INDIVIDUALIZED HEALTHCARE PLAN - DIABETES
SCHOOL AND PARENT PART

**STUDENT’S NAME:**

**Diabetes information**
- [ ] Diabetes Type 1
- [ ] Diabetes Type 2
- [ ] Other

**Date of Diagnosis:**

**PLAN**

**EFFECTIVE DATE:**

**SCHOOL INFORMATION**

**Grade:**

**Teacher:**

**504 plan on file:**
- [ ] Yes
- [ ] No

**CONTACT INFORMATION:**

**Parent/Guardian 1:**
- **Name:**
- **Call first:**
- **Phone numbers:**
  - [ ] Home
  - [ ] Work
  - [ ] Cell
  - [ ] Other

**Parent/Guardian 2:**
- **Name:**
- **Call first:**
- **Phone numbers:**
  - [ ] Home
  - [ ] Work
  - [ ] Cell
  - [ ] Other

**Other/emergency:**
- **Name:**
- **Relationship:**
- **Phone numbers:**
  - [ ] Home
  - [ ] Work
  - [ ] Cell
  - [ ] Other

**Additional Times to Contact Parent...**

- Student treated by **injection**:
  - Blood Glucose test out of target range
  - Routine Daily Insulin injections
  - Correction dose

- Student treated by **pump**:
  - Blood Glucose test out of target range
  - Carbohydrate bolus
  - Correction bolus
  - Infusion set comes out/needs to be replaced

**STUDENT DIABETES SELF-MANAGEMENT PLAN**

- Student will manage diabetes independently
- [ ] Student has signed Agreement for Student Independently Managing Diabetes

- Trained staff will supervise student self-care:
  - Verify blood glucose test
  - Check carbohydrate count
  - Confirm dose
  - Supervise insulin self-injection
  - Monitor bolus administration
  - Trouble shoot pump alarms, malfunction
  - Watch infusion set change

- Trained staff will provide care:
  - Test blood glucose
  - Count carbohydrates
  - Calculate insulin dose and inject as above
  - Provide insulin injection
  - Administer bolus
  - Trouble shoot pump alarms, malfunction
  - Change infusion set

**FOOD PLAN**

<table>
<thead>
<tr>
<th>Time</th>
<th>Notes</th>
<th>Monitor/Remind Student</th>
<th>Food at a classroom/school party:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast</td>
<td></td>
<td></td>
<td>[ ] Student will eat treat</td>
</tr>
<tr>
<td>Morning snack</td>
<td></td>
<td></td>
<td>[ ] Replace the treat with a parent-supplied alternative</td>
</tr>
<tr>
<td>Lunch</td>
<td></td>
<td></td>
<td>[ ] Put in baggie to take home with teacher note</td>
</tr>
<tr>
<td>Afternoon snack</td>
<td></td>
<td></td>
<td>[ ] Student should not eat treat</td>
</tr>
<tr>
<td>Extra snack</td>
<td></td>
<td>[ ] Yes</td>
<td>[ ] Modify the treat as follows:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] No</td>
<td></td>
</tr>
<tr>
<td>Before exercise</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>After exercise</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BUS TRANSPORTATION PLAN**

- Student may test blood glucose and self-manage diabetes while on the bus.

- Test blood 10-20 minutes before boarding school bus. **Student must have blood glucose > 70 mg/dl to board bus**; if ≤ 70, provide care based on algorithm and call to have student picked up.
- Blood test not required.

**FIELD TRIPS**

- School nurse to be notified two weeks before the field trip to assure qualified personnel are available.
- All diabetes supplies are taken and care is provided according to this Plan (copy to accompany trip).
- Lunch and snack times should not change.

**SCHEDULED AFTER- OR BEFORE-SCHOOL ACTIVITIES**

- List of clubs, sports, etc. that student anticipates:

- If parent wants trained staff coverage for an activity, parent will notify school nurse two weeks before it begins.
### ADDITIONAL NOTES

#### STUDENT’S NAME:

☐ Means student uses this item AND parent will provide.

##### Blood Glucose Test Kit

- Meter
- Test strips
- Lancing device and lancet
- Sharps container
- Anti-bacterial cleaner/alcohol swabs
- cotton balls
- spot band-aids

##### Insulin

**Treatment by Injection**

- Insulin pen
- Pre-filled syringes (labeled per dose)
- Insulin vials and syringes

**Treatment by Pump**

- Pump syringe
- Pump tubing/needle
- Batteries
- Tape
- Sof-sitter
- Insulin vial and syringes

**Pump type**

- Medtronic Minimed
  - www.minimed.com
  - (800) 826-2099
- Animas
  - www.animas.com
  - (877) 767-7373
- Omnipod
  - www.myomnipod.com
  - (800) 591-3455

##### Low Blood Glucose (5-day supply)

- Fast-acting carbohydrate drink (apple juice, orange juice, regular soda pop – NOT diet), ≥ 6 containers
- Pre-packaged snacks (e.g., crackers with cheese or peanut butter, nite bite), ≥ 5 servings
- Supply of fast-acting glucose at least equal to 15 gm per day for 5 days (e.g., ≥ 75 gm total)

##### Glucagon Kit

##### High Blood Glucose

- Urine ketone test strips/bottle
- Urine cup
- Water bottle
  - (Timing device may be wall clock or watch)

##### 3-day Disaster Kit

- Complete daily insulin dose schedule (separate page)
- Blood glucose test kit (testing strips, lancing device, lancets, meter batteries)
- Vial of insulin and 6 syringes; insulin pens and supplies
- Insulin pump and pump supplies
- Hypoglycemia treatment supplies, ≥ 3 episodes

##### Other

- Other medications, including glucagon kit
- Urine ketone strips/plastic cup
- Antiseptic wipes or hand sanitizer
- 3-day food supply with meal plan
- Other:

### SUPPLY LOCATIONS

<table>
<thead>
<tr>
<th></th>
<th>Daily breakfast, snacks and lunch</th>
<th>Extra snacks</th>
<th>Low blood glucose supplies</th>
<th>High blood glucose supplies</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>With student</td>
<td>In classroom</td>
<td>In health office</td>
<td>Other</td>
<td>Blood glucose test kit</td>
<td>Extra kit</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Pump supplies</td>
<td></td>
</tr>
</tbody>
</table>

### SIGNATURES

As parent/guardian of the above-named student, I give permission for the school nurse and/or other trained staff of ____________________________ to perform and carry out the diabetes care tasks as outlined in this Individualized Healthcare Plan.

<table>
<thead>
<tr>
<th></th>
<th>Student’s parent/guardian Date</th>
<th>Student’s parent/guardian Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>School nurse</td>
<td>Date</td>
</tr>
</tbody>
</table>