Appendix 2 – Individualized Healthcare Plan (IHP) Packet
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 hypoglycemic 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 name 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 their 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.
Diabetes Individualized Healthcare Plan

Pupil:  
Grade:   D.O.B   Educational Placement:  
School:  
District:  
School Nurse:  Pager #  Cell #  
Parent/Guardian Consent Date:  Physician Authorization Date:  

Parent Signature:  
Mother  Home #  Work #  Pager/Cell #  
Father  Home #  Work #  Pager/Cell #  
Guardian  Home #  Work #  Pager/Cell #  
Home Address  City  Zip  
Other Contact (Relationship):  Home #  Work #  
Physician  Phone #  Fax #  
Physician Address  City  Zip  

Healthcare Service Needed at School  Management of Diabetes at School and School Sponsored Events:  

Purpose of an IHP  
1. **The purpose** of an Individualized Healthcare Plan (IHP) is to provide safe management of healthcare needs and services for pupils at school and during school-related activities.  

2. **The school nurse**, in collaboration with the student and the student’s parent/guardian, healthcare providers, and school team, is responsible for:  
   a) Development, implementation, and revisions of the IHP.  
   b) The training and supervision of all designated personnel who will provide healthcare according to the IHP and standard procedures.  

3. **IHP revisions** must be directed to the school nurse prior to implementation. All physician changes must have a written physician authorization and written parent consent. Revisions, not requiring physician authorization, may be made with written parent consent.  

4. **IHP review** must occur annually and whenever necessary to ensure provision of safe care.
Individualized Healthcare Plan for Management of Diabetes at School
Completed With Parent and Pupil

<table>
<thead>
<tr>
<th>Pupil</th>
<th>DOB</th>
<th>School</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic Routines At School Per Parent Request/Consent</td>
<td>Daily Snacks:</td>
<td>Time(s)</td>
<td>Place specified</td>
</tr>
</tbody>
</table>
| | | | | □ 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 where they are at if Hypoglycemic |
| | | □ By pupil independently
| | | □ Adult verifies results
| | | □ Needs assistance (specify)
| | | □ Refer to Algorithms for Blood Glucose Results, (attach sheet).
| | ▪ Exercise: | □ None if blood glucose test results are below __________ mg/dl
| | ▪ Lunch Eaten At (time) ________ Regardless of schedule changes, field trips, disaster, etc.
| | | □ Needs daily verification of meal eaten
| | | □ Written consent with schedule changes with snack and meal times.
| | ▪ In Event of Field Trips, all diabetic supplies are taken and care is provided according to this ISHP (a copy is taken on trip)
| The School Nurse Must Be Notified Preferably Two Weeks Before The Field Trip To Plan For Qualified Personal To Provide Procedures |
| ▪ In Event of Classroom/School Parties, food treats will be handled as follows:
| | | □ Pupil will eat the treat.
| | | □ Replace with parent supplied alternative
| | | □ Put in baggie and take home with teacher note.
| | | □ Modify the treat as follows:
| | | | □ Do not eat snack.
| ▪ In Event of Bus Transportation:
| | | □ Blood test given 10 to 20 minutes before boarding. If 70 or less, provide care per Procedure For Mild to Moderate Low Blood Glucose and call parent to provide transportation home.
| | | □ Blood test not required.
| ▪ Scheduled After-School Activities: ________________________________

Training and Notification of 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 ______

Other

(Specify): ____________________________________________

Student has unrestricted use of the bathroom and water.
## Individualized Healthcare Plan
### For Management of Diabetes at School (Continued)
Completed With Parent and Pupil

<table>
<thead>
<tr>
<th>Equipment and supplies</th>
<th>DOB</th>
<th>School</th>
<th>Provided By Parent</th>
<th>Grade</th>
</tr>
</thead>
</table>

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


**Extra Snacks** (for before, after, and/or during exercise) Specify:


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

**Brand/Model:**

**Low Blood Glucose Supplies.** (5 day supply)

- 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 (Insta-Glucose, Monogel or Glucose/25--31 Gms.), 2 or more.

- Gel Cakemate (not frosting), (19 Gm., mini-purse size), 2 or more.

  **Note:** Not used in Emergency Procedure For Severe Low Blood Sugar.

- 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

  **Note:** Timing device may be wall clock or watch worn by pupil or personnel.


### Provided By Parent (Continued)

**Insulin Supplies**

- Insulin pen
- Pre-filled syringes (labeled per dose)
- Insulin and syringes
- Extra pump supplies such as:
  - Vial of insulin, syringes
  - Pump syringe
  - Pump tubing/needle
  - Batteries
  - Tape
  - Sof-Serter

**Insulin supplies stored:**

**Emergency Supplies**

- Glucagon kit stored:

- 3 day disaster food supply stored:

**3 Day Disaster Diabetes Supplies**

- Vial of insulin; 6 syringes
- Insulin pen with cartridge and needles
- Blood glucose testing kit (testing strips lancing device with lancets
- Glucose gel product and glucose tablets
- Glucagon kit
- Food supply (include daily meal plan) stored as follows:

- Ketone strips/plastic cup

**School will include a copy of the ISHP for Diabetes Management with the Disaster Supplies. Stored as follows:**

**Other Supplies** Specify:
Student’s usual LOW Blood Sugar 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 Sugar symptoms:
- Increased thirst, dry mouth
- Frequent or increased urination
- Change in appetite, nausea
- Blurry vision
- Fatigue
- Extreme thirst
- Nausea, vomiting
- Severe abdominal pain
- Fruity breath
- Heavy breathing,
  shortness of breath
- Increased sleepiness,
  lethargy

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Check Blood Glucose

**Below 70**
2. Observe for 15 minutes.
   a. If less than 70 repeat sugar source/carb.
   b. If over 70 give carbohydrate and protein snack (e.g. crackers and cheese) if not eating within an hour.
4. Notify School nurse and parent if no improvement.
5. Student should not exercise.

**70-90**
   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 sugar source/carb and protein snack.

**91-125**
Student may eat before exercising or recess

**126-300**
No action needed.
Student may eat before exercising or recess

**Above 300**
Student may eat before exercising or recess

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Check Ketones (If ordered)
(can not exercise unless urine is negative for Ketones.)
Provide extra water.

Ketones Present – Notify School Nurse Immediately. Notify Parents/PMD.
Provide 1-2 glasses of water every hour. Do not exercise.
If at any time student vomits, becomes lethargic, and/or has labored breathing CALL 911.

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Fast Acting Sugar Sources (Do not give chocolate)
- 15 gm. Glucose tablets
- 15 gm. Glucose gel
- 1/3 c. sugared soda
- 1/4 c. orange juice
- 1/4 c. apple juice
- 1/4 c. grape juice
- 1/4 tube cake mate gel

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Parents Phone Numbers:

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<th>Parent’s Name:</th>
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<tr>
<td>School:</td>
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<tr>
<td>Nurse Contact number/pager:</td>
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<tr>
<td>Physician’s number:</td>
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***Never send a child with suspected low blood glucose anywhere alone.***
Effective Date of IHP: [Blank]  
End Date of IHP: [Blank]  
Student Name: [Blank]  
DOB: [Blank]  
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.  
 
### Assessment of Student DM Skills

<table>
<thead>
<tr>
<th>Skill</th>
<th>Independent Care</th>
<th>Assisted Care</th>
<th>Dependent Care</th>
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<tbody>
<tr>
<td>Check Blood Glucose</td>
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<tr>
<td>Count Carbs</td>
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<td>Calculate insulin dose</td>
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<td>Change infusion set</td>
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<td>Injection</td>
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| Trouble shoot alarms,  
malfunctions                   |                  |               |                |

NOTES:

If student is managing diabetes independently, is Student Agreement attached? Yes No

### Supplies to be Furnished/Restocked by Parent/Guardian

- Blood glucose meter/strips/lancets/lancing device
- Ketone testing strips
- Glucagon Emergency Kit
- Fast Acting carbohydrate
- Carbohydrate containing snacks
- Carbohydrate-free beverage/snack
- Insulin vials/syringes
- Insulin pen/pen needles/cartridges

### Exercise, Sports and Field Trips Plan

- BG monitoring and snacks as ordered.
- Student should not exercise if BG level is below ___ mg/dl.
- Preferably, School nurse/UDA to be notified two weeks before the field trip to assure qualified personnel are available

### Classroom/School Parties

- Student will eat same treats as the class
- Student may not eat same treats as class
- Replace treat with parent supplied alternative
- Modified treat

### Scheduled After – or – Before – School Activities

- List of clubs, sports, etc. that student participates.

### Bus Transportation Plan

Bus Transportation:
- To School
- Home
- Student may test BG and self-manage DM while on the bus

In the event of Bus Transportation:
- BG tested 10-20 minutes before boarding. If less than or equal to 70, provide care per Algorithm
- BG test not required

64
<table>
<thead>
<tr>
<th>Schedule for Onsite School Nurse</th>
<th>Notes/Comments:</th>
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<tr>
<td>Mon</td>
<td>Tue</td>
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<td>1&lt;sup&gt;st&lt;/sup&gt; Period</td>
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<td>Field Trip</td>
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<td>Before school</td>
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<tr>
<td>After School</td>
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<td>Other</td>
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<td>After School</td>
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<tr>
<td>Other</td>
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Signature of Parent or Guardian

Date

Signature of School Nurse

Date

Signature of Unlicensed Diabetic Assistant

Date
ALABAMA STATE DEPARTMENT OF EDUCATION
SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION
School Year: __________

**STUDENT INFORMATION**

<table>
<thead>
<tr>
<th>Student’s Name: ____________________________</th>
<th>School: ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth: <strong><strong><strong>/</strong><strong>/</strong></strong></strong> Age: ______</td>
<td>Grade: ______ Teacher: ______________</td>
</tr>
<tr>
<td>☐ No known drug allergies—if drug allergies list: ____________________________</td>
<td>Weight: ______ pounds</td>
</tr>
</tbody>
</table>

**PRESCRIBER AUTHORIZATION (To be completed by licensed healthcare provider)**

<table>
<thead>
<tr>
<th>Medication Name: ____________________________</th>
<th>Dosage: ____________________________</th>
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<tbody>
<tr>
<td>Frequency/Time(s) to be given: ____________________________</td>
<td>Route: ____________________________</td>
</tr>
<tr>
<td>Reason for taking medication: ____________________________</td>
<td>Start Date: <strong>/____/</strong>___ Stop Date: <strong>/____/</strong>___</td>
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Potential side effects/contraindications/adverse reactions:

Treatment order in the event of an adverse reaction:

**SPECIAL INSTRUCTIONS:**

<table>
<thead>
<tr>
<th>Is the medication a controlled substance?</th>
<th>Yes ☐ No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is self-medication permitted and recommended?</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>If “yes” I hereby affirm this student has been instructed</td>
<td></td>
</tr>
<tr>
<td>on proper self-administration of the prescribed medication.</td>
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</tr>
<tr>
<td>Do you recommend this medication be kept “on person” by student?</td>
<td>Yes ☐ No ☐</td>
</tr>
</tbody>
</table>

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: ( ) ______

revised 5/2014
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 ________ 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:
  o With me
  o In the school health office
  o 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 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 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)