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 Dexcom G5 – 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

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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			
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: