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:**			

SECTION 504 PLAN

All students with diabetes should also have a separate Section 504 plan in place to provide accommodations necessary to access their education.

STUDENT DIABETES MANAGEMENT SKILLS	Needs Assistance	Needs Supervision	Independent
Identifying feelings of hypoglycemia			
Checking blood glucose			
Measuring out insulin			
Entering information into pump			
Administering insulin injection			
Independently counts carbohydrates			

CONTINUOUS GLUCOSE MONITORING

☐ Student has a Continuous Glucose Monitoring System: CGMS must have parent signature on CGM Addendum. Not all CGMS readings can be used to make treatment decisions.

Test blood glucose with a meter if apparent disparity between GGM reading and symptoms!

INSULIN DELIVERY (per instructions from healthcare provider, correction doses can be given with meal/snack only, unless on a pump)

Method of insulin delivery: ☐Pump ☐Insulin Pen ☐Syringe/vial

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 or if symptomatic give_____ grams of carbohydrates ☐ After 15 minutes recheck blood glucose ☐ 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:**	**School Year:**

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

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

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 student'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 above to my student. 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: