



Alabama State Department of Education



Individualized Health Care Plan

Student Name:Type Here

School Year: Type Here

Appendix 2 – Individualized Healthcare Plan (IHP) Packet



Individualized Health Care Plan

Student Name: Type Here

School Year: Type Here

Alabama Individualized Healthcare Plan - DIABETES

Instructions:

The Alabama Individualized Healthcare Plan (IHP) is for all students with diabetes that monitor blood glucose at school and/or are on insulin or other blood glucose-controlling medication and/or have a glucagon prescription. It is the result of the nurse's assessment of the student's needs and prescriber's orders and how best to meet them within the school environment.

The IHP should be updated annually and as the student's health care status or needs change. While current, this form should be filed in the school health record. A list of names of unlicensed school personnel who have successfully completed the training for insulin and/or glucagon should be kept in the office of the school nurse or the school administrator. A registered nurse (RN) **must** prepare the plan.

The IHP consists of four parts:

1. Healthcare Providers Orders

Healthcare provider orders should prescribe a particular treatment regime, which should:

- a. Provide the medical parameters for management of an individual student's diabetes in the school setting including medication(s) to be administered in the school setting.
- b. Document the ability level of the student to self-manage their diabetes.

2. Standard of Care for School Staff

Standards of care for school staff should:

- a. Provide algorithm for blood glucose results based on blood sugar ranges that include an **Emergency Action Plan (EAP)**. NOTE: The standard of care represents the care to follow in most cases; any individualization of clinical care for the student will be reflected in the *Healthcare Provider Orders*.
- b. Emergency Action Plan (EAP)
- c. Document the ability level of the student to self-manage his/her diabetes.
- d. To support quality assurance of school health services.
- e. To document diabetes supplies needed at school, and parental responsibility for maintaining certain supplies at school.
- f. To facilitate a safe process for the delegation of diabetes-management tasks to the Unlicensed Diabetic Assistant (UDA).

3. Authorizations and Agreements

Providers, parents, students and school nurses sign and date authorization and agreements that include:

- a. School Medication Prescriber/Parent Authorization Form
- b. Agreement for Student Independently Managing Their Diabetes

4. School Nurse and Parent- Authorized Trained Staff Coverage

The school nurse and unlicensed diabetic assistant may use the IHP schedule worksheet:

- a. To identify times when the school nurse will not be available to provide diabetes management assistance and plan for coverage by trained school staff.



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Diabetes Individualized Healthcare Plan

SECTION I			
Student:			WT:
			HT:
Grade:	D.O.B	Any Known Allergies	
School:			
District:		Bus (check one) <input type="checkbox"/> YES <input type="checkbox"/> NO	
		Bus #AM	Bus #PM
School Nurse:	Pager #	Cell #	
Medication taken at home: (please list)			
Contacts			
Mother	Home #	Work #	Pager/Cell #
Father	Home #	Work #	Pager/Cell #
Guardian/Custodian	Home #	Work #	Pager/Cell #
Home Address		City #	Zip
Emergency Contact (Relationship)		Home #	Work #
Physician		Phone #	Fax#
Physician Address		City	Zip
Date	Special Notes		



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Individualized Health Care Plan

Student Name: Type Here

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Individualized Healthcare Plan for Management of Diabetes at School

SECTION II (Completed with Parent and Student)

Student	DOB	School	Grade
Diabetic Routines at School Per Parent Request/Consent	<p>Daily Snacks: Time(s) <u>Type Here</u> Place specified <u>Type Here</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Done independently <input type="checkbox"/> Needs reminder <input type="checkbox"/> Needs daily compliance verification <p>• Extra Snacks:</p> <ul style="list-style-type: none"> <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>• Daily Blood Test: <input type="checkbox"/> Before Meals <input type="checkbox"/> Prior to Exercise <input type="checkbox"/> As Needed</p> <p>• Location for testing: <input type="checkbox"/> Classroom <input type="checkbox"/> Health Office</p> <p>Student is to be tested in his/her current location if Hypoglycemic</p> <ul style="list-style-type: none"> <input type="checkbox"/> By student independently <input type="checkbox"/> Adult verifies results <input type="checkbox"/> Needs assistance (specify) <u>Type Here</u> <p><input type="checkbox"/> Refer to Algorithms for Blood Glucose Results, (attach sheet).</p> <p>• Exercise: <input type="checkbox"/> None if blood glucose test results are below <u>Type Here</u> mg/dl</p> <p>• Lunch Eaten At (time) <u>Type Here</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> May amend snack and meal times according to school schedule. Please specify <u>Type Here</u> <p>• In Event of Classroom/School Parties, food treats will be handled as follows:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Student will eat the treat <input type="checkbox"/> Student will eat modified snack <input type="checkbox"/> Replace with parent supplied alternative <input type="checkbox"/> Do not eat snack. <p>• Scheduled After-School Activities: <u>Type Here</u></p> <p style="text-align: center;"><u>The School Nurse Must Be Notified Preferably Two Weeks Before The Field Trip To Plan For Qualified Personnel To Provide Procedures</u></p>		
Training and Notifying School Employees of Diabetes Basic Training Program	<p>The following personnel will be notified of my child's medical condition and participate in Diabetes Basic Training Program:</p> <ul style="list-style-type: none"> <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 <u>Type Here</u> 		
Other 504 <input type="checkbox"/> YES <input type="checkbox"/> NO	<p>(Specify): <u>Type Here</u> Student has unrestricted use of the bathroom and water.</p>		



Individualized Health Care Plan

Student Name: Type Here

School Year: Type Here

Individualized Healthcare Plan For Management of Diabetes at School (Continued)

SECTION II Continued (Completed with Parent and Student)

Student	DOB	School	Grade
<p>Equipment and supplies to be provided by parent</p>	<p>Daily Snacks (for AM/PM snack times) Specify: List Snacks Here List Snacks Here</p> <p>Blood Glucose Meter Kit (Includes meter, testing strips, lancing device with lancet, cotton balls, spot Band-Aids, alcohol prep pads) Brand/Model: Type Here</p> <p>Low Blood Glucose Supplies.</p> <p><input type="checkbox"/> Fast Acting Carbohydrate Drinks: (Apple juice and/or orange juice, sugared soda pop-NOT diet), at least 6 containers.</p> <p><input type="checkbox"/> Glucose Tablets, 1 package or more.</p> <p><input type="checkbox"/> Glucose Gel Products Note: Do not use if student is having difficulty swallowing</p> <p><input type="checkbox"/> Gel Cakemate Note: Do not use if student is having difficulty swallowing.</p> <p><input type="checkbox"/> Prepackaged Snacks (such as crackers with cheese or peanut butter, nite bite, etc.), 5 - 6 servings or more.</p> <p>High Blood Glucose Supplies</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><input type="checkbox"/> Protein Snack (Meat or cheese sticks)</p>		<p>Insulin Supplies</p> <p><input type="checkbox"/> Insulin pen</p> <p><input type="checkbox"/> Insulin and syringes</p> <p><input type="checkbox"/> Extra pump supplies such as:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Vial of insulin, syringes <input type="checkbox"/> Pump syringe <input type="checkbox"/> Pump tubing/needle <input type="checkbox"/> Batteries <input type="checkbox"/> Tape <input type="checkbox"/> Sof-Serter <p>Insulin supplies stored: List Supplies Here List Supplies Here</p> <p>Emergency Supplies</p> <p><input type="checkbox"/> Glucagon: YES or NO</p> <p>Kit stored: Type Here</p> <p><input type="checkbox"/> 3 day disaster food supply stored: List Supplies Here List Supplies Here</p> <p>School may include a copy of the IHP for Diabetes Management with the Disaster Supplies. Stored as follows: Type Here</p> <p>Other Supplies and Special Needs List Supplies Here List Supplies Here</p>



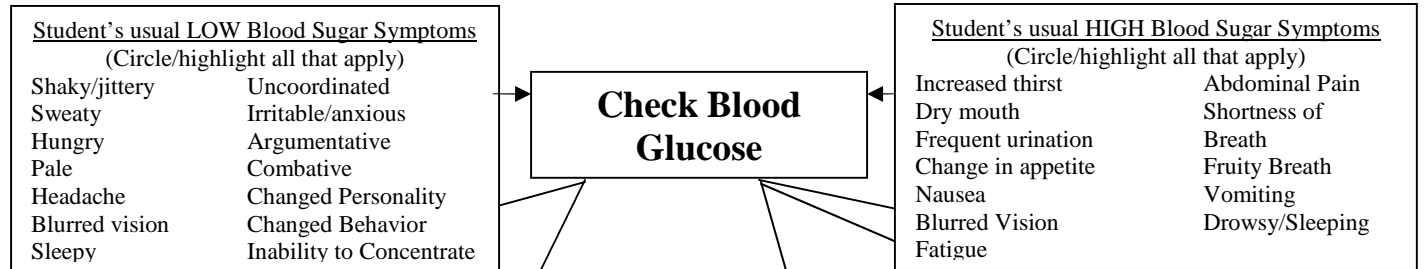
Individualized Health Care Plan

Student Name: Type Here

School Year: Type Here

EMERGENCY ACTION PLAN

SECTION III (Individualize to Student According to Physician's Orders)



Below 70

Give **fast-acting sugar source/carb.* (see chart)**

Observe for 15 minutes.

Retest blood sugar/glucose:
If < 70, repeat carb source.
If >70, give carb & protein snack if not due to eat meal within one hour.

Notify School Nurse & Parent if no improvement in blood sugar after one hour.

Student should NOT exercise.

CALL 911 if student:
Becomes unconscious
Has a seizure
Is unable to swallow
Turn student on side
Give glucagon, if ordered
Turn student on his/her side
If wearing insulin pump, suspend, disconnect pump or cut tubing. Send pump with EMS personnel

70-90

Give fast-acting sugar/carb source.
If meal or snack is to be eaten within 30 minutes, no additional carbs are needed.

If meal or snack is not scheduled to be eaten within 30 minutes, give a carb & protein snack.

If student's low sugar reading immediately follows strenuous activity, give a fast-acting sugar source/carb snack.

91-125

Student may eat prior to exercise or recess.

126-300

NO action required.

Above 300

Check for ketones. Call parent as directed by physician order.

Ketones NOT Present:

Encourage student to drink water

Ketones Present:

Notify School Nurse

Notify Parents (and PMD, if ordered)

Provide 1-2 glasses water every hour

Do NOT allow student to exercise

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

- *Fast Acting Sugar Sources (Do not give chocolate)**
- 15 gm. Glucose tablets ½ c. orange juice
 - 15 gm. Glucose gel ½ c. apple juice
 - 1/3 c. sugared soda ¼ c. grape juice
 - ½ tube cake mate gel 3tsp. Sugar (in water)

Never send a child with suspected low blood glucose anywhere alone!

EMERGENCY CONTACT INFORMATION			
School:		Phone#:	
School Nurse:		Phone #:	
Parent:	H:	W:	C:
Parent:	H:	W:	C:
Emergency Contact:	H:	W:	C:
Physician:		Phone #:	



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SECTION IV

Effective Date of IHP:

End Date of IHP:

Student Name:

DOB:

Parent/Provider Authorization on File: Yes No

Physician Orders on File: Yes No

If Yes, see attached Physician Orders.

If No, parent must provide diabetic management until physician orders received.

DIABETIC HEALTHARE PROVIDER:

Name:

Phone:

Fax:

E-mail:

Nurse Assessment of Student DM Skills

Skill	Independent Care	Assisted Care	Dependent Care
Check Blood Glucose			
Count Carbs			
Calculate insulin dose			
Change infusion set			
Injection			
Trouble shoot alarms, malfunctions			

NOTES:

If student is managing diabetes independently, is Student Agreement attached? Yes No

Plan for Field Trips

Scheduled After – or – Before – School Activities

- Bus
- Nurse
- Unlicensed Diabetic Assistant
- Parent /Guardian
- Student may test BG and self-manage DM

List of clubs, sports, after school care programs etc. that student participates.

In Event of Field Trips, all diabetic supplies are taken and care is provided according to this IHP (a copy is taken on trip)

Bus Transportation Plan

Bus Transportation:

- To School Daily
- Home
- Occasionally rides the Bus
- Student may test BG and self-manage DM while on the bus

In the event of Bus Transportation: Orders

- BG tested Type Here minutes before boarding. *If less than or equal to Type Here, follow MD Orders*
- BG test not required



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SECTION V					
Schedule for Onsite School Nurse (Typical Week)			Schedule for Onsite School Unlicensed Diabetic Assistant		
M-F Nurse available during Academic Day		<input type="checkbox"/> YES <input type="checkbox"/> NO	Name of UDA		
Plan if student is off campus			Plan if student is off campus		
Day	Time	Coverage	Day	Time	Coverage
Field Trip			Field Trip		
Before School			Before School		
After School			After School		
Other			Other or N/A		

Written Notes/Addendum to Plan of Care

Date	Notes	Nurses Signature

Signature of Parent or Guardian

Date

Signature of School Nurse

Date

Signature of Unlicensed Diabetic Assistant

Date



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SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

STUDENT INFORMATION

Student's Name: School: Date of Birth: Age: Grade: Teacher: No known drug allergies---if drug allergies list: Weight: pounds

PRESCRIBER AUTHORIZATION (To be completed by licensed healthcare provider)

Medication Name: Dosage: Route: Frequency/Time(s) to be given: Start Date: Stop Date:

Reason for taking medication: Potential side effects/contraindications/adverse reactions: Treatment order in the event of an adverse reaction:

SPECIAL INSTRUCTIONS:

Is the medication a controlled substance? Is self-medication permitted and recommended? Do you recommend this medication be kept "on person" by student?

Printed Name of Licensed Healthcare Provider: Phone: Fax:

Signature of Licensed Healthcare Provider: Date:

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication...

Prescription Medication must be registered with School Nurse or trained Medication Assistants. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be registered with the School Nurse or Trained Medication Assistant, OTC's in the original, unopened and sealed container. Local Education Agency Policy for OTC medication to be followed:

Parent's/Guardian's Signature: Date: Phone:

SELF-ADMINISTRATION AUTHORIZATION

(To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician.

Signature of Parent: Date: Phone:



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AGREEMENT FOR STUDENTS INDEPENDENTLY MANAGING THEIR DIABETES

Student Name:

Grade:

Student

- I agree to dispose of any sharps either by keeping them in my kit and taking them home, or placing them in the sharps container provided at school.
- If so indicated in my Individualized Healthcare Plan, I will notify the health office if my blood sugar is below Type Here mg/dl or above Type Here mg/dl.
- I will not allow any other person to use my diabetes supplies.
- I plan to keep my diabetes supplies:
 - With me
 - In the school health office
 - In an accessible and secure location (Type Here)
- I will seek help in managing my diabetes from Type Here if I need it.
- I understand that the freedom to manage my diabetes independently is a privilege and I agree to abide by this contract.

Student's signature: _____

Date: _____

Parent/Guardian

- I agree that my child can self-manage his/her diabetes and can recognize when he/she needs to seek help from a staff member.
- I authorize my child to carry and self-administer diabetes medications and management supplies and I agree to release the school system and school personnel from all claims of liability if my child suffers any adverse reactions from self-management or storage of diabetes medications and blood glucose management products.
- I will provide back-up supplies to the health office for emergencies.
- I understand that this contract is in effect for the current school year unless revoked by my son/daughter's physician or my son/daughter fails to meet the above safety guidelines.

Parent's signature: _____

Date: _____

School Nurse

- I will inform school staff members with "the need to know" about the student's condition and authorization to carry his/her diabetes supplies on person-

School Nurse's signature: _____

Date: _____

Based on a form posted on the Colorado Kids with Diabetes website (<http://www.coloradokidswithdiabetes.org/index.php/Nurse-Files.html>)

