**CONEJO VALLEY UNIFIED SCHOOL DISTRICT**
Student Support Services
1400 E. Janss Rd., Thousand Oaks CA 91362
(805) 497-9511

**Individualized Healthcare Plan (IHP) - DIABETES**

| | | | |
|---|---|---|---|
| **Pupil:** | | | |
| **Grade:** | **DOB:** | **Educational Placement:** | |
| **School:** | | | |
| **District:** | | | |
| **School Nurse:** | | **Cell #** | |
| **Parent/Guardian Consent Date:** | **Physician Authorization Date:** | | |
| **Parent Signature:** | | | |
| **Mother** | **Primary Phone #** | **Secondary Phone #** | |
| **Father** | **Primary Phone #** | **Secondary Phone #** | |
| **Guardian** | **Primary Phone #** | **Secondary Phone #** | |
| **Home Address** | | **City** | **Zip** |
| **Other Contact (Relationship):** | | **Primary Phone #** | **Secondary Phone #** |
| **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.<br><br>2. **The school nurse**, in collaboration with the student and the student's parent/guardian, healthcare providers, and school team, is responsible for:<br>a) Development, implementation, and revisions of the IHP.<br>b) The training and supervision of all designated personnel who will provide healthcare according to the ISHP and standard procedures.<br><br>**3. IHP revisions,** if and when revisions are needed to the IHP, parent/guardian will inform school nurse of any updates from the physician by providing a doctor's note**.**<br><br>4. **IHP review** must occur annually and whenever necessary to ensure provision of safecare. |

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Pupil: _____ DOB: _____

****Student Competency: *independent self-management (Ind), self-management with supervision (supv) or total care (total) for the following*:**

**Blood glucose testing** ☐ Ind ☐ supv ☐ total **Give insulin by insulin pen** ☐ Ind ☐ supv ☐ total
**Carbohydrate counting** ☐ Ind ☐ supv ☐ total **Give insulin by insulin pump** ☐ Ind ☐ supv ☐ total **Give insulin by injection** ☐ Ind ☐ supv ☐ total **Ketone testing** ☐ Ind ☐ supv ☐ total
**Hypoglycemia** ☐ Ind, unless cognition impaired ☐ supv ☐ total

## BLOOD GLUCOSE MONITORING:

Target range for blood glucose is: ☐ 70-150 ☐ 70-180 ☐ Other:_____

Check blood glucose: ☐ Mid-morning/before snack ☐ Before lunch ☐ Before PE/Exercise

Additional blood glucose checks:
☐ After exercise ☐ As needed for signs/symptoms of LOW or HIGH blood glucose

❒ As needed for signs/symptoms of illness ☐ 2 hours after correction dose ☐ Other:_____
_____

**BRAND/MODEL OF GLUCOSE METER**:_____

**CONTINUOUS GLUCOSE MONITOR (CGM): ☐ YES ☐ NO**

Brand/Model_____Alarms set for: ❒ HIGH ☐ LOW
***Note: Confirm CGM results with actual blood glucose meter check before taking action on sensor blood glucose level, regardless of CGM.*

## INSULIN ADMINISTRATION:

**For Hyperglycemia (high blood sugar), defined as BS >___and/or carbohydrate intake.**

Insulin Delivery Device: ❒ Pen ❒ Syringe ❒ Pump **Type of Insulin:**_____

Insulin correction to be given for HIGH BLOOD SUGAR and/or CARBOHYDRATE INTAKE at the following times:
❒ Mid-morning/snack time ❒ Lunchtime **INSULIN /CARB Ratio=**:

Parental authorization should be obtained BEFORE administering a correction dose: ❒ YES ❒NO

**Parents are authorized to adjust the insulin dosage? ❒ YES ❒ NO
Describe:_____

**INSULIN DOSING:**

**SLIDING SCALE:**
_____units if BG is_____to _____
_____units if BG is_____to_____
_____units if BG is_____to _____
_____units if BG is_____to _____
_____units if BG is_____to_____

**OR**

**CORRECTION FACTOR:**
Give_____unit(s) of insulin for every _____mg/dl (Sensitivity Factor) over target BG of_____.
To Calculate:
*Actual BG – Target BG* =_____units
*Sensitivity Factor*

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**STUDENTS WITH INSULIN PUMPS:**

Type of pump:_____Type of Insulin in Pump:_____
**Pump settings:**
Basal rates: _____to_____:_____units/hr.
_____to_____:_____units/hr.
_____ to_____:_____units/hr.
Insulin/Carbohydrate ratio: Breakfast:_____Lunch:_____Dinner:_____
Correction Factor:_____Target BG:_____

**Parent is authorized to change pump settings? ☐ YES ☐ NO

## DISASTER PLAN:

Obtain emergency supplies and back-up insulin from parent, in the event of pump failure and/or an unplanned disaster or emergency (72 hours/3 days) .
☐ Follow orders contained in this DMMP
☐ Additional insulin orders as follows (write for Lantus, sliding scale, or insulin correction factor):

_____
_____
_____
_____

## EXERCISE/SPORTS/PHYSICAL EDUCATION:

☐ Test BG BEFORE P.E. ☐ Test BG AFTER P.E.

P.E. DAYS/TIME: _____

Snack before exercise: If BG is below_____, give snack of_____carbs before exercise.

Student should NOT exercise if BG is below____, or above_____, or if moderate to

large amounts of urine ketones are present.

## HYPOGLYCEMIA (LOW BLOOD SUGAR) TREATMENT:

Student's usual symptoms of HYPOGLYCEMIA include: _____

_____

***Treatment of MILD-MODERATE LOW BLOOD GLUCOSE (BG): BG <___:***

| | |
|---|---|
| Step 1 | Always treat symptoms if unable to test blood glucose level. |
| Step 2 | Give 15 grams of **readily available** fast acting carbohydrate: i.e. *4 oz. apple or orange juice, 4 oz.soda (regular not diet), 3- 4 glucose tablets, 6 Lifesaver candies (circle with hole), 15 grams of glucose gel, 1 tablespoon sugar or honey with or without 4 ounces of water*. |

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| | |
|---|---|
| Step 3 | Monitor for 15 minutes, then:<br>• Retest if BG was <50 mg or if symptoms persist or recur.<br>Upon retest, if BG is still <70 mg or if symptoms persist/recur, repeat Steps 2 & 3<br>• If symptoms subside and BG is >70 mg **and** if lunch or snack **is more than one hour away**, give one of the following 15 grams complex carbohydrates: i.e. *2 graham cracker squares and ½ cup of milk, ½ a sandwich, or 6 saltine squares crackers with cheese or peanut butter.*<br>• If symptoms subside and/or BG is >70 mg, resume usual activity. |
| Step 4 | • Notify parent/guardian and school nurse as soon as reasonably possible. |

***Treatment of SEVERE LOW BG (Seizure, unresponsive/unconscious, combative or unable to swallow): BG <___***

| | |
|---|---|
| Step 1 | Administer Glucagon – DOSE**:** □ 0.3 mg IM/SQ □ 0.5 mg IM/SQ □ 1 mg IM/SQ |
| Step 2 | **Call 911**. Keep student on side. Ensure open airway. |
| Step 3 | Notify parent/guardian, school nurse and physician as soon as reasonably possible. |

## HYPERGLYCEMIA (HIGH BLOOD SUGAR):

Student's usual symptoms of hyperglycemia include:_____

_____

***Treatment of HYPERGLYCEMIA: BG > _____***

1. Administer insulin per protocol NO LESS THAN__hours after previous insulin dose.
2. Check urine for ketones when blood glucose is above_____.
3. Call parent if blood glucose is >_____.

## SIGNATURES:

1)_____Date:_____Stamp:
**Physician/Health Care Provider**

I, the parent/guardian of _____ give permission to the school nurse, trained diabetes personnel, and other designated staff members of _____school to perform and carry out the diabetes care tasks as outlined above. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all staff members and other adults who have custodial care of my child during the school day, and who may need to know this information to maintain my child's health and safety.

2)_____ Date:_____
**Student's Parent/Guardian**