

DIABETES – Simplified Individualized Healthcare Plan (IHP) Utah Department of Health				School Year:	Picture
STUDENT INFORMATION					
Student:		DOB:	Grade:	School:	DMMO <input type="checkbox"/> Yes <input type="checkbox"/> No
Parent:		Phone:		Email:	
Physician:		Phone:		Fax or Email:	
School Nurse:		School Phone:		Fax or Email:	
<input type="checkbox"/> Type I	<input type="checkbox"/> Type II	Age at diagnosis:			
SECTION 504 PLAN					
Most 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/smart pen					
Administering insulin injection					
Independently counts carbohydrates					
CONTINUOUS GLUCOSE MONITORING (See CGM Addendum)					
<input type="checkbox"/> Student has a Continuous Glucose Monitoring System: <u>Please attach CGM Addendum.</u> Addendum must have parent signature. Not all CGMS readings can be used to make treatment decisions. <i>Test blood glucose with a meter if apparent disparity between CGM reading and symptoms!</i>					
INSULIN DELIVERY (See Insulin Injection or Pump/Smart Pen Addendum)					
(Correction doses can be given with meal only, unless on a pump)					
Method of insulin delivery: <u>Attach appropriate addendum</u>					
<input type="checkbox"/> Pump	<input type="checkbox"/> Insulin Pen	<input type="checkbox"/> Smart insulin pen	<input type="checkbox"/> Syringe/vial		
Lunch: Student will typically eat:					
<input type="checkbox"/> School Lunch (staff can help with carb counts)			<input type="checkbox"/> Home Lunch (parent must provide carb counts)		
HYPOglycemia-Low Blood Glucose		HYPERglycemia-High Blood Glucose		ADDITIONAL INFORMATION	
<b style="color: red;">Emergency situations may occur with low blood sugar! <u>Symptoms:</u> shaky, feels low, feels hungry, confused, other (specify): <input type="checkbox"/> Student needs treatment when blood glucose is below _____ mg/dl or if symptomatic <input type="checkbox"/> If treated outside the classroom, a responsible person MUST accompany student to the office <input type="checkbox"/> If blood glucose is below _____ mg/dl or if symptomatic give _____ grams of carbohydrates <input type="checkbox"/> After 15 minutes recheck blood glucose with meter <input type="checkbox"/> Repeat until blood glucose is over _____ mg/dl <input type="checkbox"/> Disconnect or suspend pump		<u>Symptoms:</u> Increased thirst, increase need for urination, other (specify): <input type="checkbox"/> Student needs treatment when blood glucose is over _____ mg/dl <input type="checkbox"/> If blood sugar is over _____ mg/dl contact parent <input type="checkbox"/> Allow unrestricted bathroom privileges <input type="checkbox"/> Encourage student to drink water or sugar-free drinks If vomiting call parent <i>immediately!</i>		<ul style="list-style-type: none"> 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 <b style="color: red;">CALL 911 IF: <ul style="list-style-type: none"> 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					

Diabetes Individualized Healthcare Plan (IHP)

Student:	DOB:	School Year:
ADDITIONAL INSTRUCTIONS		
Please specify any additional instructions for daily management of student:		
EMERGENCY MEDICATION (See DMMO)		
Person to give Glucagon : <input type="checkbox"/> School Nurse <input type="checkbox"/> Parent <input type="checkbox"/> EMS <input type="checkbox"/> Volunteer(s) (Specify): Attach volunteer(s) training documentation if applicable.		
Location of Glucagon:		
SIGNATURES		
<i>PARENT TO COMPLETE (as required by UCA 53G-9-504 and 53g-9-506)</i>		
<input type="checkbox"/> I certify that glucagon has been prescribed for my student. <input type="checkbox"/> 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. <input type="checkbox"/> 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. <input type="checkbox"/> I authorize my student to possess and self-administer diabetes medication. My student should be in possession of diabetes medications at all times. <input type="checkbox"/> I authorize my student to possess, but not self-administer diabetes medication. My student should be in possession of diabetes medications at all times. <input type="checkbox"/> I do NOT authorize my student to possess or self-administer diabetes medication. My student should have access to their diabetes medications at all times.		
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: <input type="checkbox"/> Student carries <input type="checkbox"/> Backpack <input type="checkbox"/> Classroom <input type="checkbox"/> Health Office <input type="checkbox"/> Front office <input type="checkbox"/> Other (specify):		
IHP (this form) distributed to 'need to know' staff: <input type="checkbox"/> Teacher(s) <input type="checkbox"/> Lunchroom <input type="checkbox"/> PE teacher(s) <input type="checkbox"/> Transportation <input type="checkbox"/> Front office/admin <input type="checkbox"/> Other (specify):		
School Nurse Signature:	Date:	