APPENDIX B

*INDIVIDUAL HEALTH PLAN
SECTION 504 PLAN

Student:	School:
Birthdate:	Grade:
Address:	Phone:
Physician:	Mother:
Contact number:	Home:
	Work:
	Pager/Cell Phone:
Effective date:	Father:
Parent-designated adult:	Home:
Home phone:	Work:
Cell phone:	Pager/Cell Phone:

Brief History:

Age of onset:	Results and date of Hemoglobin A1C test:
Date(s) of recent hospitalizations:	
Concurrent illness or disability:	Related social/emotional factors:

Level of Independence (attach copy of "HCP Orders for Children with Diabetes in Washington State Schools") (Appendix K).

PURPOSE: To promote student self management of diabetes, recognize signs of high and low blood sugar, and provide appropriate assistance and/or emergency care.

PLAN: <u>Daily Diabetes Routines</u>

- **Daily snacks at school (time):** _____
- **Recess times:** _____ a.m. _____ p.m.
- **Blood sugar monitoring:**
  Time: _____ Location: _____
  Additional tests: as needed when having symptoms of low blood sugar.
- **Insulin injection:**
  Time: _____ Location: _____
- **Lunch eaten at (time):** _____
- **PE days and times:** _____
- **Notify parents of shortened school day.**

***Parents to establish plan with the school nurse and with HCP orders.**

1) In event of field trips, all diabetes supplies are taken and care is provided:

- ☐ By accompanying parent or parent-designated adult.
- ☐ According to procedure developed prior to field trip.
- ☐ According to low/high blood sugar school plans.
- ☐ Notify parent prior to planned field trip.

2) In event of classroom/school parties, food treats will be handled as follows:

- ☐ Student will eat treat.
- ☐ Replace with parent supplied alternative.
- ☐ Modify the treat as follows:
- ☐ Schedule extra insulin per prearranged plan.

3) Scheduled after school activities:

- ☐ List:
- ☐ Low/high blood sugar after school plan to:
  - ☐ Supervisor with instruction.
  - ☐ Parent-designated adult.

4) Attach copies of High Blood Sugar School Plan and Low Blood Sugar School Plan*.

***NEVER SEND A CHILD WITH LOW OR HIGH BLOOD SUGAR ANYWHERE ALONE.**

5) Activities student can self manage:

- ☐ Totally independent management.

OR

A. Blood sugar monitoring:

- ☐ Student monitors independently.
- ☐ Student monitors with verification of number on meter by designated staff.
- ☐ Student needs help with monitoring and/or to be done by school nurse or parent-designated adult.
- ☐ Monitoring needs to be done by nurse or parent-designated adult.

B. Insulin injection:

- ☐ Administers independently.
- ☐ Student self injects with verification of number on insulin pen by designated staff.
- ☐ Student self injects (syringe or pen) with school nurse supervision and/or administration by nurse or parent-designated adult.
- ☐ Administration by nurse or parent-designated adult.

C. ☐ Self treats mild hypoglycemia.

D. ☐ Monitors own snacks and meals.

E. ☐ Monitors and interprets own ketones.

F. ☐ Student implements universal precautions when lancing finger and disposing of lancets/syringes.

6) Equipment and Supplies:

EQUIPMENT AND SUPPLIES PROVIDED BY PARENT.	**Blood Sugar Meter Kit** (includes all blood monitoring supplies for school). **Low Blood Sugar Supplies:** _____ _____ **For Example:** • Fast-acting carbohydrate drinks: apple juice and/or orange juice and soda pop (regular, not diet)–6 pack. • Glucose tablets. • Glucose gel product. • Gel Cakemate (not frosting) (19gm. Mini-purse size). • Pre-packaged snacks (such as cracker/cheese; crackers/peanut butter, etc.) times 5–6. **Daily Snacks:** (for a.m./p.m. snack times):_____ _____	**Disaster Supplies (check x):** ☐Food supply for 3 days stored in:_____ ☐Low blood sugar supplies. ☐Medication and medical supplies stored in:_____ _____ ☐Insulin pen and needles. ☐Insulin and syringes. **Other Supplies (specify):**___ _____ _____ **Disaster Plan attached.**

7) School bus driver instruction:

☐Call parent to pick up student if a low blood sugar episode occurs 30 minutes or less prior to departure regardless if sugar returns to normal reading.
☐Student to eat snack on bus if part of care plan or if having signs of low blood sugar and able to swallow.
☐Driver to call for special directions.

Date of next plan review:_____
Must be reviewed before the next school year unless there is a change requiring earlier revision.

Parent	**Date**	**School Nurse**	**Date**
Student	**Date**	**Physician (optional)**	**Date**
Parent-designated adult (if one has been assigned)			**Date**

*INDIVIDUAL HEALTH PLAN
SECTION 504 PLAN
Independent Management

Student:	School:
Birthdate:	Grade:
Address:	Phone:
Physician:	Mother:
Contact number:	Home:
	Work:
	Pager/Cell Phone:
Effective date:	Father:
Parent-designated adult:	Home:
Home phone:	Work:
Cell phone:	Pager/Cell Phone:

Brief History:

Age of onset:	Result and date of Hemoglobin A1C test:
Date(s) of recent hospitalizations:	
Concurrent illness or disability:	Related social/emotional factors:

Level of Independence (attach copy of "HCP Orders for Children with Diabetes in Washington State Schools") (Appendix K).

PURPOSE: To promote student self management of diabetes, recognize signs of high and low blood sugar, and provided appropriate assistance and/or emergency care.

PLAN: **Daily Diabetes Routines**

- **Blood sugar monitoring:**
  Time: _____ Location: _____
  Additional tests: as needed when having symptoms of low blood sugar.
- **Insulin injection:**
  Time: _____ Location: _____
- **Lunch eaten at (time):**_____
- **Notify parents of shortened school day.**

1) **Scheduled after school activities:**

   ☐List:_____

2) **Attach copies of High Blood Sugar School Plan and Low Blood Sugar School Plan.****

3) **Student is:**

   ☐Totally independent in management of their diabetes.

***Parents to establish plan with school, the nurse, and with HCP orders.**

*****NEVER SEND A CHILD WITH LOW OR HIGH BLOOD SUGAR ANYWHERE ALONE.***

4) Equipment and Supplies:

EQUIPMENT AND SUPPLIES PROVIDED BY PARENT.	**Blood Sugar Meter Kit** (includes all blood monitoring supplies for school). **Low Blood Sugar Supplies:** _____ _____ **For Example:** • Fast-acting carbohydrate drinks: apple juice and/or orange juice and soda pop (regular, not diet)–6 pack. • Glucose tablets. • Glucose gel product. • Gel Cakemate (not frosting) (19 gm. mini-purse size). • Pre-packaged snacks (such as cracker/cheese; crackers/peanut butter, etc.) times 5–6. **Daily Snacks** (for a.m./p.m. snack times):_____ _____	**Disaster Supplies (check x):** ☐Food supply for 3 days stored in:_____ ☐Low blood sugar supplies. ☐Medication and medical supplies stored in:_____ _____ ☐Insulin pen and needles. ☐Insulin and syringes. **Other Supplies (specify):**___ _____ _____ **Disaster Plan attached.**

5) School bus driver instruction:

☐Student is independent in managing low blood sugars during bus transportation. Unless displaying symptoms of moderate to severe low blood sugar, follow instructions for low blood sugar (page 14).

Date of next plan review:_____
Must be reviewed before the next school year unless there is a change requiring earlier revision.

Parent	**Date**	**School Nurse**	**Date**
Student	**Date**	**MD/DO/PA/ARNP**	**Date**
Parent-designated adult (if one has been assigned)			**Date**

INDIVIDUAL HEALTH PLAN/SECTION 504 PLAN
TRAINING DOCUMENTATION

NAME/POSITION	TRAINING PROVIDED	DATE	TRAINER/TITLE

Plan distributed to the following:_____

Received entire IHP/Section 504 Plan:_____

Received High Blood Sugar School Plan and Low Blood Sugar School Plan:_____

NAME/POSITION	A/B*	DATE

Date of next plan review:_____

Must be reviewed before the next school year unless there is a change requiring earlier revision.

Parent	**Date**	**School Nurse**	**Date**
Student	**Date**	**MD/DO/PA/ARNP**	**Date**

* A. Received entire IHP/Section 504 plan.
  B. Received High Blood Sugar School Plan and Low Blood Sugar School Plan.