

Individualized School Health Care Plan (ISHP)

Pupil:			
Grade:	D.O.B:	Educational Placement:	
School:			
District:			
School Nurse:		Pager #	Cell #
Parent/Guardian Consent Date:		Authorized Health Care Provider Authorization Date:	
Key Contacts			
Mother	Home #	Work #	Pager #
Father	Home #	Work #	Pager #
Guardian	Home #	Work #	Pager #
Home Address		City	Zip
Other Contact (Relationship):		Home #	Work #
Physician		Phone #	Fax #
Physician Address		City	Zip
Health Care Service Needed at School	Management of Diabetes at School and School Sponsored Events:		
	<ol style="list-style-type: none"> 1. The purpose of an Individualized School Healthcare Plan (ISHP) is to provide safe management of health care and services for pupils at school and during school-related activities. 2. The ISHP is developed by the school nurse in collaboration with the pupil's parent/guardian, authorized health care provider and pupil (if appropriate). 3. The ISHP is a management tool that follows the nursing process and includes: <ol style="list-style-type: none"> a. A current health assessment by the school nurse identifying the health care needs of pupils and all accommodations needed in school. b. Procedures for health care provision of students in school and a school schedule plan of who will do what, when, where and how. c. Records of designated staff training and supervision by the school nurse. d. Records of who has a copy of the ISHP. e. Records of review and monitoring of the plan for outcomes by the school nurse. f. Records of evaluation of the plan by the school nurse, and changes made by the school nurse, parent or authorized health care provider. g. Records of parent written consent for the ISHP. 4. The ISHP may be included in and attached to a 504 Plan and/or IEP. 5. ISHP revisions must be directed to the school nurse prior to implementation. All authorized health care provider changes must have authorized health care provider written authorization and written parent consent. Revisions, not requiring authorized healthcare provider authorization, may be made with written parent consent. 6. ISHP review must occur annually and/or whenever changes are necessary to ensure provision of safe care. 		

Individualized School Health Care Plan School Nurse Assessment (Confidential)

School Nurse to Complete with Parent and Pupil

Pupil:	DOB:	School:	Grade:
SUBJECTIVE AND OBJECTIVE INFORMATION			
1. Height/Weight - Test date:	Height: _____ Weight: _____ Appropriate weight for height: _____		
2. Vision - Test date:	School Record Results:		
3. Hearing - Test date:	School Record Results:		
4. Immunizations:			
5. Diagnosis/ Current Status	Age at diagnosis was _____. The target range for maintaining blood glucose is _____ mg/dl to _____ mg/dl. The most recent Hemoglobin A1C level was _____ mg/dl on _____. (Hemoglobin A1C is the lab value for blood glucose control during the previous 6 weeks to 3 months. Ranges are: 6 - 8 (good), 9 - 10 (fair), 11+ (poor))		
6. Current Health Status and Management of Health Care at Home (include school attendance if appropriate)			
7. Other Health Problems			
8. Health Agencies/School DIS Service			
9. Health Care Procedure Requests for School and Special Considerations			
10. Observation of Student - Physical Finding			
11. Observations of Health Care Procedures Performed by Parent/Student			
12. Other			

**Individualized School Health Care Plan
School Nurse Assessment Continued (Confidential)**

School Nurse to Complete with Parent and Pupil

Pupil:	DOB:	School:	Grade:
Analysis Determination of Level of Care Needed in School	<input type="checkbox"/> School nurse (responsible for training, monitoring, and supervising designated staff)		
	<input type="checkbox"/> Designated unlicensed school personnel..... <input type="checkbox"/> One: One		
	<input type="checkbox"/> Licensed personnel..... <input type="checkbox"/> One: One		
	Pupil: <input type="checkbox"/> Independent <input type="checkbox"/> Needs assistance <input type="checkbox"/> Needs supervision <input type="checkbox"/> Needs total care		
Explanation of Who Will be Providing Health Care Services in Accordance with State Law:			
Authorization Forms Reviewed and Given to Parent			
Discussion of Plan with Parent: Identify School Goals and Nursing Intervention			

Individualized School Health Care Plan (ISHP)
For Management of Diabetes at School & School Sponsored Events
 School Nurse to Complete with Parent and Pupil

Pupil	DOB	School	Grade
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Routines for Diabetes Care At School Per Parent Request/Consent

MEAL PLAN:

Snacks: To eat snack at/in (specify location) _____
 Completes task independently
 Needs reminder
 Needs compliance verification of task completion

Lunch: Completes task independently
 Needs compliance verification of task completion

Classroom/School Parties, food treats will be handled as follows if “at parent discretion” is approved on authorization page - under “Meal Plan”):

- Pupil will eat the treat
- Replace with parent supplied alternative
- Put in baggie and take home with teacher note
- Modify the treat as follows: _____
- Other: _____

Blood Glucose Testing:

Location for testing _____
 Completes task independently
 Needs adult to verify results
 Needs assistance (specify) _____

 Send parent copy of blood glucose log every: ____month ____week ____day

TREATMENT OF HYPERGLYCEMIA:

- Requests water bottle appropriately during classtime (if symptomatic from hyperglycemia)
- Tests ketones independently
- Requires assistance (specify) _____
- Other: _____

INSULIN ADMINISTRATION:

Dose Preparation & Administration by:

- Pupil Completes task independently Requires assistance (specify): _____
- Parent Parent designee Licensed nurse

EXERCISE:

- Student requires compliance verification of physician orders
- Vigorous exercise (if any) to include the following: _____
- _____
- Other _____

OFF CAMPUS, SCHOOL RELATED ACTIVITIES:

Field Trips: All diabetic supplies taken and care is provided according to this ISHP (a copy is taken on trip).

Scheduled After-school Activities: (Note: all school related activities must have trained staff available at all times):

SPECIFY

Individualized School Health Care Plan (ISHP)
For Management of Diabetes at School & School Sponsored Events (Continued)
 School Nurse to Complete with Parent and Pupil

Pupil	DOB	School	Grade
Routines for Diabetes Care At School Per Parent Request/ Consent	<p>OFF CAMPUS, SCHOOL RELATED ACTIVITIES: (CONTINUED)</p> <p style="text-align: center;">Scheduled After-School Activities (NOTE: all school related activities must have trained staff available at all times): _____ _____</p>		
Other	Specify:		

**Individualized School Health Care Plan (ISHP)
For Management of Diabetes at School
School Nurse to Complete with Parent and Pupil**

Pupil	DOB	School	Grade	
<p>Equipment And Supplies</p>	<p><u>Provided By Parent</u></p> <p><u>Daily Snacks</u> (for AM/PM snack times) Specify: _____</p> <p><u>Extra Snacks</u> (for before, after, and/or during exercise) Specify: type of snacks: _____ _____</p> <p><u>Blood Glucose Meter Kit</u> (Includes meter, testing strips, lancing device with lancet, cotton balls, spot bandages)</p> <p><u>Brand/Model:</u> _____</p> <p><u>Low Blood Glucose Supplies</u> (5 day supply preferable)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fast acting carbohydrate drinks: (Apple juice and/or orange juice, sugared soda pop-NOT diet) <input type="checkbox"/> Glucose tablets, 1-2 packages preferred <input type="checkbox"/> Glucose gel products (Insta-Glucose, Monogel or Glutose/25-31 gms.) 1-2 preferred <input type="checkbox"/> Gel cakemate (not frosting), (19 gm., mini-purse size), 1-2 preferred <input type="checkbox"/> Prepackaged snacks (such as crackers with cheese or peanut butter, Nite-Bite™, etc.) <p><u>High Blood Glucose Supplies</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Ketone test strips/bottle or meter kit <input type="checkbox"/> Urine cup <input type="checkbox"/> Water bottle <p>Note: Timing device may be wall clock or watch worn by pupil or personnel.</p>		<p><u>Provided By Parent (Continued)</u></p> <p><u>Insulin Supplies</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Insulin pen <input type="checkbox"/> Pre-filled syringes (labeled per dose) <input type="checkbox"/> Insulin and syringes <input type="checkbox"/> Extra pump supplies such as: <ul style="list-style-type: none"> <input type="checkbox"/> Vial of insulin, syringes <input type="checkbox"/> Pump syringe <input type="checkbox"/> Pump tubing/needle <input type="checkbox"/> Batteries <input type="checkbox"/> Tape <input type="checkbox"/> Insertion device <p>Insulin supplies storage location: _____ _____</p> <p><u>Emergency Supplies</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Glucagon kit stored: _____ <p><u>3 Day Disaster Diabetes Supplies</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Vial of insulin; 6 syringes <input type="checkbox"/> Insulin pen with cartridge and needles <input type="checkbox"/> Blood glucose testing kit (testing strips, lancing device with lancets) <input type="checkbox"/> Glucose gel product and glucose tablets <input type="checkbox"/> Glucagon kit <input type="checkbox"/> Food supply (include daily meal plan) stored as follows: _____ <input type="checkbox"/> Ketone strips/plastic cup <p>School will include a copy of the ISHP for diabetes management with the disaster supplies. Stored as follows: _____ _____</p> <p><u>Other Supplies</u>, Specify:</p>	

