|  |  |  |  |
| --- | --- | --- | --- |
| **CONFIDENTIAL** | **District:** |  | Student Picture |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Individualized Health Plan: Diabetes in School Setting** | | | **Date of Plan:** | |  | | | | **Date of Orders:** |  |
| *To be completed by School Nurse in consultation with Parent, School staff and per HealthCare Provider Orders*  *See Colorado Diabetes Standard of Care Guidelines for the School Setting* | | | | | | |
| **Student:** |  | | DOB: |  | | | |
| **School:** |  | Grade: |  | Teacher: | |  | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Health Concern:** | | Type 1 Diabetes | | Type 2 Diabetes | | | Other: |  | Date of Diagnosis: | |  |
| **Mother/Guardian:** | | |  | | | | | Preferred Tel #: |  | | |
| **Father/Guardian:** | | |  | | | | | Preferred Tel #: |  | | |
| **School Nurse:** | | |  | | | | | Work#: |  | | |
| **Physician:** | | |  | | | | | Work#: |  | | |
| **Diabetes Educator:** | | |  | | | | | Work#: |  | | |
| **Hospital of Choice:** | | |  | | 504 on file? | Yes | | No | |
| **Comments:** |  | | | | | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **TARGET RANGE – Blood Glucose:** | mg/dl | **TO** | **mg/dl** |
| **Notify Parents if Blood Glucose values below:** | **mg/dl** | **or greater than:** | **mg/dl** |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Medications:** | | Insulin Dosing – see *Insulin Injection Administration or Pump Administration Addendum* | | | | | | | | |
| Insulin Delivery Device: | | | Insulin Pen | | Insulin Pump | | Syringe & Vial | | Insulin Type: |  |
| Parent/guardian elects to give insulin needed at school | | | | | | Notify parent/guardian for correction if Blood Glucose **>** | | | | **mg/dl** |
| **G****lucagon Dose:** | **mg** | | | **Intramuscular in** **Arm** | | | Buttock | Thigh - \*See Severe Hypoglycemia Care | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Required Blood Glucose Monitoring at School** *(See Blood Glucose Treatment Plan)* | | | | | | | | |  |  | |  | |  |
| Where to check Blood Glucose: | | Health Room | | | Classroom | Other: | |  | | | | | | |
| Student can carry supplies and test where needed and when needed | | | | | | |  |  | | |  | |  | |
| Continuous glucose monitoring: *Always Confirm glucose level with a fingerstick/meter prior to treatment* | | | | | | | | | | | | | | |
| Alarms set for: **Low:** | **mg/dl** |  | **High:** | **mg/dl** | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **When to Check Blood Glucose:** | | |  |  | | |  | | |  | |
| As needed for signs/symptoms of low/high blood glucose and/or does not feel well | | | | | | | | Behavior Concern | |  | |
| Before School Program | | Before Snack | | Mid-morning | | After School Program/Extracurricular Activity | | | | |  |
| Before Lunch | | After Lunch | | Recess | | Before PE | | After PE | | | |
| School Dismissal | Before riding bus/walking home | | | | 2.5 hrs after correction | | | Other: |  | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Student’s Schedule:** | | | Location of Snacks: | |  | | | Location Eaten: | | |  | |
| Lunch: |  | PE: | |  | | Recess: |  | | Snack: | am | | pm |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Class School Parties or Events with Food:** | | | | | |
| In the event of Class Party – may eat the treat and insulin dosage per Provider Orders | | | | | |
| Student able to determine whether to eat the treat | | | | | |
| Replace with parent supplied treat | | May *NOT* eat the treat | | Contact Parent Prior to event for instructions | |
|  | |  | | |  |
| **Classroom Emergency Preparedness:** | | | Snack/Water in classrooms (provided by parent) | |  |
| Supplies to be kept: (indicate location) |  | | | |  |

**Standardized Academic Testing Procedures:** School Staff to notify Parents and School Nurse of upcoming standardized testing in order to create a plan for Blood Glucose monitoring and treatment.

**Student’s Self Care** (ability level to be determined by School Nurse and Parent with input from Health Care Provider prn)

Totally Independent Management  Yes  No  Agreement for Student’s Independent Management Completed

Assist/supervise blood glucose testing by trained staff  Yes  No

Blood glucose testing to be done by trained staff  Yes  No

Administers Insulin Independently  Yes  No

Insulin injections to be done by trained staff  Yes  No

Self-Injects with verification of dose & supervision  Yes  No

Monitors own snack and meals  Yes  No

Trained staff to monitor food intake  Yes  No

Independently Counts Carbs  Yes  No

Trained staff to assist with carb counting  Yes  No

Self-treats mild hypoglycemia  Yes  No

Tests and interprets urine/blood ketones  Yes  No

Other:

\*See Pump Addendum for self-care pumps skills

**Additional Information**

F**ield Trip Information and Special Events:**

1. Notify parent and school nurse in advance so proper training can be accomplished
2. Adult staff must be trained and responsible for student’s needs on field trip
3. Extra snacks, BG meter, copy of health plan, glucagon, insulin & emergency supplies must accompany student on field trip
4. Adult(s) accompanying student on a field trip will be notified of student’s health accommodations on a need to know basis

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Exercise and Sports:** | | | | | |
| Snack prior to PE | Snack after PE | Snack before Recess | Snack after Recess | # of Snack Carbs: |  |
| In general, there are no restrictions on activity except in these cases: | | | | | |
| Student should not exercise if blood glucose is >300 and ketones is > small or until hypoglycemia/hyperglycemia is resolved | | | | | |
| A source of fast-acting glucose & glucagon should be available in case of hypoglycemia | | | | | |
| Special Instructions: |  | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Staff Trained:** | | Monitor blood glucose & treat hypo/hyperglycemia | Give Insulin | Give Glucagon |
| 1. | |  |  |  |
| 2. | |  |  |  |
| 3. | |  |  |  |
|  | |  |  |  |
| **Further Instructions:** |  | | | |

**See Addendum(s):**  Emergency Action Plan: Glucose Monitoring & Treatment  Insulin Pump

Insulin Injection & Medication Management  Continuous Glucose Monitor  Supplies Activity Plan

PARENT/GUARDIAN PERMISSION

I understand that:

* Medication orders are valid for this school year only & need to be renewed at the beginning of each school year.
* New Physician Orders are needed when there are any changes in the medication orders. (e.g. at quarterly clinic visits)
* Medication orders will become part of my child’s permanent school health record.
* Medications must be in original container and labeled to match physician’s order for school use including field trips.
* I have the responsibility for notifying the school nurse of any changes in Medication or care orders.
* I give permission to the school nurse to share information with appropriate school staff relevant to the prescribed medication administration as he/she determines appropriate for my child’s health and safety.
* I give permission to the school nurse to contact the above health care provider for information relevant to the prescribed medication administration, provider orders, and related student health information appropriate for my child’s health and safety.
* I give my permission to the school nurse and designated staff to perform and carry out the diabetes tasks as outlined in this Individualized Health Plan (IHP).
* I understand that the information contained in this plan will be shared with school staff on a need-to-know basis.
* Parent/Guardian & student are responsible for maintaining necessary supplies,snacks,blood glucose meter,medications & other equipment.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Parent Name: |  | Parent Signature: |  | Date: |  |
| School Nurse: |  | School Nurse Signature: |  | Date: |  |