INDIVIDUALIZED HEALTHCARE PLAN – DIABETES WITH INJECTION
HEALTHCARE PROVIDER ORDERS

EFFECTIVE DATE: | End Date:

STUDENT'S NAME: | Date of Birth:

DIABETES HEALTHCARE PROVIDER INFORMATION Name:
Phone #: Fax #: Email

SCHOOL: School Fax:

STUDENTS WITH DIABETES TREATED BY INJECTION

Monitor Blood Glucose – test ...

☒ If student has symptoms of high or, ***without moving student,*** low blood glucose

☐ Before breakfast ☐ After lunch ☐ Before exercise/PE
☐ Before mid-morning snack ☐ Before afternoon snack ☐ After exercise/PE
☐ Before lunch ☐ Before leaving school ☐ Other:

Where to test: ☐ Classroom ☐ Health office ☐ Other: _____
☒ ***Without moving student if has low blood glucose symptoms***

Routine Daily Insulin Injection:

Insulin Delivery: ☐ Syringe/vial ☐ Pen

Type: ☐ rapid acting (Humalog / NovoLog / Apidra) ☐ regular or ☐ other: _____

☐ Calculate insulin dose for carbohydrate intake:

Give _____ unit(s) of rapid-acting insulin for ___ grams of carbohydrate.

Give at: ☐ breakfast ☐ AM snack ☐ lunch ☐ PM snack ☐ parties.

OR

☐ Standard daily insulin injection:

Type	Dose	Time

***Correction insulin dose for high blood glucose*:**

Time to be given: ☐ Before lunch **ONLY** ☐ Other: _____

☐ Use correction scale

Blood glucose range	Insulin units
mg/dl	
mg/dl	
mg/dl	
mg/dl	
mg/dl	
mg/dl	
mg/dl	

☐ Use Formula to calculate correction dose
(Blood glucose- _____ ÷ _____) = _____ units of insulin.

☐ Carbohydrate coverage and pre-meal correction doses may be combined.

Check ketones if nausea, vomiting or abdominal pain OR if blood glucose >300 twice when tested 3 hours apart.

- Give _____ units of rapid-acting insulin for moderate and _____ units for large ketones.
- Repeat ketone test in 2 hours, and repeat additional insulin if moderate or large ketones are still present.

☐ If BG <70 before a meal treat with carbohydrate OR subtract _ unit insulin.

Do not give insulin correction dose more than once every 2 to 3 hours.

Exercise and Sports ☐ Student should monitor blood glucose hourly.

Parent/Guardian Authority to Adjust Insulin Dose

Dose adjustment allowed up to 20% higher or lower ☐ Yes ☐ No

Other Health Concerns and Medications

Other health concerns: | Allergies:

☐ Glucagon Dose: _____ IM or SC per thigh or arm
☐ Oral diabetes medication(s)/dose: _____ Times to be given: _____
☐ Other medication(s)/dose: _____ Times to be given: _____
_____ Times to be given: _____

HCP Assessment of Student's Diabetes Management Skills:

Skill	Independent	Needs supervision	Cannot do
Check blood glucose			
Count carbohydrates			
Calculate insulin dose			
Injection			

Note

HEALTHCARE PROVIDER SIGNATURE/STAMP: Date:

UPDATED Change Date Initials

INDIVIDUALIZED HEALTHCARE PLAN – DIABETES WITH PUMP
HEALTHCARE PROVIDER ORDERS

EFFECTIVE DATE: | End Date:

STUDENT'S NAME: | Date of Birth:

DIABETES HEALTHCARE PROVIDER INFORMATION Name:

Phone #: Fax #: Email

SCHOOL: School Fax:

STUDENTS WITH DIABETES TREATED BY PUMP

Monitor Blood Glucose – test ...

☒ If student has symptoms of high or low blood glucose

☐ Before breakfast ☐ After lunch ☐ Before exercise/PE

☐ Before mid-morning snack ☐ Before afternoon snack ☐ After exercise/PE

☐ Before lunch ☐ Before leaving school ☐ Other:

☐ All test results should be entered into pump to determine need for bolus correction.

Where to test: ☐ Classroom ☐ Health office ☐ Other: _____

☒ ***Without moving student if has low blood glucose symptoms***

Insulin Pump Information ☐ *Humalog or NovoLog or Apidra by pump*

Basal rates during school: _____ _____

☐ Place pump on suspend when blood glucose is less than _____mg/dl and re-activate it when blood glucose is at least _____ mg/dl.

Pump settings should not be changed by school staff.

Carbohydrate Bolus

Give 1 unit of insulin per
gm carbohydrate at breakfast
gm carbohydrate at AM snack
gm carbohydrate at lunch
gm carbohydrate at PM snack

Bolus should occur: ☐ before eating, or ☐ other:

_____

Correction Bolus for Hyperglycemia

Time to be given: ☐ Before lunch **ONLY** ☐ Other: _____

- Give ___ units of insulin for each _____mg/dl of blood glucose with a target blood glucose of _____mg/dl.
- **Check ketones** if nausea, vomiting or abdominal pain OR if blood glucose >300 twice when tested 3 hours apart.
  - **Via syringe,** give _____ units for moderate and ___ units of rapid-acting insulin for large ketones. Repeat blood glucose test in 2 hours, and repeat additional insulin if moderate or large ketones are still present.

☐ If BG <70 before a meal treat with carbohydrate OR subtract _ unit insulin.

Do not give correction dose of insulin more than once every 2 to 3 hours.

If infusion set comes out or needs to be changed: ☐ Change set at school ☐ Insulin via syringe every 3 hours

Exercise and Sports with Pump

Temporary Basal Decrease: ☐ No ☐ Yes (___% or _____ units for _____ minutes or ☐ duration of exercise)

✓ Student should monitor blood glucose hourly.

HCP Assessment of Student's Diabetes Management Skills:

Skill	Independent	Needs supervision	Cannot do
Check blood glucose			
Count carbohydrates			
Calculate insulin dose			
Change infusion set			
Injection			
Trouble shoot alarms, malfunctions			

Notes:

Note

Parent/Guardian Authority to Adjust Insulin Dose

Dose adjustment allowed up to 20% higher or lower ☐ Yes ☐ No

Other health concerns: | Allergies:

☐ Glucagon Dose: _____ IM or SC per thigh or arm

☐ Oral diabetes medication(s)/dose: _____ Times to be given: _____

☐ Other medication(s)/dose: _____ Times to be given: _____

HEALTHCARE PROVIDER SIGNATURE/STAMP: | Date:

UPDATED Change Date Initials

STUDENT'S NAME:

ALGORITHMS FOR BLOOD GLUCOSE RESULTS

Student's usual LOW blood glucose symptoms:

_ Shaky or jittery
_ Sweaty
_ Hungry
_ Pale
_ Headache
_ Blurry vision
_ Sleepy
_ Dizzy
_ Uncoordinated
_ Irritable, nervous
_ Argumentative
_ Combative
_ Changed personality
_ Changed behavior
_ Unable to concentrate
_ Weak, lethargic

Student's usual HIGH blood glucose symptoms:

Hyperglycemia
_ Increased thirst, dry mouth
_ Frequent or increased urination
_ Change in appetite, nausea
_ Blurry vision
_ Fatigue
Other

Emergency levels
_ Extreme thirst
_ Nausea, vomiting
_ Severe abdominal pain
_ Fruity breath
_ Heavy breathing, shortness of breath
_ Increasing sleepiness, lethargy

CHECK BLOOD GLUCOSE

BELOW 70

1. Give 15 gm fast-acting carbohydrate
2. Observe for 15 minutes
3. Retest blood glucose.
   a. If less than 70, repeat 15 gm carbohydrate.
   b. If over 70, give carbohydrate and protein snack (e.g., crackers and cheese) if not eating a meal within an hour.
4. Notify school nurse and parent if no improvement
5. Student should not exercise

CALL 911 if student becomes unconscious, seizures or is unable to swallow

- Turn student on side to ensure open airway
- Give glucagon as ordered. Keep student in recovery position on side.
- If on insulin pump, either place it in 'suspend' or stop mode, disconnect it at the pigtail or clip, or cut tubing. If pump was removed, send it with EMS to the hospital.
- Notify school nurse, parent and HCP
- Wait 15 minutes; if no response, repeat glucagon.
  - If responsive, offer juice. Wait 15 minutes and give protein & carbohydrate snack.

70 – 90

1. Give 15 gm carbohydrate.
   a. If meal or snack is within 30 minutes, no additional carbs are needed.
   or
   b. If student is not going to eat within 30 minutes, give carbohydrate and protein snack.

If student's blood glucose result is immediately following strenuous activity, give 15 gm carbohydrate snack.

15 GM **FAST-ACTING** CARBOHYDRATE =

- ½ c. juice
- 3-4 glucose tablets
- Tube of glucose **gel**
- ½ c. regular (not diet) soda
- 6-7 small sugar candies (to chew)
- 1 c. skim milk

Do not give chocolate

91-125

Student may eat before exercising or recess.

126-300

No action needed.

ABOVE 300

STUDENT TREATED BY **INJECTION**

1. Use correction scale or formula at lunch or every 2-3 hours
2. Check ketones if symptoms or if blood glucose>300 twice in a row:
   a. If ketones are *absent or small*, encourage exercise and water
   b. If ketones moderate or large:
      - No exercise; give water
      - Add units of insulin per orders
3. Notify school nurse and parent
4. **Provide free, unrestricted access to water and the restroom.**

STUDENT TREATED BY **PUMP**

1. If 2-3 hours since last bolus, treat with correction bolus via pump. Re-check in 2- 3 hrs. Trouble shoot pump function.
   - Check for redness at site, tubing for kinks or air bubble, insulin supply
2. If blood glucose still ≥ 300 mg/dl and not explained, check ketones:
   a. If ketones are *absent or small*, encourage exercise and water
   b. If ketones moderate or large:
      - Give insulin correction dose per orders **via syringe**.
      - No exercise; encourage water
3. Change infusion set or continue insulin injections every 2-3 hours via syringe.
4. Notify school nurse and parent
5. **Provide free, unrestricted access to water and the restroom.**

CALL 911 if the student vomits, becomes lethargic and/or has labored breathing.
Notify school nurse, parent and HCP.

EXERCISE AND SPORTS

✓ Assure has quick access to water for hydration, fast-acting carbohydrates, snacks and monitoring equipment.
✓ Student should not exercise if blood glucose level is below 70 mg/dl or if has moderate to large ketones.

Never send a child with suspected low blood glucose *anywhere* alone.

INDIVIDUALIZED HEALTHCARE PLAN - DIABETES
SCHOOL AND PARENT PART

Student's photo

STUDENT'S NAME: | **PLAN EFFECTIVE DATE:**

Diabetes information Date of Diagnosis:

☐ Diabetes Type 1 ☐ Diabetes Type 2 ☐ Other

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	Time	Notes	Monitor/Remind Student	
			Yes	No
Breakfast				
Morning snack				
Lunch				
Afternoon snack				
Extra snack Before exercise				
After exercise				

Food at a classroom/school party:

- ☐ Student will eat treat
- ☐ Replace the treat with a parent-supplied alternative
- ☐ Put in baggie to take home with teacher note
- ☐ Student should not eat treat
- ☐ Modify the treat as follows:

BUS TRANSPORTATION PLAN

Bus transportation: ☐ To school ☐ Home

- ☐ Test blood 10-20 minutes before boarding school bus home. **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.

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

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:	**PLAN EFFECTIVE DATE:**

SUPPLY LIST

☑ 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

Glucose meter brand/model:

☐ *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-serter
☐ Insulin vial and syringes

Infusion set type: _____

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

☐ *Other*

SUPPLY LOCATIONS

	With student	In classroom	In health office	Other		With student	In classroom	In health office	Other
Daily breakfast, snacks and lunch					Blood glucose test kit Extra kit				
Extra snacks					Pump supplies				
Low blood glucose supplies					Insulin Daily use Extra/emergency				
High blood glucose supplies					Disaster Disaster food				
Other									

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.
(school)

- I have reviewed this plan and agree with the indicated instructions. I understand that the school is not responsible for equipment loss or damage, or expenses associated with these treatments and procedures.
- I understand that the information contained in this plan will be shared with other school staff on a need-to-know basis.
- I give permission to the school nurse to contact my child's physician/health care provider and discuss my child's care related to this plan.
- I will notify the school nurse whenever there is any change in my child's health status or care.
- My child and I are responsible for maintaining the necessary supplies, snacks, blood glucose meter, medications and other equipment.

_____ _____
Student's parent/guardian Date Student's parent/guardian Date

_____
School nurse Date

AGREEMENT FOR STUDENTS INDEPENDENTLY MANAGING THEIR DIABETES

Student: _____ 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 _____ mg/dl or above _____ 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 (_____)
- ☐ I will seek help in managing my diabetes from _____ 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 district 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 assure that school staff members that have the need to know about the student's condition and the need to carry their diabetes supplies with them have been notified.

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)

Individualized Healthcare Plan - Diabetes
School Nurse and Parent-Authorized Trained Staff Coverage ***Worksheet***

School nurse will be on-site

	Mon	Tue	Wed	Thurs	Fri
First period					
Second period					
Third period					
Fourth period					
Fifth period					
Sixth period					
Seventh period					
Field Trip					
Before school starting __ AM					
After school ending __ PM					
Other					

Notes/comments:

Schedule for Parent-Authorized Trained Staff

Staff person's Name	Day(s) responsible	Time(s) responsible	Contact phone
	☐ M ☐ T ☐ W ☐ Th ☐ F	From: To: or Period:	
	☐ M ☐ T ☐ W ☐ Th ☐ F	From: To: or Period:	
	☐ M ☐ T ☐ W ☐ Th ☐ F	From: To: or Period:	
	☐ M ☐ T ☐ W ☐ Th ☐ F	From: To: or Period:	
	☐ M ☐ T ☐ W ☐ Th ☐ F	From: To: or Period:	
	☐ M ☐ T ☐ W ☐ Th ☐ F	From: To: or Period:	
	☐ M ☐ T ☐ W ☐ Th ☐ F	From: To: or Period:	
	☐ M ☐ T ☐ W ☐ Th ☐ F	Before school starting ____AM	
	☐ M ☐ T ☐ W ☐ Th ☐ F	After school ending ______PM	
	Field trip		
	Other		
	Other		

Attach if needed

☐ Delegation training completion

☐ Parent delegation authorization

ALASKA INDIVIDUALIZED HEALTHCARE PLAN – DIABETES WITH INJECTION OR WITH PUMP

Instructions

Purposes:

This healthcare plan is for all students with diabetes that monitor blood glucose at school and/or are on insulin or other hypoglycemic medication and/or have a glucagon prescription.

1. Healthcare providers should use it to prescribe a particular treatment regimen including medication(s) for school (HEALTHCARE PROVIDER ORDERS pages)
   a. It documents the ability level of the student to self-manage their diabetes.
   b. It provides the medical parameters for management of an individual student's diabetes in the school setting.
2. It describes the standard of care for school staff to follow based on blood glucose test results and is the *Emergency Care Plan* for students with diabetes. (ALGORITHMS FOR BLOOD GLUCOSE RESULTS page) 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.
3. School nurses and parents should use it to plan and implement individualized health interventions in the school setting, based on the Healthcare Provider Orders page. (SCHOOL AND PARENT PART pages)
   a. To support quality assurance of school health services.
   b. To document parental wishes for diabetes management-related contact by school staff.
   c. To document diabetes supplies needed at school, their locations and parental responsibility for maintaining certain supplies at school.
   d. To facilitate a safe process for the delegation of diabetes-management tasks to trained unlicensed school staff, as needed.
4. School nurses and parents *may* use it to identify times when the school nurse will not be available to provide diabetes management assistance and plan for coverage by trained school staff. (SCHOOL NURSE AND PARENT-AUTHORIZED TRAINED STAFF COVERAGE WORKSHEET)

While current, this form should be kept in the school health office or with the staff member who is assisting with the health management of the student.

Process:

1. Healthcare provider completes either the WITH INJECTION or the WITH PUMP page of the form to describe anticipated medications/treatment needs for the entire school year, and sends it to the school nurse (if known) and/or the student's parent to brings into the school.
   a. If medications and/or treatment change during the school year, a new form should be completed. Fax only the page with new orders to the school.
   b. Most categories are self-explanatory. On either form, check all boxes that apply and add information as appropriate.

      DIABETES WITH INJECTION notes:

      - In the *Routine Daily Insulin Injection* box, there are three options for Type. NPH and Lantis are examples of "other." The relevant doses/times for these injections would be listed in the "Standard daily insulin injection" table.
      - Instructions in the *Correction insulin dose for high blood glucose* box are for a routine day as correction dosing is generally given at mealtime, which means that:
        - Action directed by the algorithm page supersedes "before lunch only" when it is checked because it is based on the student's symptoms and blood glucose levels.

        - The "Do not give insulin correction dosing more often than every 2 to 3 hours" statement applies to symptomatic treatment based on blood glucose levels in most instances.
    - In the *Parent/Guardian Authority to Adjust Insulin Dose* box, parental authority to adjust the dose up to 20% higher or lower allows the parent to recommend dose adjustments to the nurse which the nurse could follow without contacting the health care provider **if the dose is within 20% of the range ordered by the provider**. If the dose recommended by the parent falls outside of the range, either higher or lower, the nurse would need to contact the health care provider to verify the dose.

c. Healthcare provider signs and dates the WITH INJECTION or WITH PUMP page and faxes or sends the orders to the school.

2. While meeting with the school nurse, the parent uses the boxes at the top of the ALGORITHMS page to indicate which of the symptoms of low and high blood sugar generally occur for their child.

3. Together, the school nurse, parent and the student, if student is self-managing his/her diabetes, complete the SCHOOL AND PARENT PART of the form.

   a. Most categories are self-explanatory. Check all boxes that apply and add information as appropriate.
      - In the *Student Diabetes Self-Management Plan* box:
        - The repeated skills list (from the healthcare provider section) allows parent input and school nurse assessment of the student skill level and the level of supervision or assistance needed. If the student skill level increases during the school year, this section allows the school nurse and parent to adjust the self-management plan accordingly.
        - "Trained staff" (right-side column) in this instance includes the school nurse.
        - For "Change infusion set" under "Trained staff will provide care", the school nurse is typically **the only** trained staff changing the infusion set for a student on a pump. Add this comment when needed.
      - The SUPPLY LIST is intended to promote best practice. Generally, it should be interpreted by the nurse and the parent as a guide.
      - If the parent is unable to provide urine ketone test strips, contact the American Diabetes Association (907 272-1424). They will send some.

   b. Parents and School Nurse sign and date the SCHOOL AND PARENT PART. If student will be self-managing, student signs the STUDENT SELF-MANAGEMENT AGREEMENT.

   c. Update as needed and/or on a yearly basis.

4. The school nurse may use the WORKSHEET page to identify times when he/she will regularly be unavailable to assist the student with diabetes management and plan for coverage by trained school staff.

5. File the entire document with student's health record at the end of the year or upon student withdrawal.