Individualized Healthcare Plan(IHP)/Emergency Action Plan(EAP) for Student with Diabetes

Name _____Date of Birth_____

Parent/Guardian_____

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

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

Physician _____
Phone_____ Fax_____

Specifics of Management

1. Target Range for Blood Glucose_____

2. Student needs assistance/supervision with glucose monitoring: Yes ____ No____.

3. Blood Glucose Monitoring Times:

- ☐ daily before breakfast (student eating breakfast at school)
- ☐ daily 2 hours after breakfast
- ☐ daily before lunch
- ☐ daily 2 hours after lunch
- ☐ before PE/Gym Class
- ☐ after PE/Gym Class
- ☐ Other_____

4. Parent to be notified when blood sugar below_____or over_____.

5. Blood glucose readings to be shared with parent:

- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Other_____
- ☐ Paper copy sent home
- ☐ Fax
- ☐ Email
- ☐ Other_____

6. Physical education/recess restricted for blood glucose over _____or under _____.

_____

7. Snack needed prior to physical education/recess if blood glucose under_____.

Snack time/location_____

Physical Education Days/Time_____

Recess Time_____

CARE OF HYPOGLYCEMIA (LOW BLOOD SUGAR):

Student's usual symptoms of hypoglycemia_____

_____

Usual treatment of hypoglycemia_____

_____

Rule of 15 Protocol for Hypoglycemic, listed below, will be followed if specific treatment for student is not provided.

Signs/Symptoms of Hypoglycemia:

1. **Early** (Blood sugar 50-60 mg/dl) shaky, sweaty, pale, hungry, irritable, rapid pulse, stomachache,nausea,vomiting
2. **Late** (Blood sugar 40mg/dl or less): confusion, poor coordination, restlessness, mood changes (aggression, crying)
3. **Advanced**: loss of consciousness, seizure, convulsion, coma. Permanent brain damage can result if reaction is prolonged.

Rule of 15:

It is preferable to test before treating unless immediate risk to student safety is apparent.

Give 15 grams of carbohydrate, wait 15 minutes, retest, repeat 15 grams of carbohydrate if necessary.

If blood sugar is below 50 amount of carbohydrate should be doubled to 30 grams.

15 grams of carbohydrate include small carton of juice or milk, hard candy such as 5 lifesavers, 15 skittles, 15 jelly beans or 2 rolls of smarties. If student carries glucose tablets, 4 tablets should be given to equal 15 grams.

If meal is not be be eaten within 1 hour of episode, give snack of 4-6 crackers and 2 Tablespoons of peanut butter, or a glass of milk and 1/2 sandwich.

Parent should be notified of low blood sugar episode. If student experiences 3 low blood sugars in one week, suggest parent contact doctor for advice on insulin dose changes.

GLUCAGON ADMINISTRATION

Glucagon ordered _____Yes_____No

911 should be called and parent notified.

Follow the directions on the glucagon for administration.

CARE OF HYPERGLYCEMIA (HIGH BLOOD SUGAR):

1. Check for ketones when blood sugar is above_____
2. Notify parent/guardian.
3. Administer sliding scale insulin, if ordered.

Insulin Injections at School: (Pump Users see below)

Type of Insulin: _____

Dose Preparation :

- ☐ Student drawn independently
- ☐ Needs assistance/supervision
- ☐ Prefilled syringe
- ☐ Insulin Pen Mealtime Dosing for Insulin Injections

Insulin dose for School Breakfast:

Give _____units of Insulin for every _____grams of carbohydrates. Maximum grams of carbohydrates for breakfast_____.

Insulin dose for School Lunch:

Give_____units of Insulin for every_____grams of carbohydrates. Maximum grams of carbohydrates for lunch_____.

Maximum bolus dose of Insulin is _____units (if applicable)

Dosing for Sliding Scale Insulin Injections (if applicable)

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_____

Pump Users Only

Type of pump_____

Type of Insulin in pump_____

How long has student had pump_____

Functions student needs assistance with_____

Basal rate during school hours_____

Insulin to carbohydrate ratio for school breakfast_____

Insulin to carbohydrate ratio for school lunch_____

Blood glucose correction factor (if used): _____unit(s) of rapid-acting insulin for each_____mg/dL over target blood sugar of_____

Use correction factor _____with meals_____between meals

Physician Consent for Diabetes Management IHP

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

_____

Physician Signature Date

Most recent HgB A1C _____Date_____

Parent/Guardian Consent for Diabetes Management IHP

- ☐ 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 give permission for my child to self-administer medication for diabetes as prescribed by their physician and/or as written in their individual healthcare plan (IHP).

- ☐ 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.

- ☐ I consent to the school nurse storing and/or administering to my child medication in the event that my child is incapable of self-storage and/or self-administration of the medication at school

_____

Parent Signature Date

Supplies to be provided by Parent/Guardian:

- ☐ glucose meter
- ☐ insulin vial and syringes
- ☐ glucose meter test strips
- ☐ insulin pen and needles
- ☐ extra battery for glucose meter
- ☐ insulin pump
- ☐ lancets
- ☐ extra insertion site
- ☐ glucose tablets
- ☐ extra reservoir
- ☐ snacks
- ☐ extra insulin
- ☐ ketone test strips
- ☐ extra tubing
- ☐ glucagon
- ☐ extra battery for pump