

DIABETES INDIVIDUAL HEALTH CARE PLAN - Elementary

Student: _____ **Student ID #** _____ **Grade:** _____ **Birthdate:** _____
School: _____

Goal: To promote student self-management of diabetes, recognize signs of high and low blood sugar, and provide appropriate assistance and emergency care. Use in conjunction with School Diabetes Medication Orders from endocrinology clinic/provider.

Preferred parent/guardian contact name and number(s) _____

Age at student's diabetes diagnosis: _____ ☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Other: _____

Any hospitalizations in the last year? ☐ No ☐ Yes, include dates: _____

Other illnesses or disabilities ☐ No ☐ Yes: _____

Last A1C _____ on date _____ (optional)

Insulin delivery-----

Injections ☐ No ☐ Yes, type: _____. See health care provider's orders for current dosing.

Other medication(s): _____

Pump? ☐ No ☐ Yes, type: _____

CGM? ☐ No ☐ Yes, type: _____. Does parent monitor CGM remotely? ☐ No ☐ Yes

CGM alarms are set for below _____ or above _____

The school nurse can check CGM for alarms for students who are not independent. It is not feasible to constantly monitor the device due to other responsibilities. The school nurse may review readings at specific times and respond to alerts when necessary, as outlined in this individual health care plan (IHP).

Does your child have a PDA (Parent Designated Adult)? ☐ No ☐ Yes. Specific [training](#) and [consent forms](#) required.

Name of PDA: _____ Contact information: _____

Check CGM and/or Monitor Blood Glucose (see orders describing when fingerstick needed)-----

☒ signs/symptoms of hypo or hyperglycemia ☐ before school

☐ before lunch ☐ after lunch ☐ behavioral concerns

☐ before PE ☐ after PE ☐ before recess ☐ after recess

☐ before bus ride or walking home ☐ other: _____

Low and High Blood Sugar

When blood sugar is low, what symptoms does your child usually experience and how does he/she describe it?

Treatment of low blood sugar (what works for your student, list preferred carb source):

Preferred carb source for treating low blood sugar per orders: _____

Call parent ☐ after first treatment and still symptomatic ☐ after second treatment and still symptomatic

☐ any time Blood Glucose is less than _____

LOCATION OF GLUCAGON rescue medication: ☐ Health Room ☐ Student's backpack ☐ Other _____

Glucagon route is ☐ nasal ☐ injection

When blood sugar is high, what symptoms does your child usually experience and how does he/she describe it?

Treatment of high blood sugar (what works for your student): ☐ drink water ☐ exercise ☐ insulin correction

See orders for ketone testing parameters.

Student's Self Care Ability

	Needs assistance:	Independent:	n/a:
Testing blood glucose	<input type="checkbox"/>	<input type="checkbox"/>	
Counting carbohydrates	<input type="checkbox"/>	<input type="checkbox"/>	
Calculating insulin doses	<input type="checkbox"/>	<input type="checkbox"/>	
Entering information into pump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administering insulin injection/bolus	<input type="checkbox"/>	<input type="checkbox"/>	
Identifying feelings of hypoglycemia and hyperglycemia	<input type="checkbox"/>	<input type="checkbox"/>	
Treating mild hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	
Changing pump site	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Testing ketones	<input type="checkbox"/>	<input type="checkbox"/>	

Daily Routine and Activity Planning

Transportation to school? ☐ Bus, route # _____, duration ~_____ min. ☐ Walk ☐ Parent drop-off

☐ Other: _____

Transportation home? ☐ Bus, route # _____, duration ~_____ min. ☐ Walk home ☐ Parent pick-up

☐ Other: _____

☐ Discuss transportation plan with parent if blood glucose is less than: _____

Meals/snacks: What time does your student eat breakfast? _____. What time does student get breakfast insulin? _____.

Will your student purchase school lunches? ☐ Yes ☐ Home Only – parent to provide carb counts

Does your student require a snack between meals? ☐ No ☐ Yes, when _____

PE/recess: Does your student experience low blood sugar with PE or activity? ☐ No ☐ Yes _____

PE days and times _____ Elementary only: Recess times _____

Does your student need a snack before physical activity? ☐ No ☐ Yes _____

☐ If blood glucose between _____ and _____ before PE, give _____ gram carbohydrate snack _____

☐ If blood glucose between _____ and _____ before PE, give _____ gram carbohydrate snack _____

☐ If blood glucose below _____ do not participate in PE until _____

Switch pump to exercise mode ☐ No ☐ Yes, in these circumstances: _____ ☐ Student will do

Class parties: Food treats will be handled as follows: ☐ Student will eat the treat ☐ Give carb coverage insulin per prearranged plan. ☐ Replace with parent-supplied alternative

Field trips: Diabetes supplies are taken and care is provided: ☐ by parent ☐ by PDA ☐ by student (middle/high school only) ☐ other: _____

Before or after school activities: Is your student involved in school-sponsored activities or sports outside the school day?

☐ No ☐ Yes* _____ *It is the responsibility of parent to inform adult/coach of student's condition and medication requirements, and to provide medication for the activity.

Academic considerations and accommodations, in addition to those on Emergency Care Plan

- Student is allowed access and time for blood glucose testing, snacks, hydration, and insulin administration, in the classroom and/or in the health room.
- If the student needs to take breaks to check blood glucose, or treat hypoglycemia or hyperglycemia during a test or other activity, the student will be given extra time to finish the test or activity.
- When the student experiences either a high blood glucose reaction or low blood glucose reaction, his or her thought processes are likely to be adversely affected. Accommodations may be needed during the time immediately before and for at least one hour after the high or low episode was treated without penalty. The student may inform the

teacher at that time and request to reschedule academic work impacted, if blood glucose is not in target range at time of classwork or testing.

- Student needs access to his/her own phone and/or smart watch to monitor and treat blood sugar.

Student Accommodations/504 Consent -----

- ☐ Yes, I DO CONSENT to an evaluation and placement for a Section 504 Plan. I am aware that there will be an annual review of the plan and periodic evaluations. I have received a copy of [Your Rights Under Section 504](#), and the district [Board Policy on the Use of Isolation, Restraint, and Other Uses of Reasonable Force](#).
- ☐ My student has an IEP.

Parent/Guardian Responsibilities-----

- Provide supplies and prescribed medications with the Medication Authorization Form or Seattle Children's Diabetes Orders signed by the health care provider prior to the first day of school.
- Provide properly pharmacy-labeled medications and replace medications after use or upon expiration.
- Inform school nurse of any changes in student's health status, care, or medication orders.
- If your student is self-carrying medication, arrange for your student to always have supplies at school and school activities. A back-up set of emergency supplies in the health room is strongly recommended.

Nurse Responsibilities-----

- Complete Emergency Care Plan and share with school staff and transportation department
- Provide annual health training to staff, and as needed, individual education regarding student's needs

Nurse Signature: _____

Date: _____

Parent Signature: _____

Date: _____

For Nurse Use Only:

- ☐ Medication Authorization form or diabetes orders received
- ☐ Medication and supplies received
- ☐ 504 entered in Synergy
- ☐ Emergency Care Plan complete
- ☐ Synergy Student Notifications complete for health alert