APPENDIX B

INDIVIDUAL HEALTH PLAN/SECTION 504 PLAN*

Student: ______________________________
Birthdate: ______________________________
Address: ______________________________
Physician: ______________________________
Contact No.: ___________________________

Effective date: ____________________

Brief history:
____
____
____
____

School: ____________________________
Grade: __________________
Phone: __________________
Mother: ______________________
Home: ______________________
Work: ______________________
Pager/cell phone: _____________

Father: ______________________
Home: ______________________
Work: ______________________
Pager/cell phone: _____________

Age of onset: ____________________

Date(s) of recent hospitalizations: ______________

Concurrent illness or disability:
____
____

Result and date of HbA_1C test: _________

Related social/emotional factors:
____
____
____
____

Level of independence (attach copy of "HCP Orders for Students with Diabetes in Washington State Schools") (Appendix C).

PURPOSE: To promote student self-management of diabetes, recognize signs of high and low blood sugar, and provide appropriate assistance and/or emergency care.

PLAN:

Daily Diabetes Routines

- **Daily snacks** at school (time)____________
- **Recess times** ______ a.m. and _____ p.m.
- **Blood sugar test**
  Time:__________________ Location:_________________________
- **Insulin injection**
  Time:__________________ Location:_________________________
- **Lunch eaten at** (time)___________ regardless of schedule changes, field trips, disaster, etc.
- **P.E. days and times** ______________________________
- **Notify parents of shortened school day.**

***Parents to establish plan with school nurse and with HCP orders**

1. **Notify parent prior to planned field trip.** All diabetes supplies are taken and care is provided:

   ______By accompanying parent.
   ______According to procedure developed prior to field trip.
   ______According to low/high blood sugar school plans.

2. **In event of classroom/school parties,** food treats will be handled as follows:

   ☐ Student will eat treat. ☐ Replace with parent-supplied alternative.
   ☐ Modify the treat as follows: ______________________________________
   ____
   ☐ Schedule extra insulin per prearranged plan.

3. **Scheduled after-school activities:**

   ☐ List:____
   ____

   ☐ Low/high blood sugar school plans to supervisor with instruction.

4. **Attach copies of High Blood Sugar School Plan and Low Blood Sugar School Plan****

5. **Activities students can self-manage:**

   ☐ Totally independent management.
   OR

   A. Blood sugar testing:
      ☐ Student tests independently.
      ☐ Student tests with verification of number on meter by designated staff.
      ☐ Student needs help with testing and/or to be done by school nurse.
      ☐ Test needs to be done by nurse.

   B. Insulin injection:
      ☐ Administers independently.
      ☐ Student self-injects with verification of number on insulin pen by designated staff.
      ☐ Student self-injects (syringe or pen) with school nurse supervision.
      ☐ Administration by nurse.

   C. ☐ Self-treats mild hypoglycemia.

   D. ☐ Monitors own snacks and meals.

   E. ☐ Tests and interprets own ketones.

   F. ☐ Student implements universal precautions when lancing finger and disposing of lancets/syringes.

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

6.

<table>
<tr>
<td>EQUIPMENT AND SUPPLIES PROVIDED BY PARENT</td>
<td><u>Blood sugar meter kit</u> (includes all blood testing supplies for school).
<u>Low blood sugar supplies:</u>

For example:
• Fast-acting carbohydrate drinks: apple juice and/or orange juice and soda pop (regular, not diet) – 6-pack
• Glucose tablets
• Glucose gel product
• Gel cakemate (not frosting) (19 gm. mini-purse size)
• 5–6 Prepackaged snacks (such as cracker/cheese, crackers/peanut butter, etc.).

<u>Daily snacks</u> (for A.M./P.M. snack times).

Snacks stored:
____
______________________________</td>
<td>Disaster supplies (check x):

_____Food supply for three days stored in:

_____Low blood sugar supplies

_____Medication and medical supplies stored in:

_____Insulin pen and needles

_____Insulin and syringes

<u>Other supplies</u> (specify):

<u>Disaster preparedness plan (appendix N) attached</u>.</td>
</tr>
</table>

7. School bus driver instructions:

☐ Call parent to pick up student if a low blood sugar episode occurs 30 minutes or less prior to departure regardless if sugar returns to normal reading.

☐ Student to eat snack on bus if part of care plan or if having signs of low blood sugar and able to swallow.

☐ Driver to call for special directions.

Date of next plan review:____
Must be reviewed before the beginning of the next school year unless there is a change requiring an earlier revision.

Parent	**Date**	**School Nurse**	**Date**
Teacher	**Date**	**HCP/Physician**	**Date**
Student	**Date**		

Adapted with permission from form of the Orange County Department of Education, Costa Mesa, CA and the Orange County School Nurses Association.

INDIVIDUAL HEALTH PLAN/SECTION 504 PLAN

DIABETES TRAINING RECORD

Student:___________________________ **School:**______________________________

NAME/POSITION	TRAINING PROVIDED	DATE	TRAINER/TITLE

Plan distributed to the following:

NAME/POSITION	A/B*	DATE	SIGNATURE

* A. Received entire **IHP/Section 504 plan.**

B. Received **High Blood Sugar School Plan and Low Blood Sugar School Plan.**

INDIVIDUAL HEALTH PLAN/SECTION 504 PLAN

Skills Checklist for: Blood Glucose Meter and Insulin Pen

Student:___________________________________

Person Trained:__________________________

Position:__________________________________

Glucose meter		**Return Demonstration**			
	Demo Date	Date	Date	Date	Date
A. States name and purpose of procedure					
B. Identifies Supplies:					
1. Glucose meter					
2. Test strips					
3. Lancing device and/or lancet					
C. Steps:					
1. Verify the number on the machine's display window.					
2. Write the number down on the date log.					
3. Notify personnel as appropriate.					
4. Assure appropriate action per IHP					

Insulin Pen		**Return Demonstration**			
	Demo Date	Date	Date	Date	Date
A. States name and purpose of procedure					
B. Identifies Supplies:					
1. Insulin pen with cartridge					
2. Pen needles					
3. Alcohol wipes					
C. Steps:					
1. Verify the number dialed into the window of the pen.					
2. Write the number down on the date log.					
3. Notify personnel as appropriate.					
4. Assure appropriate action per IHP.					

Checklist content approved by:

_____________________________________ _____________________________

Parent/Guardian Signature Date

_____________________________________ _____________________________

Instructor Date