

LWSD Health Services  
**DIABETES - Individual Health Plan (IHP)**

**Student Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
**School:** \_\_\_\_\_ **Year:** \_\_\_\_\_  
**Grade:** \_\_\_\_\_ **Student #:** \_\_\_\_\_  
**Teacher:** \_\_\_\_\_  
**Transportation:** ☐ Walker ☐ Bus ☐ Parent/Guardian ☐ Student Driver ☐ Other: \_\_\_\_\_

Parent Designated Adult (PDA) ☐ Yes: Name: \_\_\_\_\_ ☐ No, contact Health Room Ext: \_\_\_\_\_

**HYPOGLYCEMIA (LOW BLOOD SUGAR) EMERGENCY CARE PLAN**

Moderate Symptoms	Immediate Response	Student Specific Management
<ul style="list-style-type: none"> <li>• Shakiness</li> <li>• Dizzy / lightheadedness</li> <li>• Sweating</li> <li>• Hunger or nausea</li> <li>• Pallor (looking pale)</li> <li>• Fast or irregular heartbeat</li> <li>• Confusion, disorientation</li> <li>• Loss of coordination</li> <li>• Weakness, fatigue</li> <li>• Headache</li> <li>• Behavior or mood change</li> <li>• Argumentative, combative</li> <li>• Difficulty concentrating</li> <li>• Blurry vision</li> <li>• Slurred speech</li> <li>• Irritability or anxiety</li> </ul> <p>Some students may not be able to communicate their symptoms clearly due to their age or developmental challenges.</p>	<p><b>If student is experiencing any moderate symptoms follow orders to raise blood sugar.</b></p> <ul style="list-style-type: none"> <li>• Maintain adult supervision and notify trained staff member</li> <li>• Support them to eat snack as ordered</li> <li>• Snack Location: _____</li> <li>• Document time and amount of carbohydrates given</li> <li>• Stay with student and continue to follow their specific orders</li> <li>• If symptoms worsen or are not improving after orders have been followed, CALL 911, contact School Nurse and parent/guardian</li> </ul> <p><b>Do NOT give insulin to cover carbohydrates that are given to treat low blood glucose</b></p>	<p><b>Student normal range:</b> ____ to ____</p> <p><b>Call home if blood sugar is:</b> below ____ or above ____</p> <p>► <b>If Blood Glucose (BG) is below ____:</b></p> <ol style="list-style-type: none"> <li>1. If student is conscious and able to swallow, immediately give ____ grams fast-acting carbohydrate (i.e. glucose tabs, juice) such as: _____</li> <li>2. Recheck blood glucose in 15 minutes</li> <li>3. Repeat carbohydrate treatment if indicated per orders, or if student remains symptomatic. Recheck blood glucose in 15 minutes.</li> <li>4. If BG remains below 70, or student is symptomatic, repeat carbohydrate treatment per orders and notify parent/guardian. Request pick up if indicated.</li> <li>5. Do not allow student to return to class until symptoms and blood glucose trend are improving.</li> </ol> <p><b>Carbohydrates should NEVER be withheld if the student is symptomatic and testing is not available.</b></p>
SEVERE Symptoms	IMMEDIATE Response	Student Specific Management
<ul style="list-style-type: none"> <li>• Loss of consciousness</li> <li>• Unresponsive</li> <li>• Difficulty swallowing</li> <li>• Seizures</li> </ul>	<p><b>If student is experiencing any severe symptoms: CALL 911 and request paramedic response. Request AED to student location.</b></p> <ul style="list-style-type: none"> <li>• Turn on side to keep airway open</li> <li>• Do NOT give anything by mouth</li> <li>• Administer glucagon per orders</li> <li>• If the student is unresponsive, not breathing, and/or has no pulse, start CPR, turn on and follow AED prompt</li> <li>• Notify nurse and parent/guardian</li> </ul>	<p><b>Glucagon Type &amp; Route:</b></p> <p>_____</p> <p><b>Location:</b></p> <p>_____</p> <ul style="list-style-type: none"> <li>• Glucagon can only be administered by trained staff</li> <li>• Document time Glucagon was administered</li> </ul>

## HYPERGLYCEMIA (HIGH BLOOD SUGAR) EMERGENCY CARE PLAN

Symptoms		Immediate Response/Management
<b>Mild</b> <ul style="list-style-type: none"> <li>• Extreme thirst</li> <li>• Dry mouth</li> <li>• Frequent urination</li> <li>• Fatigue</li> <li>• Change in appetite</li> <li>• Blurry vision</li> <li>• Loss of concentration</li> <li>• Fruity/sweet breath</li> <li>• Mood changes</li> <li>• Irritability</li> </ul>	<b>Moderate</b> <ul style="list-style-type: none"> <li>• Nausea/vomiting</li> <li>• Stomach cramps</li> </ul> <b>Severe</b> <ul style="list-style-type: none"> <li>• Labored breathing</li> <li>• Extreme weakness</li> <li>• Loss of consciousness</li> </ul>	<p style="text-align: center;"><b>► If Blood Glucose (BG) above _____:</b></p> <p>While hyperglycemia is not an immediate emergency, it may progress to a more serious condition</p> <ul style="list-style-type: none"> <li>• Notify trained staff member</li> <li>• Encourage student to drink water and rest</li> </ul> <p>Trained staff member or student will check blood glucose, provide insulin corrections, inspect tubing and infusion site and check ketones per orders. Notify School Nurse.</p> <p style="text-align: center;"><b>No exercise with positive ketones or if having nausea or abdominal pain.</b></p> <p style="text-align: center;"><b>If urine ketones are MODERATE/LARGE, student is required to go home.</b></p>

**Scheduled Supervised Glucose Checks during the School Day?:** ☐ No, continue to next section ☐ Yes, see below for details

Meal Times: ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Pre-Dismissal Snack ☐ Other \_\_\_\_\_

Physical Activity: ☐ Before Recess ☐ Before PE ☐ Before Sports ☐ After Physical Activity ☐ Other \_\_\_\_\_

Additional Anticipated Checks: \_\_\_\_\_

### Student Level of Self-Management:

- ☐ Self-Care: Manages diabetes independently. Support is provided upon request and as needed.
- ☐ Supervision: Trained staff to assist & supervise. Guide & encourage independence.
- ☐ Full Support: All care performed by School Nurse and trained staff (as permitted by state law).

Self Management Notes:

\_\_\_\_\_

### Medications / Devices / Interventions:

Allergies: ☐ No ☐ Yes If yes, list: \_\_\_\_\_

**INSULIN DELIVERY:** ☐ Syringe ☐ Pen ☐ Pump ☐ Other: \_\_\_\_\_ Brand & Model: \_\_\_\_\_

**LOCATION OF INSULIN:** ☐ Health Room ☐ In Pump ☐ Self-carry Location: \_\_\_\_\_ ☐ Other: \_\_\_\_\_

Continuous Glucose Monitor (CGM): ☐ No ☐ Yes, Brand & Model: \_\_\_\_\_ Viewing Device: \_\_\_\_\_

Location of Diabetes Supplies: \_\_\_\_\_

Non-Diabetes Medication at School: ☐ No ☐ Yes If yes, list: \_\_\_\_\_

• Location of Medication: ☐ Health Room ☐ Self-Carry Location: \_\_\_\_\_ ☐ Other: \_\_\_\_\_

Medication at Home: ☐ No ☐ Yes If yes, list: \_\_\_\_\_

Preferred Hospital: ☐ Seattle Children's Hospital ☐ Other: \_\_\_\_\_

Diabetes History:
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Date of Diagnosis: \_\_\_\_\_ ☐ Type 1 ☐ Type 2

Has student ever lost consciousness, had a seizure, or required Glucagon? ☐ No ☐ Yes If yes, date of last event: \_\_\_\_\_

Has student ever been admitted for DKA after diagnosis? ☐ No ☐ Yes If yes, date of last event: \_\_\_\_\_

List of previously experienced hypoglycemia symptoms or student description of symptoms:

List of previously experienced hyperglycemia symptoms or student description of symptoms:

**Additional Diabetes Information (optional):** i.e. recess/PE considerations, dismissal instructions, schedule, half-day or late start considerations, communication preferences, etc.

## Parent / Guardian and Teacher Considerations:

### Parent/Guardian and/or student is responsible for:

- Communicating individualized diabetes care needs.
- Device training and management, this may include setup, placement and/or removal of devices .Examples: CGM, insulin pod.
- Remotely monitoring CGM.
- Notifying the program director regarding their student's medication and health care needs outside of the school day.  
Examples: extended day/childcare, clubs before & after school, evening, or summer activities.
- Providing additional supplies and snacks.
- Providing written number of carbohydrates contained in snack and lunch from home.
- Providing written notification to the nurse regarding dosing or insulin adjustments. i.e. insulin-to-carb ratio (ICR), correction factor (CF), target blood glucose. Dosing adjustments require 24-hour prior written notice for implementation.
- Adhering to appropriate cell phone use and school policy regarding the use of electronic devices.

### Teacher is responsible for:

- Notifying the parent/guardian, school nurse, PDA , and office staff of schedule changes, such as field trips, parties, or special activities, to allow for safe insulin or meal adjustments.
- Recognizing and responding to symptoms of high and low blood sugar and following this health plan. Students with signs or symptoms of low blood sugar should never go anywhere alone.
- Allowing unrestricted access to water, snacks, restroom, glucose monitoring, and diabetes care devices including cell phone.
- Allowing devices to be within appropriate distance for proper operation and to reduce data loss. If the student is using their cell phone inappropriately, notify administration.
- Allowing treatment to be provided without delay. May include stepping outside of the classroom or in the current location.
- Allowing student devices to alarm in class. Most are audible beep or vibration. Do not penalize for alarms.

## Supplementary Information:

**Before signing, parent/guardian should review and complete this IHP in its entirety. A new IHP must be submitted each school year. The School Nurse must be notified if any changes are needed to this plan during the school year.**

- School Nurse and parent/guardian will collaborate to update this IHP as needed to account for changes in the student's health needs, level of diabetes care independence, and school schedule.
- LWSD schools do not staff a nurse on site during all school hours.
- Parent-designated adults (PDA) are individuals trained to provide diabetes care for a specific student consistent with their IHP. See the School Nurse, as training and additional paperwork is required.
- Teacher will communicate medical concerns to their substitutes by placing a copy of each health plan in the substitute file.
- School Nurse will ensure a copy of the health plan is kept in the health room, available for field trips, and in Skyward for staff.
- According to Washington State Law (RCW 28A.210.320 & RCW 28A.210.330) the attendance of every child shall be conditioned upon the presentation before or on the child's first day of attendance, an annual individual health plan, a medication or treatment order addressing any life-threatening health condition that the child has that may require medical services to be performed at school, and the provision for storage of medical equipment and medication provided by the parent. Once such a health plan, order, and medication/supplies have been presented if applicable, the child shall be allowed to attend school.

### Parents / Guardians:

Name	Relationship	Phone Number	Other Number	Address

### Additional Contact (optional):

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Parent Name (Print): \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_

School Nurse Signature: \_\_\_\_\_

Date: \_\_\_\_\_