

## **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**

<b>Pupil:</b>			
<b>Grade:</b>	<b>D.O.B</b>	<b>Educational Placement:</b>	
<b>School:</b>			
<b>District:</b>			
<b>School Nurse:</b>		<b>Pager #</b>	<b>Cell #</b>
<b>Parent/Guardian Consent Date:</b>		<b>Physician Authorization Date:</b>	
<b>Parent Signature:</b>			
<b>Mother</b>	<b>Home #</b>	<b>Work #</b>	<b>Pager/Cell #</b>
<b>Father</b>	<b>Home #</b>	<b>Work #</b>	<b>Pager/Cell #</b>
<b>Guardian</b>	<b>Home #</b>	<b>Work #</b>	<b>Pager/Cell #</b>
<b>Home Address</b>		<b>City</b>	<b>Zip</b>
<b>Other Contact (Relationship):</b>		<b>Home #</b>	<b>Work #</b>
<b>Physician</b>		<b>Phone #</b>	<b>Fax #</b>
<b>Physician Address</b>		<b>City</b>	<b>Zip</b>
<b>Healthcare Service Needed at School</b>	<b>Management of Diabetes at School and School Sponsored Events:</b>		
<b>Purpose of an IHP</b>	<ol style="list-style-type: none"> <li><b>The purpose</b> 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.</li> <li><b>The school nurse</b>, in collaboration with the student and the student's parent/guardian, healthcare providers, and school team, is responsible for:             <ol style="list-style-type: none"> <li>Development, implementation, and revisions of the IHP.</li> <li>The training and supervision of all designated personnel who will provide healthcare according to the IHP and standard procedures.</li> </ol> </li> <li><b>IHP revisions</b> 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.</li> <li><b>IHP review</b> must occur annually and whenever necessary to ensure provision of safe care.</li> </ol>		

**Individualized Healthcare Plan for Management of Diabetes at School  
Completed With Parent and Pupil**

Pupil	DOB	School	Grade
<b>Diabetic Routines At School Per Parent Request/Consent</b>	<p><b>Daily Snacks:</b> Time(s) _____ Place specified _____</p> <p><input type="checkbox"/> Done independently <input type="checkbox"/> Needs reminder <input type="checkbox"/> Needs daily compliance verification</p> <p>• <b>Extra Snacks:</b> <input type="checkbox"/> Before exercise <input type="checkbox"/> After exercise <input type="checkbox"/> 10 gms. CHO every 30 minutes during vigorous exercise <input type="checkbox"/> Needs daily compliance verification</p> <p>• <b>Daily Blood Test:</b> <input type="checkbox"/> Before Meals <input type="checkbox"/> Prior to Exercise <input type="checkbox"/> As Needed Location for testing <input type="checkbox"/> Classroom <input type="checkbox"/> Health Office</p> <p align="center"><b>Student is to be tested where they are at if Hypoglycemic</b></p> <p><input type="checkbox"/> By pupil independently <input type="checkbox"/> Adult verifies results <input type="checkbox"/> Needs assistance (specify) _____</p> <p><input type="checkbox"/> <b>Refer to Algorithms for Blood Glucose Results, (attach sheet).</b></p> <p>• <b>Exercise:</b> <input type="checkbox"/> None if blood glucose test results are below _____ mg/dl</p> <p>• <b>Lunch Eaten At</b> (time) _____ Regardless of schedule changes, field trips, disaster, etc. <input type="checkbox"/> Needs daily verification of meal eaten <input type="checkbox"/> Written consent with schedule changes with snack and meal times.</p> <p>• <b>In Event of Field Trips</b>, all diabetic supplies are taken and care is provided according to this ISHP (a copy is taken on trip)</p> <p align="center"><b><u>The School Nurse Must Be Notified Preferably Two Weeks Before The Field Trip To Plan For Qualified Personnel To Provide Procedures</u></b></p> <p>• <b>In Event of Classroom/School Parties</b>, food treats will be handled as follows: <input type="checkbox"/> Pupil will eat the treat. <input type="checkbox"/> Replace with parent supplied alternative <input type="checkbox"/> Put in baggie and take home with teacher note. <input type="checkbox"/> Modify the treat as follows: <input type="checkbox"/> Do not eat snack.</p> <p>• <b>In Event of Bus Transportation:</b> <input type="checkbox"/> Blood test given 10 to 20 minutes before boarding. If 70 or less, provide care per <b>Procedure For Mild to Moderate Low Blood Glucose</b> and call parent to provide transportation home. <input type="checkbox"/> Blood test not required.</p> <p>• <b>Scheduled After-School Activities:</b> _____</p>		
<b>Training and Notification of School Employees of Diabetes Basic Training Program</b>	<p><b>The following personnel will be notified of my child's medical condition and participate in Diabetes Basic Training Program:</b> <input type="checkbox"/> All School Personnel <input type="checkbox"/> School Personnel that have contact with my child <input type="checkbox"/> Cafeteria Staff <input type="checkbox"/> Other _____</p>		
<b>Other</b>	<p>(Specify): _____ <b>Student has unrestricted use of the bathroom and water.</b></p>		

**Individualized Healthcare Plan  
For Management of Diabetes at School (Continued)**  
Completed With Parent and Pupil

Pupil	DOB	School	Grade
<p><b>Equipment and supplies</b></p>	<p><b><u>Provided By Parent</u></b></p> <p><b><u>Daily Snacks</u></b> (for AM/PM snack times) Specify: _____</p> <p>_____</p> <p><b><u>Extra Snacks</u></b> (for before, after, and/or during exercise) Specify: _____</p> <p>_____</p> <p><b><u>Blood Glucose Meter Kit</u></b> (Includes meter, testing strips, lancing device with lancet, cotton balls, spot Band-Aids)</p> <p><b>Brand/Model:</b> _____</p> <p><b><u>Low Blood Glucose Supplies.</u></b> (5 day supply)</p> <p><input type="checkbox"/> <b>Fast Acting Carbohydrate Drinks:</b> (Apple juice and/or orange juice, sugared soda pop-NOT diet), at least 6 containers.</p> <p><input type="checkbox"/> <b>Glucose Tablets,</b> 1 package or more.</p> <p><input type="checkbox"/> <b>Glucose Gel Products</b> (Insta-Glucose, Monogel or Glucose/25--31 Gms.), 2 or more.</p> <p><input type="checkbox"/> <b>Gel Cakemate</b> (not frosting), (19 Gm., mini-purse size), 2 or more. <b>Note:</b> Not used in Emergency Procedure For Severe Low Blood Sugar.</p> <p><input type="checkbox"/> <b>Prepackaged Snacks</b> (such as crackers with cheese or peanut butter, nite bite, etc.), 5 - 6 servings or more.</p> <p><b><u>High Blood Glucose Supplies</u></b></p> <p><input type="checkbox"/> Ketone Test Strips/Bottle</p> <p><input type="checkbox"/> Urine cup</p> <p><input type="checkbox"/> Water bottle</p> <p><b>Note:</b> Timing device may be wall clock or watch worn by pupil or personnel.</p>	<p><b><u>Provided By Parent (Continued)</u></b></p> <p><b><u>Insulin Supplies</u></b></p> <p><input type="checkbox"/> Insulin pen</p> <p><input type="checkbox"/> Pre-filled syringes (labeled per dose)</p> <p><input type="checkbox"/> Insulin and syringes</p> <p><input type="checkbox"/> Extra pump supplies such as:</p> <p><input type="checkbox"/> Vial of insulin, syringes</p> <p><input type="checkbox"/> Pump syringe</p> <p><input type="checkbox"/> Pump tubing/needle</p> <p><input type="checkbox"/> Batteries</p> <p><input type="checkbox"/> Tape</p> <p><input type="checkbox"/> Sof-Serter</p> <p>Insulin supplies stored: _____</p> <p><b><u>Emergency Supplies</u></b></p> <p><input type="checkbox"/> <b>Glucagon kit stored:</b> _____</p> <p><input type="checkbox"/> <b>3 day disaster food supply stored:</b> _____</p> <p><b><u>3 Day Disaster Diabetes Supplies</u></b></p> <p><input type="checkbox"/> Vial of insulin; 6 syringes</p> <p><input type="checkbox"/> Insulin pen with cartridge and needles</p> <p><input type="checkbox"/> Blood glucose testing kit (testing strips lancing device with lancets)</p> <p><input type="checkbox"/> Glucose gel product and glucose tablets</p> <p><input type="checkbox"/> Glucagon kit</p> <p><input type="checkbox"/> Food supply (include daily meal plan) stored as follows: _____</p> <p><input type="checkbox"/> Ketone strips/plastic cup</p> <p>School will include a copy of the ISHP for Diabetes Management with the Disaster Supplies. Stored as follows: _____ _____</p> <p><b><u>Other Supplies,</u></b> Specify:</p>	

**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

**Check Blood Glucose**

**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

**Below 70**

1. Give fast-acting sugar source/carb.
2. Observe for 15 minutes.
3. Retest Blood Glucose.
  - 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.
5. Notify School nurse and parent if no improvement.
6. Student should not exercise.

**70-90**

1. Give fast-acting sugar source/carb.
    - a. If meal or snack is within 30 minutes, no additional carbs are needed.
    - b. If student is not going to eat within 30 minutes, give sugar source/carb and protein snack.
- OR*

**If student's BG result is immediately following strenuous activity, give carbohydrate snack.**

**91-125**

Student may eat before exercising or recess

**126-300**

No action needed.

**Above 300**

Student may eat before exercising or recess

Student may eat before exercising or recess

**Call 911 if student becomes unconscious, has a seizure or is unable to swallow**

1. Turn student on side to ensure open airway.
2. Give glucagon as ordered. Keep student in recovery position on side. If on insulin pump, either pump in suspend/stop mode, disconnect pump at the pigtail or clip, or cut tubing. If pump removed, send with EMS to the hospital.

**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.**

**Fast Acting Sugar Sources (Do not give chocolate)**

- 15 gm. Glucose tablets
- 15 gm. Glucose gel
- 1/3 c. sugared soda
- 1/2 c. orange juice
- 1/2 c. apple juice
- 1/4 c. grape juice
- 1/2 tube cake mate gel

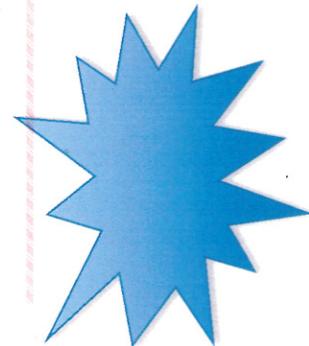
**Parents Phone Numbers:**

Student's Name:

School:

Nurse Contact number/pager:

Physician's number:



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

<b>Effective Date of IHP:</b>		<b>End Date of IHP:</b>	
<b>Student Name:</b>		<b>DOB:</b>	
<b>Parent/Provider Authorization on File: Yes No</b> <b>Physician Orders on File: Yes No</b>  <b>If Yes, see attached Physician Orders.</b> <b>If No, parent must provide diabetic management until physician orders received.</b>		<b>DIABETIC HEALTHARE PROVIDER:</b> <input type="checkbox"/> Providers Name: Phone: Fax: E-mail:	
<b>Assessment of Student DM Skills</b>			
<b>Skill</b>	<b>Independent Care</b>	<b>Assisted Care</b>	<b>Dependent Care</b>
<b>Check Blood Glucose</b>			
<b>Count Carbs</b>			
<b>Calculate insulin dose</b>			
<b>Change infusion set</b>			
<b>Injection</b>			
<b>Trouble shoot alarms, malfunctions</b>			
NOTES:			
If student is managing diabetes independently, is Student Agreement attached? Yes No			
<b>Supplies to be Furnished/Restocked by Parent/Guardian</b>		<b>Exercise, Sports and Field Trips Plan</b>	
<input type="checkbox"/> Blood glucose meter/strips/lancets/lancing device <input type="checkbox"/> Ketone testing strips <input type="checkbox"/> Glucagon Emergency Kit <input type="checkbox"/> Fast Acting carbohydrate <input type="checkbox"/> Carbohydrate containing snacks <input type="checkbox"/> Carbohydrate-free beverage/snack <input type="checkbox"/> Insulin vials/syringes <input type="checkbox"/> Insulin pen/pen needles/cartridges		<input type="checkbox"/> BG monitoring and snacks as ordered. <input type="checkbox"/> Student should not exercise if BG level is below _____ mg/dl. <input type="checkbox"/> <i>Preferably</i> , School nurse/UDA to be notified two weeks before the field trip to assure qualified personnel are available	
<b>Classroom/School Parties</b>		<b>Scheduled After – or – Before – School Activities</b>	
<input type="checkbox"/> Student will eat same treats as the class <input type="checkbox"/> Student may not eat same treats as class <input type="checkbox"/> Replace treat with parent supplied alternative <input type="checkbox"/> Modified treat		List of clubs, sports, etc. that student participates.	
<b>Bus Transportation Plan</b>			
Bus Transportation: <input type="checkbox"/> To School <input type="checkbox"/> Home <input type="checkbox"/> Student may test BG and self-manage DM while on the bus  In the event of Bus Transportation: <input type="checkbox"/> BG tested 10-20 minutes before boarding. <i>If less than or equal to 70, provide care per Algorithm</i> <input type="checkbox"/> BG test not required			

Schedule for Onsite School Nurse						Notes/Comments:
	Mon	Tue	Wed	Thurs	Fri	
1 <sup>st</sup> Period						
2 <sup>nd</sup> Period						
3 <sup>rd</sup> Period						
4 <sup>th</sup> Period						
5 <sup>th</sup> Period						
6 <sup>th</sup> Period						
7 <sup>th</sup> Period						
Field Trip						
Before school						
After School						
Other						

Schedule for Onsite Unlicensed Diabetic Assistant						Notes/Comments:
	Mon	Tue	Wed	Thurs	Fri	
1 <sup>st</sup> Period						
2 <sup>nd</sup> Period						
3 <sup>rd</sup> Period						
4 <sup>th</sup> Period						
5 <sup>th</sup> Period						
6 <sup>th</sup> Period						
7 <sup>th</sup> Period						
Field Trip						
Before school						
After School						
Other						

Schedule for Onsite Unlicensed Diabetic Assistant						Notes/Comments:
	Mon	Tue	Wed	Thurs	Fri	
1 <sup>st</sup> Period						
2 <sup>nd</sup> Period						
3 <sup>rd</sup> Period						
4 <sup>th</sup> Period						
5 <sup>th</sup> Period						
6 <sup>th</sup> Period						
7 <sup>th</sup> Period						
Field Trip						
Before school						
After School						
Other						

\_\_\_\_\_  
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**

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: ( ) \_\_\_\_\_ - \_\_\_\_\_

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:
  - 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 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>)*