DIABETES - Individualized Healthcare Plan (IHP)

Utah Department of Health

School Year:

Picture

STUDENT INFORMATION

Student:	**DOB:**	**Grade:**	**School:**	**DMMO** ☐Yes ☐No
Parent:	**Phone:**		**Email:**	
Physician:	**Phone:**		**Fax or Email:**	
School Nurse:	**School Phone:**		**Fax or Email:**	
☐ **Type I** ☐ **Type II**	**Age at diagnosis:**			

BLOOD GLUCOSE MONITORING

☐ Student is independent ☐ Student needs assistance ☐ Student needs supervision

☐ Student has a Continuous Glucose Monitoring System (CGMS readings are for trends only, ALWAYS verify with blood glucose before any dosing, unless using certain GCMs – must have parent signature on DMMO)

Always test if student is showing signs/symptoms of high or low blood glucose!

INSULIN DELIVERY (per instructions from PCH, correction doses can be given at mealtime only, unless on a pump)

Method of insulin delivery: ☐Pump ☐Insulin Pen ☐Syringe/vial	☐Student is independent ☐Student needs supervision ☐Student needs assistance (attach training documentation if applicable)

High Blood Glucose Correction Dose for **PUMP** only: If BG over _____mg/dl, give correction per pump calculation

Lunch: Student will typically eat: ☐ School Lunch (staff can help with carb counts)
☐ Home Lunch (parent must provide carb counts)

HYPOglycemia Low Blood Glucose	**HYPER**glycemia High Blood Glucose	**ADDITIONAL INFORMATION**
Emergency situations may occur with low blood sugar! Symptoms: shaky, feels low, feels hungry, confused, other (specify): ☐ Student needs treatment when blood glucose is below _____ mg/dl or if symptomatic ☐ If treated outside the classroom, a responsible person MUST accompany student to the office ☐ If blood glucose is below _____ mg/dl give_____ ☐ After 15 minutes recheck blood sugar ☐ Repeat until blood glucose is over _____ mg/dl ☐ Disconnect or suspend pump	Symptoms: Increased thirst, increase need for urination, other (specify): ☐ Student needs treatment when blood glucose is over _____ mg/dl ☐ If blood sugar is over _____ mg/dl contact parent ☐ Allow unrestricted bathroom privileges ☐ Encourage student to drink water or sugar-free drinks If vomiting call parent ***immediately!***	• Student must always be allowed access to fast-acting sugar. • Student is allowed to carry a water bottle and have unrestricted bathroom privileges. • Student is allowed to test his/her blood glucose when/where needed • Substitute teachers must be aware of the student's health situation, but still respecting privacy **CALL 911 IF:** • Glucagon is administered • Student is unable to cooperate to eat or drink anything • Decreasing alertness or loss of consciousness • Seizure

Notify parent(s)/guardian when blood glucose is below _____ mg/dl or above _____ mg/dl

CONTINUED ON NEXT PAGE

Student:	**DOB:**

SPECIAL CONSIDERATIONS (Academic testing, Snacks, PE, School Parties, Field Trips)

PE: ☐ Check BG before PE ☐ Do not exercise if BG is below _____mg/dl or above _____mg/dl
☐ 15 gram carb (free) snack before PE ☐ Other (specify):

SPECIAL CONSIDERATIONS AND PRECAUTIONS:
School Parties: ☐ No coverage for parties ☐ I:C Ratio ☐ Student to take snack home
☐ Parent will provide alternate snack ☐ Other (specify):
Field Trips:

ACADEMIC TESTING:
☐ Student may reschedule academic testing with teacher, as needed, if blood glucose is below ___ or over ___

Other (specify):

EMERGENCY MEDICATION (See DMMO)

Person to give **Glucagon**: ☐ School Nurse ☐ Parent ☐ EMS ☐ Volunteer(s) (Specify):
Attach volunteer(s) training documentation if applicable.

Location of Glucagon:

SIGNATURES

PARENT TO COMPLETE (as required by UCA 53G-9-504 and 53g-9-506)

☐ I certify that glucagon has been prescribed for my student.
☐ I request the school identify and train school personnel who volunteer to be trained in the administration of glucagon. I authorize the administration of glucagon in an emergency to my student.
☐ I authorize my student to possess or possess and self-administer diabetes medication. I acknowledge that my student is responsible for, and capable of, possessing or possessing and self-administering the diabetes medication.

Parent Name:	Signature:	Date:

As parent/guardian of the above named student, I give permission for my child's healthcare provider to share information with the school nurse for the completion of this plan. I understand the information contained in this plan will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the School Nurse of any change in the student's health status, care or medication order. If medication is ordered I authorize school staff to administer medication described below to my child. If prescription is changed a new prescriber order must be completed before the school staff can administer the medication. Parents/Guardian are responsible for maintaining necessary supplies, medications and equipment.

Parent:	Signature:	Date:
Emergency Contact:	Relationship:	Phone:

SCHOOL NURSE

Diabetes medication and supplies are kept: ☐ Student carries ☐Backpack ☐Classroom ☐Health Office ☐Front office ☐ Other (specify):

IHP (this form) distributed to 'need to know' staff: ☐ Teacher(s) ☐ Lunchroom ☐ PE teacher(s) ☐Transportation ☐Front office/admin ☐ Other (specify):

School Nurse Signature:	Date:

Addendum: