

IHP/EAP for Student with Diabetes

Name _____ Date of Birth _____

Parent/Guardian _____

Phone (w) _____ (h) _____ (c) _____

Phone (w) _____ (h) _____ (c) _____

Physician _____ Phone _____

Target Range for Blood Glucose

Parents should be notified when blood glucose is below _____ or above _____

Blood Glucose Monitoring Schedule

Student needs assistance/supervision with glucose monitoring: Yes ____ No ____

- | | |
|---|---|
| ☐ daily before breakfast (if student eating breakfast at school) | ☐ before exams |
| ☐ daily 2 hours after breakfast | ☐ before physical activity (PE/Recess) |
| ☐ daily before lunch | ☐ after physical activity |
| ☐ daily 2 hours after lunch | ☐ other _____ |

Physical Education/Recess

No participation in physical activity if blood glucose below _____ or above _____

Provide snack prior to physical activity if blood glucose below _____

Insulin

Type of Insulin: _____

Mealtime Dosing for Insulin Injections

Breakfast:

Give _____ units of Insulin for every _____ grams of carbohydrates

Lunch:

Give _____ units of Insulin for every _____ grams of carbohydrates

Maximum bolus dose of Insulin is _____ units (if applicable)

- ☐ Student uses sliding scale ☐ Separate sliding scale included/attached

Blood Glucose from _____ to _____ = _____ Units

Blood Glucose from _____ to _____ = _____ Units

Blood Glucose from _____ to _____ = _____ Units

Blood Glucose from _____ to _____ = _____ Units

Blood Glucose from _____ to _____ = _____ Units

Blood Glucose from _____ to _____ = _____ Units

Times to use sliding scale: With meals _____ Between meals _____

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CARE OF HYPOGLYCEMIA (LOW BLOOD GLUCOSE):

MILD OR MODERATE HYPOGLYCEMIA	SEVERE HYPOGLYCEMIA
<p>Please check previous symptoms</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> ☐ Anxiety ☐ Behavior change ☐ Blurry Vision ☐ Confusion ☐ Crying ☐ Dizziness ☐ Drowsiness ☐ Hunger ☐ Headache </div> <div style="width: 45%;"> ☐ Irritability ☐ Paleness ☐ Personality change ☐ Poor concentration ☐ Poor coordination ☐ Shakiness ☐ Slurred speech ☐ Sweating ☐ Other _____ </div> </div>	<div> ☐ Combative ☐ Inability to eat or drink ☐ Unconscious ☐ Unresponsive ☐ Seizures ☐ Other _____ </div>
ACTIONS FOR MILD OR MODERATE HYPOGLYCEMIA	ACTIONS FOR SEVERE HYPOGLYCEMIA
<ol style="list-style-type: none"> 1. Give 15 grams of carbohydrate 2. Wait 15 minutes and retest blood glucose 3. Repeat 15 grams of carbohydrate if necessary. 4. If meal is not within 1 hour of episode, give snack. 5. Other: _____ <p>Parent/guardian should be notified of low blood sugar episodes.</p>	<ul style="list-style-type: none"> ▪ Don't attempt to give anything by mouth. ▪ Position on side, if possible. ▪ Call for additional staff support. ▪ Administer glucagon if ordered. ▪ Call 911 and stay with student. ▪ Contact parent ▪ Other: _____

CARE OF HYPERGLYCEMIA (HIGH BLOOD GLUCOSE):

Check for ketones when blood glucose is above

MILD OR MODERATE HYPERGLYCEMIA	SEVERE HYPERGLYCEMIA
<p>Please check previous symptoms</p> <div> ☐ Behavior Change ☐ Blurry Vision ☐ Fatigue/sleepiness ☐ Frequent Urination ☐ Headache ☐ Stomach pains ☐ Thirst/dry mouth ☐ Other </div>	<p>Please check previous symptoms</p> <div> ☐ Blurred vision ☐ Breathing changes (Kussmaul breathing) ☐ Chest pain ☐ Decreased consciousness ☐ Increased hunger ☐ Nausea/vomiting ☐ Severe abdominal pain ☐ Sweet, fruity breath ☐ Other </div>
ACTIONS FOR MILD OR MODERATE HYPERGLYCEMIA	ACTIONS FOR SEVERE HYPERGLYCEMIA
<ul style="list-style-type: none"> ▪ Allow liberal bathroom privileges. ▪ Encourage student to drink water or sugar-free drinks. ▪ Administer correction dose. ▪ Notify parent/guardian. ▪ Other: _____ 	<ul style="list-style-type: none"> ▪ Administer correction dose of insulin ▪ Call parent/guardian. ▪ Stay with student ▪ Call 911 if student has breathing changes or decreased consciousness. Stay with student until EMS arrives

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Pump Information

Type of pump: _____ Type of Insulin in pump: _____

How long has student had pump _____

Functions student needs assistance with _____

Basal rate during school hours _____

Continuous Glucose Monitor (CGM) Information

Type of CGM: _____

- ☐ School nurse will track CGM using school issued device with [parent consent](#).
- Calibrate the CGM according to the manufacturer's instructions if needed.
- Review and document the CGM readings according to student's monitoring schedule (see above).
- Perform fingerstick _____

All supplies are to be provided by the parents/guardians including snacks and drinks for hypoglycemic incidents.

Healthcare Provider Consent for Diabetes Management

I have reviewed and approved this management plan and included any recommended modifications. This consent is for a maximum of one year. If changes in procedure are indicated, I will provide written orders accordingly.

- ☐ This student needs assistance with managing diabetic condition at school.
- ☐ This student is capable of self-managing his/her diabetic condition at school.

Healthcare Provider Signature

Date

Most recent HgB A1C _____ Date _____

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Parent/Guardian Consent for Diabetes Management

I, as parent/guardian, concur with the above management plan, will provide the necessary supplies and equipment, notify the school nurse if there is any change in my child's health status or doctor's orders, and authorize the school nurse to contact the physician when necessary.

- ☐ I request that my child's medication and supplies be kept in the nurse's office and care is managed by the nurse.
- ☐ I give permission for my child to self manage diabetes as prescribed by their physician and/or as written in their individual healthcare plan (IHP). This self management plan will be in effect until rescinded by either party.
 - ☐ I hereby certify that my child has been fully instructed and is capable of self-administration of the medication. I consent to my child carrying, storing and self-administering the medication at school. I acknowledge that I am responsible for providing my child with the medication, properly labeled from the pharmacy, and that I am responsible for any and all monitoring of my child's use of the medication and for any and all consequences of my child's self-administration of medication at school. I will indemnify and hold harmless Grand Island Public Schools, its employees and agents, against any and all claims arising out of my child's self-administration of medication at school, or at a school-related event.

Parent/Guardian Signature

Date

Student Consent for Self Management of Care

I will not share or allow other students to handle my medications or supplies.
I will notify the school nurse or other designated adult when I use my medication.
I will present to the nurse's office or designated adult if further medical care is needed.

Student Signature

Date