Student ID # _____ Current School Year _____

McKinney Independent School District

Health Services

Diabetes Individualized Healthcare Plan (IHP)

A copy of medical orders MUST be attached to this IHP. Please respond to 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 (photo of student attached)

Name: _____ DOB: _____ Grade: _____

Homeroom/1st Period Teacher Name: _____

Date Diabetes Diagnosis: _____ Type 1: _____ Type 2: _____

Physician's Orders Attached: **YES/NO** Physician's Name: _____

- *Please list any other diagnoses that may impact your child's ability to participate in caring for their diabetes* _____

EMERGENCY CONTACT INFORMATION

Parent/Guardian Name: _____ Phone #_____

Parent/Guardian Name: _____ Phone #_____

SUPPLIES **Parent/Guardian will provide all supplies for diabetes care. Check all that apply.* **INITIALS** ___

Blood Glucose Meter Manufacturer/Model _____Blood Glucose Testing Strips _____

Insulin _____ Pump Supplies _____ Syringes _____ Injectable Glucagon _____ Nasal Glucagon _____

Alcohol Prep Pads _____Fast-Acting Carbs (juice, carb tabs/gel) _____ Ketone Strips _____

Water Bottles _____ Snacks _____ Insulin Pen _____ Syringe Needles _____

Parent/Guardian Assessment of Student's Diabetes Self-Management Skills

Skill	Independent	Requires Supervision	Dependent on Adult
Prepare Insulin Dosage			
Administer Insulin			
Perform Glucose Test			
Interpreting Test Results			
Perform Ketone Test			
Count Meal/Snack Carbohydrates			
Calculate Insulin Carb Ratio			
Recognizes Signs/Symptoms of Hyper/Hypoglycemia			
Treat Hyper/Hypoglycemia			

Insulin Pump ONLY

Skill	Independent	Requires Supervision	Dependent on Adult
Calculating/Administering Bolus and Correction			
Treat Hyperglycemia			
Reinsert Pod/Catheter			
Perform SQ Injection, as indicated by the Physician			

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

MEDICATIONS

All medication MUST be in an unopened, prescription labeled container for the named student.
NO EXPIRED MEDICATION WILL BE ACCEPTED.

INSULIN

Name of Insulin _____ Initial: _____

McKinney ISD Standard for Rounding Insulin with Shot Therapy (unless otherwise specified by the health care 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.

GLUCAGON

Injectable or nasal glucagon should be administered if the student is unconscious, having a seizure, or unable to swallow. If any form of glucagon is required, administer it immediately and then call 9-1-1 and the parent/guardian. **INJECTABLE/NASAL** (circle one) **Name** _____ **Expiration Date** _____

EQUIPMENT

The student's first and last names MUST be on all equipment. McKinney ISD employees are NOT responsible for damages to any equipment transferred from home to school by the student/parent/guardian.
INITIALS _____

BLOOD GLUCOSE METER

Student's Blood Glucose (BG) Meter Manufacturer & Model: _____

CONTINUOUS GLUCOSE MONITOR (CGM)

Student **DOES** or **DOES NOT** have a Continuous Glucose Monitor (circle one).
Student's CGM Manufacturer & Model: _____

KETONES

Treat hyperglycemia per physician's orders. **Students with positive ketones DO NOT need to leave school unless ketones are not improving with fluids and/or parent/guardian/RN feels management of ketones would be more efficient at home.* **INITIALS** _____

TYPE OF INSULIN PUMP/INFUSION SET (if applicable) **_____**

EMERGENCY PROCEDURES – INSULIN PUMPS

If the insulin pump becomes disabled or pod/tubing becomes dislodged, the parent/guardian will be notified immediately as this is considered a medical emergency. Emergency Medical Services (9-1-1) may be contacted by the school if the parent/guardian cannot be reached within 30 minutes OR the student is unable to perform the task. If the student has demonstrated proficiency in reinserting the pod/catheter (see page 1), the student may perform the reinsertion of pod/catheter without supervision from a parent or MISD personnel**. INITIALS** _____

In accordance with MISD policy, MISD personnel will NOT perform pump reinsertions, basal rate changes, or calibration of the continuous glucose monitor.* **INITIALS _____

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Health Services
Diabetes Individualized Healthcare Plan (IHP)

EXERCISE/SPORTS/ATHLETICS

Students should NOT exercise if blood glucose level is BELOW _____ mg/dl or ABOVE _____ mg/dl.
Students should NOT exercise if MODERATE to LARGE ketones are present. **INITIALS** _____
Is your student enrolled in extracurricular activities or fine arts (band, drill team, etc.)* **YES/NO

MEALS AND SNACKS AT SCHOOL

Insulin bolus is **PRIOR to lunch/snack unless otherwise stated IN THE PHYSICIAN'S ORDERS, this includes a bolus extension.* **INITIALS** _____
Lunch Time: _____ Student will **BRING LUNCH** or **BUY LUNCH** or **COMBO of BOTH** (circle one).
Snack Time: _____ MUST have Insulin Carb Ratio for snack on physician's order.

Opportunity for Food Consumption in Class (class party, curriculum event, etc.)
Parent/Guardian Instructions PRIOR to the event outlined below:
_____

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 _____

REGISTERED NURSE ONLY

Beginning of the Year Skills Assessment

BG Testing _____ Insulin Admin. _____ Ketone Testing _____ Carb Count _____ Meal Planning _____
**Student Demonstrates Correct Techniques to Campus Nurse:*

_____ _____
RN Signature **Date**

The RN will periodically review students' diabetes care skills and knowledge, including facilitating carrying diabetes supplies, and self-management at school. **RN Initials** _____

EXPECTED OUTCOMES (RN/PARENT Collaboration)

School personnel will facilitate and assist with the student's diabetes management plan with minimal disruption to the educational program and will be prepared and trained to respond in an emergency.

____ Student demonstrates correct BG testing Date _____
____ Student demonstrates correct insulin administration Date _____
____ Student demonstrates correct carbohydrate counting Date _____
____ Student demonstrates understanding of prescribed meal plan Date _____
____ Student demonstrates correct ketone testing and treatment Date _____
____ Student demonstrates correct insulin pump management Date _____
____ Student verbalizes correct management of hyper/hypoglycemia Date _____
____ Student recognizes symptoms of hyper/hypoglycemia Date _____
____ Student demonstrates correct action for hyper/hypoglycemia Date _____

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____ Student demonstrates an understanding of the effects of exercise/physical activity related to their diabetes diagnosis. Date _____

____ Student adheres to physician's orders Date _____

____ Student INDEPENDENT in all above skills. Date _____ **RN Signature** _____

Trained Staff	**Name**	**Phone Number**
Campus Nurse		
UDCA/Trained Staff		
UDCA/Trained Staff		
UDCA/Trained Staff		

***All campus unlicensed diabetic care assistants have been trained and paperwork has been filed in the appropriate places according to the MISD policy. **Date _____ RN Signature _____**

Parent/Guardian Consent for Unlicensed Diabetic Care Assistant (UDCA)

I authorize the District to designate unlicensed diabetic care assistants who have been trained by MISD Health Services to perform and carry out the diabetic care tasks as outlined in this document. I understand that if at any time the supervising adult believes my child's life is in danger, Emergency Medical Services (EMS) 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 the administration of medication or any care provided to a student with diabetes. I further understand that it is my responsibility to notify the campus nurse if my child will participate in any after-school activities.

_____ _____

Printed Parent Name **Parent Signature**

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**

_____

The following medication has been returned to the parent/guardian, disposed of after being discontinued or the parent/guardian failed to pick up the medication prior to the last day of school:

Medication (s) Name & Amount Returned to Parent/Guardian _____
Time _____ Date _____RN Signature _____ Witness Signature _____

Medication (s) Name & Amount Disposed _____ Time _____ Date _____
RN Signature _____ Witness Signature _____
_____

****Individualized Healthcare Plan reviewed and accepted by MISD Campus Nurse.**
RN Initials/Date _____