KENAI PENINSULA BOROUGH SCHOOL DISTRICT HEALTH SERVICES

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

KENAI PENINSULA BOROUGH SCHOOL DISTRICT HEALTH SERVICES

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

_____ (school) to perform and carry out the diabetes care tasks as outlined in this Individualized Healthcare Plan.

- 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 understand that the school nurse may 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