

Student:

DOB:

Grade:



Individualized Healthcare Plan for Management of Diabetes at School

Student Name: _____

Date of Plan: _____

School Year: _____

Date of Diagnosis: _____

Type 1 ☐ Type 2 ☐

CONTACT INFORMATION

Mother/Guardian:		
Address:		
Home:	Work:	Cell:
Email:		
Father/Guardian:		
Address:		
Home:	Work:	Cell:
Email:		
Physician/Provider:		
Address:		
Phone:		
Emergency Contact:		
Home	Work:	Cell:
Email:		
School Nurse/UDCA:		
Email:	Work:	Cell:

The purpose of an Individualized School Healthcare Plan is to provide safe management of healthcare needs and services for pupils at school and during school-related activities. Revisions must be directed to the school prior to implementation. All physician changes must have a written physician authorization and written parent consent. Review must occur annually and whenever necessary to ensure provision of safe care.

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CHECKING BLOOD GLUCOSE

Target range of blood glucose: ☐ 70-130 mg/dL ☐ 70-180 mg/dL ☐ Other: _____

Check blood glucose level:

- ☐ Mid-morning
- ☐ Before lunch
- ☐ _____ Hours after lunch
- ☐ 2 hours after a correction dose
- ☐ Before PE
- ☐ After PE
- ☐ Before dismissal
- ☐ Other _____
- ☐ As needed for signs/symptoms of low or high blood glucose
- ☐ As needed for signs/symptoms of illness

Brand/Model of blood glucose meter: _____

Student's self-care blood glucose checking skills:

- ☐ Independently checks own blood glucose
- ☐ May check blood glucose with supervision
- ☐ Requires school nurse or trained diabetes personnel to check blood glucose
- ☐ Uses a smartphone or other monitoring technology to track blood glucose values

Continuous Glucose Monitor (CGM): ☐ Yes ☐ No

Brand/Model: _____

Alarms set for: ☐ (low) and ☐ (high)

If student has symptoms or signs of hypoglycemia, check fingertip blood glucose level regardless of CGM reading.

Student's Self-care CGM Skills	Independent	
The student trouble shoots alarms and malfunctions	☐ Yes	☐ No
The student knows what to do and is able to manage a HIGH alarm	☐ Yes	☐ No
The student knows what to do and is able to manage a LOW alarm	☐ Yes	☐ No
The student can calibrate the CGM	☐ Yes	☐ No
The student knows what to do when the CGM indicates a rapid trending rise or fall in the blood glucose level	☐ Yes	☐ No

HYPOGLYCEMIA TREATMENT

Low Blood Glucose Supplies:

- ☐ Fast-acting carbohydrate drinks (fruit juices, non-diet sodas)
- ☐ Glucose tablets
- ☐ Glucose gel products
- ☐ Gel cake icing
- ☐ Prepackaged snacks
- ☐ Glucagon* (for emergency use, required for all diabetic students on campus)

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Student's usual symptoms of hypoglycemia (list):

If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than _____ mg/dL, give a quick-acting glucose product equal to _____ grams of carbohydrate.

Recheck blood glucose in _____ minutes and repeat treatment if blood glucose level is less than _____ mg/dL.

If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movements), give glucagon per diabetes medical management plan (DMMP) and prescribed orders, contact emergency services and parent/guardian.

HYPERGLYCEMIA TREATMENT

High Blood Glucose Supplies:

- Ketone test strips
- Urine cup
- Water bottle

Student's usual symptoms of hyperglycemia (list):

- Check ☐ Urine ☐ Blood for ketones every _____ hours when blood glucose levels are above _____ mg/dL.
- For blood glucose greater than _____ mg/dL AND at least _____ hours since last insulin dose, give correction dose of insulin (see orders)
- For insulin pump users: see additional information for student with insulin pump
- Give extra water and/or non-sugar-containing drinks (not fruit juices)
- Follow physical activity and sports orders
- Notify parents/guardian of onset of hyperglycemia
- Additional treatment for ketones: _____

If the student has symptoms of a hyperglycemia emergency, including dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy, or depressed level of consciousness, contact emergency services and the student's parents/guardian.

INSULIN THERAPY

Insulin delivery device:

- syringe
- insulin pen
- insulin pump

Student:

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Type of insulin therapy at school:

- Adjustable (basal-bolus) insulin therapy
- Fixed insulin therapy
- No insulin

Refer to DMMP for all insulin dosing, times and calculations.

Parent/Guardian Authorizations		
Parent/Guardian authorization should be obtained before administering a correction dose.	☐ Yes	☐ No
Parents/guardians are authorized to increase or decrease correction dose scale within the following range: +/- _____ units of insulin.	☐ Yes	☐ No
Parents/Guardians are authorized to increase or decrease insulin-to- carbohydrate ratio within the following range: _____ units per prescribed grams of carbohydrate, +/- _____ grams of carbohydrate.	☐ Yes	☐ No
Parents/Guardians are authorized to increase or decrease fixed insulin dose within the following range: +/- _____ units of insulin	☐ Yes	☐ No

ADDITIONAL INFORMATION FOR STUDENT WITH INSULIN PUMP

Brand/Model of pump: _____

Type of insulin in pump: _____

- For blood glucose greater than _____ mg/dL that has not decreased within _____ hours after correction, consider pump failure or infusion site failure. Notify parents/guardian.
- For infusion site failure: Insert new infusion set and/or replace reservoir.
- For suspected pump failure: suspend pump and give insulin by syringe or pen.

Student's Self-care Pump Skills	Independent	
Counts carbohydrates	☐ Yes	☐ No
Calculates correct amount of insulin for carbohydrates consumed	☐ Yes	☐ No
Administers correction bolus	☐ Yes	☐ No
Calculates and sets basal profiles	☐ Yes	☐ No
Calculates and sets temporary basal rate	☐ Yes	☐ No
Changes batteries	☐ Yes	☐ No
Disconnects pump	☐ Yes	☐ No
Reconnects pump to infusion set	☐ Yes	☐ No
Prepares reservoir, pod, and/or tubing	☐ Yes	☐ No
Inserts infusion set	☐ Yes	☐ No
Troubleshoots alarms and malfunctions	☐ Yes	☐ No

OTHER DIABETES MEDICATIONS

Name: _____ Dose: _____ Route: _____ Times given: _____

Name: _____ Dose: _____ Route: _____ Times given: _____

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MEALS/SNACKS

Meal/Snack	Time	Carbohydrate Content
Breakfast		_____ to _____
Mid-morning snack		_____ to _____
Lunch		_____ to _____
Mid-afternoon snack		_____ to _____
Before/During/After PE, Athletics		_____ to _____

Special event/party food permitted: ☐ Parent/Guardian discretion ☐ Student discretion

Instructions for when these foods are provided:

FIELD TRIPS

All necessary diabetic supplies are taken and care is provided according to the DMMP and ISHP (copies accompany student on trip).

The school nurse must be notified two weeks before the field trip to plan for qualified personnel to provide care.

Prior to bus transportation, a blood glucose check is performed within 15 minutes of boarding. If the result is 70 mg/dL or less, provide care as dictated by the DMMP, and consult with parent/guardian regarding the decision to allow the student to board.

PHYSICAL ACTIVITY AND SPORTS

May disconnect from pump for sports activities ☐ Yes, for _____ hours ☐ No

Set a temporary basal rate ☐ Yes, _____ %temp basal for _____ hrs ☐ No

Suspend pump use ☐ Yes ☐ No

A quick-acting source of glucose such as glucose tabs and/or sugar-containing juice must be available at the site of physical education activities and sports.

Refer to CHECKING BLOOD GLUCOSE and MEALS/SNACKS sections for instructions related to PE/athletics.

If most recent blood glucose is less than _____ mg/dL, student can participate in physical activity ONLY when blood glucose is corrected and above _____ mg/dL.

Avoid physical activity when blood glucose is greater than _____ mg/dL and/or if urine/ blood ketones are moderate to large.

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SIGNATURES

This Individualized Healthcare Plan has been approved by: (Student's Physician/Health Care Provider): _____ . I, (parent/guardian):

_____ give permission to the school nurse or another qualified health care professional or trained diabetes personnel of (school):

_____ to perform and carry out the diabetes care tasks as outlined in (student): _____ 's ISHP. I also consent to the release of the

information contained in this ISHP to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified health care professional to contact my child's physician/health care provider.

Parent/Guardian Signature: _____
Date

Physician Signature: _____
Date

School Nurse Signature: _____
Date