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.

Individualized Health Care Plan **Student Name:** Type Here **School Year:** Type Here

Diabetes Individualized Healthcare Plan

SECTION I			
Student:			**WT:** **HT:**
Grade:	**D.O.B**	**Any Known Allergies**	
School:			
District:		**Bus (check one) ☐YES ☐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

Individualized Health Care Plan **Student Name:** Type Here **School Year:** Type Here

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	**Daily Snacks:** Time(s) Type Here Place specified Type Here ☐ Done independently ☐ Needs reminder ☐ Needs daily compliance verification • **Extra Snacks:** ☐ Before exercise ☐ After exercise ☐ 10 gms. CHO every 30 minutes during vigorous exercise ☐ Needs daily compliance verification • **Daily Blood Test:** ☐ Before Meals ☐ Prior to Exercise ☐ As Needed • **Location for testing:** ☐ Classroom ☐ Health Office **Student is to be tested in his/her current location if Hypoglycemic** ☐ By student independently ☐ Adult verifies results ☐ Needs assistance (specify) Type Here ☐ **Refer to Algorithms for Blood Glucose Results, (attach sheet).** • **Exercise:** ☐ None if blood glucose test results are below Type Here mg/dl • **Lunch Eaten At** (time) Type Here ☐ May amend snack and meal times according to school schedule. Please specify Type Here • **In Event of Classroom/School Parties**, food treats will be handled as follows: ☐ Student will eat the treat ☐ Student will eat modified snack ☐ Replace with parent supplied alternative ☐ Do not eat snack. • **Scheduled After-School Activities:** Type Here **<u>The School Nurse Must Be Notified Preferably Two Weeks Before The Field Trip To Plan For Qualified Personnel To Provide Procedures</u>**
Training and Notifying School Employees of Diabetes Basic Training Program	**The following personnel will be notified of my child's medical condition and participate in Diabetes Basic Training Program:** ☐ All School Personnel ☐ School Personnel that have contact with my child ☐ Cafeteria Staff ☐ Other Type Here
Other **504** ☐ **YES** ☐ **NO**	(*Specify):* Type Here **Student has unrestricted use of the bathroom and water.**

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

SECTION II Continued ***(Completed with Parent and Student)***

Student	DOB	School	Grade

Equipment and supplies to be provided by parent

Daily Snacks (for AM/PM snack times) Specify:

List Snacks Here

List Snacks Here

Blood Glucose Meter Kit
(Includes meter, testing strips, lancing device with lancet, cotton balls, spot Band-Aids, alcohol prep pads)

Brand/Model: Type Here

Low Blood Glucose Supplies,

☐ **Fast Acting Carbohydrate Drinks:** (Apple juice and/or orange juice, sugared soda pop-NOT diet), at least 6 containers.

☐ **Glucose Tablets**, 1 package or more.

☐ **Glucose Gel Products**
Note: Do not use if student is having difficulty swallowing

☐ **Gel Cakemate**
Note: Do not use if student is having difficulty swallowing.

☐ **Prepackaged Snacks** (such as crackers with cheese or peanut butter, nite bite, etc.), 5 - 6 servings or more.

High Blood Glucose Supplies

☐ Ketone Test Strips/Bottle

☐ Urine cup

☐ Water bottle

☐ Protein Snack (Meat or cheese sticks)

Insulin Supplies

☐ Insulin pen

☐ Insulin and syringes

☐ Extra pump supplies such as:

- ☐ Vial of insulin, syringes
- ☐ Pump syringe
- ☐ Pump tubing/needle
- ☐ Batteries
- ☐ Tape
- ☐ Sof-Serter

Insulin supplies stored:

List Supplies Here

List Supplies Here

Emergency Supplies

☐ **Glucagon: YES or NO**

Kit stored:

Type Here

☐ **3 day disaster food supply stored**:

List Supplies Here

List Supplies Here

School may include a copy of the IHP for Diabetes Management with the Disaster Supplies. Stored as follows:

Type Here

Other Supplies and Special Needs

List Supplies Here

List Supplies Here

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)*

Check Blood Glucose

Student's usual LOW Blood Sugar Symptoms
(Circle/highlight all that apply)

Shaky/jittery	Uncoordinated
Sweaty	Irritable/anxious
Hungry	Argumentative
Pale	Combative
Headache	Changed Personality
Blurred vision	Changed Behavior
Sleepy	Inability to Concentrate

Student's usual HIGH Blood Sugar Symptoms
(Circle/highlight all that apply)

Increased thirst	Abdominal Pain
Dry mouth	Shortness of Breath
Frequent urination	Fruity Breath
Change in appetite	Vomiting
Nausea	Drowsy/Sleeping
Blurred Vision	
Fatigue	

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 #:	

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 **In Event of Field Trips**, all diabetic supplies are taken and care is provided according to this IHP (a copy is taken on trip)	List of clubs, sports, after school care programs etc. that student participates.

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

SECTION V					
Schedule for Onsite School Nurse (Typical Week)			**Schedule for Onsite School Unlicensed Diabetic Assistant**		
M-F **Nurse available during Academic Day**	☐ **YES** ☐ **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**

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? Yes ☐ No ☐
Is self- medication permitted and recommended? Yes ☐ No ☐
If "yes" I hereby affirm this student has been instructed
On proper self-administration of the prescribe medication.
Do you recommend this medication be kept "on person" by student? Yes ☐ No ☐

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 in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up with the 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. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent: _____ **Date:** ____/____/_____ **Phone: ( )** _____-_____

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 need 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 of 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)

Communication of the Individualized Health Care Plan

SECTION VI

☐ Check this Box if Read Receipt is used to communicate Individualized Health Care Plan to staff.
* Nurse to attach Read Receipt document to this packet.

☐ Check this box if staff receives and signs below for Individualized Health Care Plan.

I have read and understand this student's Individualized Healthcare Plan, and have printed a copy to be maintained in my confidential folder/binder of instructions for substitute teachers.

I have been given the opportunity to ask questions.

I understand my role in addressing this students medical needs.

I am aware the school nurse is available to help clarify any future concerns

Employee Name	Employee Signature	Position	Date