweet breath, nausea/stomach pains, vomiting, weakness, confusion, labored breathing, unconsciousness/coma.

Check Blood Glucose

Below 70

1. Give fast acting sugar source and carbohydrate*.
2. Observe for 15 minutes.
3. Retest blood glucose; if less than 70, repeat sugar source. If over 70 give carbohydrate and protein snack (e.g. Crackers and cheese) if NOT eating meal within ____ minutes.
4. Notify School nurse.

If Student Becomes Unconscious, Seizures, or is Unable to Swallow:
1. Call 911
2. Administer Glucagon, if ordered and provided.
3. Place student on his/her side in recovery position.
4. Notify school nurse, parents/PMD.

70-90

1. Give fast acting carbohydrate. If meal or snack is within ____ minutes, no additional carbs are needed. If student is not going to eat within ____ minutes, additional carb and protein snack is to be given.

If student's blood sugar result is immediately following strenuous activity, give an additional fast acting sugar.

91-125

If exercise is planned before a snack or a meal, including recess, the student must have a snack before participating.

126-250

No treatment needed.

Above 250

Check Ketones (If ordered; cannot exercise until ketones are negative.)
Provide extra water.

Ketones Present – Notify School Nurse Immediately.

Provide 1-2 glasses of water every hour.

No exercise until ketones have cleared.

If at any time student vomits, becomes lethargic, and/or has labored breathing CALL 911.

Fast Acting Sugar Sources (Do not give chocolate)	
• 3-4 glucose tablets • 15 gm glucose gel • 4 oz. sugared soda • 4 oz. juice	• 3 tsp. sugar (in water)

Student's Name:
School:
Nurse Contact number:
Physician's number:
Parents Phone Numbers:

******Never send a child with suspected low blood glucose anywhere alone.**