

# DIABETES INDIVIDUALIZED HEALTHCARE PLAN (IHP)

Student:

School:

Grade:

Parent/Guardian:

Healthcare Provider:

Provider Phone:

**ASSESSMENT DATA:** (check or circle if applicable)      Date of Assessment \_\_\_\_\_

|   |  |                        |                        |
|---|--|------------------------|------------------------|
| <b>Reviewed:</b>  | Diabetes MMP ___   | Quick Reference EP ___ |                        |
| Height & Weight Date: ___   | Height: _____  | Weight: _____          | Height/Weight %: _____ |
| Vision Screening Date: ___  | Results:   |                        |                        |
| Hearing Screening Date: ___   | Results:   |                        |                        |
| Immunization Status:  |  |                        |                        |
| Diagnosis/Current Status:   | Age @ diagnosis: ___    Target blood glucose is ___ mg/dl to ___ mg/dl.<br>Most recent Hemoglobin A1C level was ___ mg/dl on _____ (date).<br>Hemoglobin A1C-value for blood glucose control previous 6 wks. to 3 mo.<br>Ranges are: 6-8 (good), 9-10 (fair), 11+ (poor) |                        |                        |
| <b>Family Resources:</b>  |  |                        |                        |
| Primary Contact: _____  |  |                        |                        |
| Preferred Type of Contact: Phone: ___ Written: ___ In Person: ___ email: ___ (obtained on separate form.) |  |                        |                        |
| Physician who manages diabetes: _____   |  |                        |                        |
| follow-up: 1 month ___ 3 month ___ 6 month ___ 9 month ___ 12 month ___                                   |  |                        |                        |
| Parent has phone: yes ___ no ___  |  |                        |                        |
| Parent has transportation: yes ___ no ___   |  |                        |                        |
| Uses community resources yes ___ no ___   |  |                        |                        |
| <b>Attendance Issues</b>  | School yes/ no   | Classroom yes/ no      |                        |
| <b>Student's strengths:</b>   | developed age appropriate self-management skills ___<br>good problem solving ability ___<br>communicates needs ___ accepts diagnosis ___<br>effective coping skills ___ good social skills ___   |                        |                        |
| <b>Self-Management:</b>   |  |                        |                        |
| <b>Meal Plan:</b>   | Carb counting Y / N    Scheduled Snacks: Y / N    Time: _____    Other: _____  |                        |                        |
| <b>Blood Glucose Monitoring:</b>  | Meter Type: _____    Testing Independently: Y / N  |                        |                        |
| <b>Exercise Plan:</b>   | Amount: _____  |                        |                        |
| <b>Current Medications:</b>   |  |                        |                        |
| Insulin type:   | Dose:  | Time:                  | Delivery Method        |
|   |  |                        |                        |
|   |  |                        |                        |
| Correction dose: _____ Units insulin per _____ above _____ mg/dl.   |  |                        |                        |
| Student- self-adjust insulin:   | Y / N  | Comment:               |                        |
| <b>Oral Diabetes Medication:</b>  | Y / N  | Name:                  |                        |
| <b>NOTES:</b>   |  |                        |                        |

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Student ID: \_\_\_\_\_ Grade: \_\_\_\_\_

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**NURSING DIAGNOSIS:**

**GOALS:**

|   |  |
|---|--|
| 1. Potential for less than optimal school achievement due to diabetes management.       | 1. Increase knowledge &/or skills related to diabetes to maintain optimal blood glucose control.   |
| 2. Potential knowledge deficit for diabetes management.                                 | 2. Participate in regular school/ class activities with modifications as necessary.  |
| 3. Potential for physiological acute and chronic injury related to diabetes management. | 3. Student will recognize and treat early signs of insulin shock appropriately and know how to recognize and respond to early signs of ketoacidosis. |
| 4.  | 4.   |

**INTERVENTIONS:**

**Annual Review Date:**

|   |   |
|---|---|
| Provides standard of care and education as listed on diabetes health record.              | Met: <input type="checkbox"/> Not Met: <input type="checkbox"/> |
| Provides individual education with staff regarding students unique needs.                 | Met: <input type="checkbox"/> Not Met: <input type="checkbox"/> |
| Coordination among school staff, Physician and family regarding diabetes management.      | Met: <input type="checkbox"/> Not Met: <input type="checkbox"/> |
| Coordinate with school staff for classroom or school modification.                        | Met: <input type="checkbox"/> Not Met: <input type="checkbox"/> |
| Provide education to student/parent related to diabetes management and school attendance. | Met: <input type="checkbox"/> Not Met: <input type="checkbox"/> |
| Assist student to identify motivators/ barriers related to diabetes self-care.            | Met: <input type="checkbox"/> Not Met: <input type="checkbox"/> |
| Assist student to develop appropriate decision making skills.                             | Met: <input type="checkbox"/> Not Met: <input type="checkbox"/> |
| Develop Emergency Plan of Care for student (attached)                                     | Met: <input type="checkbox"/> Not Met: <input type="checkbox"/> |
| Comments:   |   |

**STUDENT OUTCOMES:**

|  |
|--|
| 1. Student will demonstrate increasing knowledge and self-management skill in diabetes management at school. |
| 2. Student will participate in classroom/school activities with modifications as needed.                     |
| 3. Other   |

Parent/ Guardian Statement: I/We have read this plan and agree to its implementation:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**School RN Signature:** \_\_\_\_\_ **Date Plan Developed:** \_\_\_\_\_

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Student ID: \_\_\_\_\_ Grade: \_\_\_\_\_