

### Diabetes Individualized Healthcare Plan

<b>Pupil:</b>			
<b>Grade:</b>	<b>D.O.B</b>	<b>Educational Placement:</b>	
<b>School:</b>			
<b>District:</b>			
<b>School Nurse:</b>		<b>Pager #</b>	<b>Cell #</b>
<b>Parent/Guardian Consent Date:</b>		<b>Physician Authorization Date:</b>	
<b>Parent Signature:</b>			
<b>Mother</b>	<b>Home #</b>	<b>Work #</b>	<b>Pager/Cell #</b>
<b>Father</b>	<b>Home #</b>	<b>Work #</b>	<b>Pager/Cell #</b>
<b>Guardian</b>	<b>Home #</b>	<b>Work #</b>	<b>Pager/Cell #</b>
<b>Home Address</b>		<b>City</b>	<b>Zip</b>
<b>Other Contact (Relationship):</b>		<b>Home #</b>	<b>Work #</b>
<b>Physician</b>		<b>Phone #</b>	<b>Fax #</b>
<b>Physician Address</b>		<b>City</b>	<b>Zip</b>
<b>Healthcare Service Needed at School</b>	<b>Management of Diabetes at School and School Sponsored Events:</b>		
<b>Purpose of an ISHP</b>	<ol style="list-style-type: none"> <li>1. <b>The purpose</b> of an Individualized School Healthcare Plan (ISHP) is to provide safe management of healthcare needs and services for pupils at school and during school-related activities.</li> <li>2. <b>The school nurse</b>, in collaboration with the student and the student's parent/guardian, healthcare providers, and school team, is responsible for:             <ol style="list-style-type: none"> <li>a) Development, implementation, and revisions of the ISHP.</li> <li>b) The training and supervision of all designated personnel who will provide healthcare according to the ISHP and standard procedures.</li> </ol> </li> <li>3. <b>ISHP revisions</b> must be directed to the school nurse prior to implementation. All physician changes must have a written physician authorization and written parent consent. Revisions, not requiring physician authorization, may be made with written parent consent.</li> <li>4. <b>ISHP review</b> must occur annually and whenever necessary to ensure provision of safe care.</li> </ol>		

**Individualized Healthcare Plan For Management of Diabetes at School  
Completed With Parent and Pupil**

Pupil	DOB	School	Grade
<b>Diabetic Routines At School Per Parent Request/Consent</b>	<p><b>Daily Snacks:</b> Time(s) _____ Place specified _____</p> <p><input type="checkbox"/> Done independently <input type="checkbox"/> Needs reminder <input type="checkbox"/> Needs daily compliance verification</p> <p>• <b>Extra Snacks:</b> <input type="checkbox"/> Before exercise <input type="checkbox"/> After exercise <input type="checkbox"/> 10 gms. CHO every 30 minutes during vigorous exercise <input type="checkbox"/> Needs daily compliance verification</p> <p>• <b>Daily Blood Test:</b> <input type="checkbox"/> Before Meals <input type="checkbox"/> Prior to Exercise <input type="checkbox"/> As Needed Location for testing <input type="checkbox"/> Classroom <input type="checkbox"/> Health Office</p> <p align="center"><b>Student is to be tested where they are at if Hypoglycemic</b></p> <p><input type="checkbox"/> By pupil independently <input type="checkbox"/> Adult verifies results <input type="checkbox"/> Needs assistance (specify) _____</p> <p><input type="checkbox"/> <b>Refer to Algorithms for Blood Glucose Results, ( attach sheet).</b></p> <p>• <b>Exercise:</b> <input type="checkbox"/> None if blood glucose test results are below _____ mg/dl</p> <p>• <b>Lunch Eaten At</b> (time) _____ Regardless of schedule changes, field trips, disaster, etc. <input type="checkbox"/> Needs daily verification of meal eaten <input type="checkbox"/> Written consent with schedule changes with snack and meal times.</p> <p>• <b>In Event of Field Trips</b>, all diabetic supplies are taken and care is provided according to this ISHP (a copy is taken on trip)</p> <p align="center"><b><u>The School Nurse Must Be Notified Two Weeks Before The Field Trip To Plan For Qualified Personal To Provide Procedures</u></b></p> <p>• <b>In Event of Classroom/School Parties</b>, food treats will be handled as follows: <input type="checkbox"/> Pupil will eat the treat. <input type="checkbox"/> Replace with parent supplied alternative <input type="checkbox"/> Put in baggie and take home with teacher note. <input type="checkbox"/> Modify the treat as follows: <input type="checkbox"/> Do not eat snack.</p> <p>• <b>In Event of Bus Transportation:</b> <input type="checkbox"/> Blood test given 10 to 20 minutes before boarding. If 70 or less, provide care per <b>Procedure For Mild to Moderate Low Blood Glucose</b> and call parent to provide transportation home. <input type="checkbox"/> Blood test not required.</p> <p>• <b>Scheduled After-School Activities:</b> _____</p>		
<b>Training and Notification of School Employees of Diabetes Basic Training Program</b>	<p>The following personnel will be notified of my child's medical condition and participate in Diabetes Basic Training Program: <input type="checkbox"/> All School Personnel <input type="checkbox"/> School Personnel that have contact with my child <input type="checkbox"/> Cafeteria Staff <input type="checkbox"/> Other _____</p>		
<b>Other</b>	<p>(Specify): _____ <b>Student has unrestricted use of the bathroom and water.</b></p>		

**Individualized Healthcare Plan  
For Management of Diabetes at School (Continued)**  
Completed With Parent and Pupil

Pupil	DOB	School	Grade
<p><b>Equipment and supplies</b></p>	<p><b><u>Provided By Parent</u></b></p> <p><b><u>Daily Snacks</u></b> (for AM/PM snack times) Specify: _____</p> <p><b><u>Extra Snacks</u></b> (for before, after, and/or during exercise) Specify: _____</p> <p><b><u>Blood Glucose Meter Kit</u></b> (Includes meter, testing strips, lancing device with lancet, cotton balls, spot Band-Aids)</p> <p><b>Brand/Model:</b> _____</p> <p><b><u>Low Blood Glucose Supplies</u></b>, (5 day supply)</p> <p><input type="checkbox"/> <b>Fast Acting Carbohydrate Drinks:</b> (Apple juice and/or orange juice, sugared soda pop-NOT diet), at least 6 containers.</p> <p><input type="checkbox"/> <b>Glucose Tablets</b>, 1 package or more.</p> <p><input type="checkbox"/> <b>Glucose Gel Products</b> (Insta-Glucose, Monogel or Glutose/25--31 Gms.), 2 or more.</p> <p><input type="checkbox"/> <b>Gel Cakemate</b> (not frosting), (19 Gm., mini-purse size), 2 or more. <b>Note:</b> Not used in Emergency Procedure For Severe Low Blood Sugar.</p> <p><input type="checkbox"/> <b>Prepackaged Snacks</b> (such as crackers with cheese or peanut butter, nite bite, etc.), 5 - 6 servings or more.</p> <p><b><u>High Blood Glucose Supplies</u></b></p> <p><input type="checkbox"/> Ketone Test Strips/Bottle</p> <p><input type="checkbox"/> Urine cup</p> <p><input type="checkbox"/> Water bottle</p> <p><b>Note:</b> Timing device may be wall clock or watch worn by pupil or personnel.</p>	<p><b><u>Provided By Parent (Continued)</u></b></p> <p><b><u>Insulin Supplies</u></b></p> <p><input type="checkbox"/> Insulin pen</p> <p><input type="checkbox"/> Pre-filled syringes (labeled per dose)</p> <p><input type="checkbox"/> Insulin and syringes</p> <p><input type="checkbox"/> Extra pump supplies such as:</p> <p style="padding-left: 20px;"><input type="checkbox"/> Vial of insulin, syringes</p> <p style="padding-left: 20px;"><input type="checkbox"/> Pump syringe</p> <p style="padding-left: 20px;"><input type="checkbox"/> Pump tubing/needle</p> <p style="padding-left: 20px;"><input type="checkbox"/> Batteries</p> <p style="padding-left: 20px;"><input type="checkbox"/> Tape</p> <p style="padding-left: 20px;"><input type="checkbox"/> Sof-Serter</p> <p>Insulin supplies stored: _____</p> <p><b><u>Emergency Supplies</u></b></p> <p><input type="checkbox"/> <b>Glucagon kit stored:</b> _____</p> <p><input type="checkbox"/> <b>3 day disaster food supply stored:</b> _____</p> <p><b><u>3 Day Disaster Diabetes Supplies</u></b></p> <p><input type="checkbox"/> Vial of insulin; 6 syringes</p> <p><input type="checkbox"/> Insulin pen with cartridge and needles</p> <p><input type="checkbox"/> Blood glucose testing kit (testing strips lancing device with lancets)</p> <p><input type="checkbox"/> Glucose gel product and glucose tablets</p> <p><input type="checkbox"/> Glucagon kit</p> <p><input type="checkbox"/> Food supply (include daily meal plan) stored as follows: _____</p> <p><input type="checkbox"/> Ketone strips/plastic cup</p> <p>School will include a copy of the ISHP for Diabetes Management with the Disaster Supplies. Stored as follows: _____ _____</p> <p><b><u>Other Supplies</u></b>, Specify:</p>	

**Signs of Low Blood Sugar:**  
 Fatigue, excessive sweating, trembling, clammy, dizziness, headache, hunger pangs, visual impairment, accelerated heart beat, anxiety, difficulty concentration, blackouts, confusion, crying, irritability, poor coordination, nausea, inappropriate behavior.

**Signs of high Blood sugar:**  
**Early Symptoms:**  
 Thirsty /dry mouth, frequent urination, fatigue/sleepiness, increased hunger, blurred vision, lack of concentration.  
**Symptoms progressively become worse:**  
 Sweet breath, nausea/stomach pains, vomiting, weakness, confusion, labored breathing, unconsciousness/coma.

**Algorithms for Blood Glucose Results**

**Check Blood Glucose**

**Below 70**

**70-90**

**91-125**

**126-240**

**Above 240**

1. Give fast Acting sugar source and carbohydrate\*.
  2. Observe for 15 minutes.
  3. Retest Blood Glucose, if less than 70 repeat sugar source. If over 70 give carbohydrate and protein snack (e.g. Crackers and cheese) if not eating within 15 minutes.
  4. Notify School nurse.
  5. Notify Parent/PMD if less than 50.
- If Student Becomes Unconscious, Seizures, or is Unable to Swallow:**
1. Call 911
  2. Turn student on side to ensure open airway.
  3. Give glucose gel and glucagons if ordered.
  4. Notify school nurse, parents/PMD.

1. Give fast acting carbohydrate. If meal or snack is within 30 minutes, no additional carbs are needed. If student is not going to eat within 30 minutes additional carb and protein snack is to be given.
- If student's blood sugar result is immediately following strenuous activity, give an additional fast acting sugar.**

If exercise is planned before a snack or a meal, including recess, the student must have a snack before participating.

Student is fine

**Check Ketones (If ordered)**  
 (can not exercise unless urine is negative for Ketones.)  
**Provide extra water.**

**Ketones Present – Notify School Nurse Immediately. Notify Parents/PMD.**

Provide 1-2 glasses of water every hour.

Do not exercise.

**If at any time student vomits, becomes lethargic, and/or has labored breathing CALL 911.**

Fast Acting Sugar Sources (Do not give chocolate)	
<ul style="list-style-type: none"> <li>• 15 gm. Glucose tablets</li> <li>• 15 gm. Glucose gel</li> <li>• 1/3 c. sugared soda</li> <li>• ½ c. orange juice</li> </ul>	<ul style="list-style-type: none"> <li>• ½ c. apple juice</li> <li>• ¼ c. grape juice</li> <li>• ½ tube cake mate gel</li> </ul>

<b>Student's Name:</b>
<b>School:</b>
<b>Nurse Contact number/pager:</b>
<b>Physician's number:</b>
<b>Parents Phone Numbers:</b>

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