Valid School Year_____

McKinney Independent School District
School Health Services
Diabetes Individualized Health Plan (IHP)

A copy of medical orders must be attached to this IHP. Please address all areas of the plan. All communication regarding your student's diabetes care will be communicated in writing. Insulin changes will ONLY be accepted via the MISD Parent Request-Insulin Change Form. Student information will not be accepted verbally, over the phone, or by text message.

Student Information:

Student's Name: _____ Date of Birth:_____ID _____
Grade: _____ Homeroom Teacher: _____
Date of Diabetes Diagnosis: _____
Condition: Diabetes Type 1_____Diabetes Type 2_____
Medication: Insulin Pump_____Insulin Injections_____Oral Medications_____
Diabetes Management and Treatment Plan: Dated_____Physician_____

Emergency Contact Information:

Parent/Guardian OR Relationship to Student: _____
Home_____Work_____Cell_____

Blood Glucose Monitoring:

Manufacturer and model of student's blood glucose meter: _____
Parent(s) provide(s) all supplies for procedures and treatment. **Initials _____**
BG Testing Supplies_____Juice/Carbs Tabs/Gel_____Ketone Testing Strips_____Pump Supplies _____ Insulin_____
Glucagon_____Snacks _____

McKinney ISD Standard for Rounding Insulin with Shot Therapy (unless specified otherwise from the healthcare provider):

- Round down to the nearest whole number if the amount of insulin to be administered is .4 and below
- Round up to the nearest whole number if the amount of insulin to be administered is .5 or higher

Hyper/Hypoglycemia:

If feeling Hypo/Hyperglycemic in class, student will check blood glucose: **in class_____in clinic _____**

Hypoglycemia (low blood sugar) **Treatment (see MD orders)**
Usual symptoms of hypoglycemia: _____

Hyperglycemia (high blood sugar) **Treatment (see MD orders)**
Usual symptoms of hyperglycemia: _____

CARBOHYDRATES/LUNCH WILL NOT BE WITHHELD FOR ANY REASON. * **Initials _____**

Ketones:

If ketones moderate or greater, student must go home unless specific orders are received from physician. **Initials _____**

Continuous Glucose Monitors:

All treatment of glucose and insulin administration by a campus nurse or other trained MISD personnel will be based upon a diabetic finger stick only and not solely upon the CGM alarms or notices - UNLESS physician's orders, including specific blood glucose ranges and treatment protocols, have been received and the device utilized is FDA approved for the student's age**. ****The Parent Request for School Personnel to Access Continuous Glucose Monitoring via an On-line Computer Application or Program form must be signed and specific physician's orders attached.****

Type of Insulin Pump/Infusion Set: (if applicable) _____

Field Trip and/or any School Related Activity Instructions:

(IF UNLICENSED DIABETIC CARE ASSISTANT IS NEEDED PARENT MUST NOTIFY SCHOOL NURSE NO LATER THAN **2 WEEKS PRIOR TO THE ACTIVITY**).
FIELD TRIPS INCLUDE: Overnight Camp, UIL events, Day Trips, Special Olympics, After-School Activities. **Initials _____**
Plan for Extracurricular Activity: _____

Exercise and Sports:

A fast-acting carbohydrate provided by parent should be available at the site of exercise or sports **Yes/No**
Student should not exercise if blood glucose level is below_____mg/dl or above_____mg/dl or if moderate to large urine ketones are present.

Meals and Snacks Eaten at School:

Lunch Time_____bring lunch (with carbohydrates calculated)_____buy lunch_____
Bolus before lunch (See physician's order): **Yes/No** Exceptions: _____
Snack Time: _____ Bolus before snack (See physician's order): **Yes/No** Exceptions: _____
Foods to avoid, if any: _____
Instructions for when food will be provided to the class (e.g., as part of a class party or food sampling event):_____

_____

Printed Parent Name	Parent Signature	Initials	Date

Valid School Year_____

Student's Name:_____Date of Birth:_____ID _____

EMERGENCY PROCEDURES:
Insulin utilizing Continuous Insulin Pump Therapy (physicians pump failure orders MUST be included):
If the insulin pump/pod becomes disabled it is a medical emergency-call the parent/guardian immediately. If the parent cannot be reached, 911 will be called.

If parent or parent designee **CAN** arrive within 30 minutes, ketones and blood glucose will be checked and monitored until parent/designee arrival. If parent **CANNOT** arrive within 30 minutes, follow pump failure orders.

***In accordance with MISD policy, MISD personnel will not perform medical actions required less than four times/day at school. This includes, but is not limited to; pump reinsertion, basal rate changes and/or calibration of the CGM. **Initials** _____

PLEASE INCLUDE BASAL RATES IN CASE OF EMERGENCY:
Basal rates:_____to _____ _____to _____
_____to _____ _____to _____

GLUCAGON: should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow. If glucagon is required, administer it promptly. Then call 911 (or other emergency service) and the parents/guardian.

504 Accommodations
I understand my child may be eligible for 504 accommodations. Please initial one of the following.
_____I am interested in learning more about 504 accommodations.
_____My student is already serviced by 504 accommodations. The last 504 meeting date was_____.
_____I am not interested in pursuing 504 accommodations at this time.

Student/Family Goals for this School Year:
Student will increase self-management as evidenced by:
1._____Date of Completion _____
2. _____Date of Completion _____
3. _____Date of Completion _____

Position	Name	Phone
School Nurse		
UDCA/Trained Staff		
UDCA/Trained Staff		
UDCA/Trained Staff		

I give permission to the school nurse, unlicensed trained diabetes personnel, and other designated staff members of McKinney ISD to perform and carry out the diabetes care tasks as outlined in this Diabetes Individualized Health Plan/HCIS. I understand that if at any time the supervising adult believes my child's life is in danger, Emergency Medical Services (911) will be activated, and I agree that my insurance carrier or I will assume the responsibility for all costs incurred as a result. I understand that the School District, Board of Trustees, and District employees shall not be held responsible for damages or injuries resulting from administration of this medication.
I consent to the release of medical information contained on this form to school officials who have a legitimate educational interest in the information, according to MISD Board Policy and the Family Education and Privacy act. I give permission for the release of confidential information regarding my child's specific health problems to third parties, other than school officials, as required to facilitate medical care and/or treatment of my child. I authorize the nurse and the prescribing physician to confidentially discuss or clarify this medication order and to discuss the student's response to the prescribed medication as needed per law (Nurse Practice and Medical Practice Acts of Texas).

_____ _____ _____ _____
Printed Parent Name Parent Signature Initials Date

Reviewed & accepted as IHP by MISD Campus RN_____(Nurse signature/date)

The following medication was destroyed due to failure to pick up the medication prior to the last day of school, medication was discontinued or medication was picked up by parent:

Medication(s) name & amount disposed _____Time _____Date _____

RN Signature: _____Witness Signature: _____

OR

Medication(s) name & amount picked up_____Parent signature and date _____

Valid School Year_____

McKinney Independent School District
School Health Services
Health Condition Information Sheet
(For general staff use, copy and distribute as needed)

Attach Photo

Student's Name_____ D.O.B. _____

Condition_____ Grade _____

Physician's Name_____ Phone # _____

Parent's Name(s)_____ Home Phone # _____

Street Address_____ Work Phone # _____

Employer_____ Cell/Mobile # _____

Emergency Contact #1 _____ Phone # _____

Emergency Contact #2_____ Phone # _____

If signs or symptoms of the above condition are noted, please take the following steps:

A) If this happens: _____

Then do this: _____

B) If this happens: _____

Then do this: _____

C) If this happens: _____

Then do this: _____

Please circle one of the following to indicate the level at which this student can perform this care.

Independently Needs Assistance/Supervision Cannot do for self

Additional Comments: _____

_____

_____

_____

The IHP has been reviewed and discussed by the school nurse &/or parent/guardian & have listed the above information as staff awareness and individualized student information to expedite the care of the student during times when a school nurse may not be readily available. **The campus RN may also complete this form when information from the physician or parent has not been received and a teacher/substitute teacher needs to be advised of a medical condition & steps to ensure safety during times when a school nurse may not be readily available.**

School RN's Printed Name:_____ Signature:_____ Date: _____

Optional Parent Printed Name:_____ Signature:_____ Date: _____

Optional MD Printed Name:_____ Signature:_____ Date: _____