BRIGHTER HORIZONS ACADEMY

COLLEGE PREPARATORY

3145 Medical Plaza Dr., Garland, TX 75044

Tel: 972-675-2062 Fax: 972-675-2063

"Where Knowledge, Faith, Academics and Character Meet."

This information is valid for the _____ school year only.

Maintain this plan in the diabetic binder utilizing the medical provider's orders and share with relevant school staff, Health Office. Please attach copy of medical orders to this IHP.

Student's Name:_____ Date of Birth:_____

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_____

Contact Information

Parent/Guardian: _____

Address: _____

Telephone: Home_____ Work_____ Cell_____

Parent/Guardian: _____

Address: _____

Telephone: Home_____ Work_____ Cell_____

Notify parents/guardian or emergency contact in the following situations:_____

_____

_____

Parent(s) must be available when blood glucose is checked at school. The parent is responsible for providing the correct dosage that needs to be given daily to the child.

Blood Glucose monitoring

Parent(s) provide(s) all supplies for procedures and treatment.___ Initials

Target blood glucose is _____

Times to Check blood glucose: Before lunch_____ Before exercise ____After exercise _____ Other_____

Type of blood glucose meter student uses: _____

If feeling Hypo/Hyperglycemic in class, student will check blood glucose in class/in clinic. (circle)

Insulin utilizing shot therapy

Humalog/Novolog/other_____ insulin administered at lunch (circle type used).

_____ units or does flex dosing using _____ units/ _____ grams carbohydrate.

Carbohydrate range/Meal plan_____ Carbohydrates at lunch, _____Carbohydrates at snack,

Other_____

Parental authorization before administering a correction does for high blood glucose levels Yes/No.

___ units if blood glucose is ___to___ mg/dl

___ units if blood glucose is ___to___ mg/dl

___ units if blood glucose is ___to___ mg/dl

___ units if blood glucose is ___to___ mg/dl

___ units if blood glucose is ___to___ mg/dl

Can student give own injections? Yes/No

Can student draw correct does of insulin? Yes/No

Parents are authorized to adjust the insulin dosage under the following circumstances (per Dr. Order):

_____

_____	_____	_____	_____
Printed Parent Name	Parent Signature	Initials	Date

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Student name_____ ID _____

Insulin utilizing Continuous Insulin Pump Therapy:
*****Personnel will not perform medical actions required less than four times/day at school. This includes but is not limited to pump reinsertion and/or basal rate changes. _____Initials**

Humalog/novolog/other_____ (circle type) insulin prior to lunch, snack and PRN
Insulin Sensitivity Factor: 1 unit lowers glucose _____ milligrams/deciliter. Determines correction dosage of insulin (subtract target glucose from current blood glucose).
Pump automatically calculates correction Yes/No
Type of pump: _____ Type of infusion set: _____

Basal rates: ____ 12 am to ____ ____ ____ to ____
____ ____ to ____ ____ ____ to ____

Insulin/carbohydrate ratio: _____lunch
Insulin/carbohydrate ratio: _____snack
Insulin/carbohydrate ratio: _____other

Skill	Independent	Requires Supervision	Requires Assistance	Dependent on trained personnel
Calculating/administering insulin bolus and correction dose				
Problem Solving High Blood Glucose				
Using SQ Injections when indicated by diabetes plan				
Performing glucose/ketone test				
Recognizing and treating Hypoglycemia				
Counting Carbohydrates and calculating meal amount				
Priming/inserting catheter or Pod				
Disconnect/Reconnect pump at infusion site				

For students taking Oral Diabetes Medications
Type of medication: _____Timing: _____
Other medications: _____Timing: _____

Meals and Snacks Eaten at School
Lunch time_____ Bring Lunch with carbohydrates calculated____ Buy Lunch____
Bolus before lunch Yes/No_____Exceptions_____
Snack time: _____ Preferred snack foods:_____
Foods to avoid, if any: _____
Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event):
_____

_____ _____ _____ _____
Printed Parent Name Parent Signature Initials Date

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Student name_____ **ID** _____

Exercise and Sports

A fast-acting carbohydrate such as _____, provided by parent should be available at the site of exercise or sports Yes/No.

Restriction on activity, if any: _____

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.

Any activity or field trip outside Brighter Horizons Academy must be accompanied by a parent.
Parent Signature:_____

Hypoglycemia (low blood sugar) Standard procedure for low blood sugar (____)

Usual symptoms of hyperglycemia:_____

_____

_____

_____

Treatment of hyperglycemia;_____

_____

_____

_____

Parents must provide all needed supplies in any case of a Hypoglycemia episode, ex: juice, candy, glucose, burst, etc, with instructions._____(Initials)

Hyperglycemia (High blood sugar) Standard procedure for high blood sugar (____)

Usual symptoms of hyperglycemia:_____

_____

_____

_____

Treatment of hyperglycemia;_____

_____

_____

_____

If symptoms of hyperglycemia are unmanageable prior to parent/ guardian contact, EMT will be notified.

_____	_____	_____	_____
Printed Parent Name	Parent Signature	Initials	Date

Student name_____ ID _____

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Please list all supplies given to the Health Office, ex: insulin, blood glucose test supplies, pump, snacks, juice, etc.
All supplies are to be provided by parents._____ Initials

Supply 1	Supply 2	Supply 3	Date Given	Office Initials	Parents Signature

Following medical re-evaluations throughout the school year, any treatment changes for the student from the physician **must** be given to the appropriate School Health campus (ECE or Main) in writing (not email)._____ Initials

Treatment Changes_____ Date_____
Treatment Changes_____ Date_____
Treatment Changes_____ Date_____
Treatment Changes_____ Date_____
Treatment Changes_____ Date_____
Treatment Changes_____ Date_____

I give permission to the School Health Offices (Main and ECE campus), unlicensed trained diabetes personnel, and other designated staff members of Brighter Horizons Academy 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 Brighter Horizons Academy School and employees shall not be held responsible for damages or injuries resulting from administration of any 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. 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.

_____ _____
Student's Parent/Guardian Name/Signature Date

Reviewed & accepted as IHP.

_____ _____ _____
School health Office Name/Signature Campus Date

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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 Health Office and 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 Health nurse may not be readily available.

School Health Printed Name:_____ Signature: _____ Date:_____

Parent Printed Name:_____ Signature: _____ Date: _____

MD Printed Name:_____ Signature: _____ Date: _____