Alaska Diabetes IHP Addendum: Diabetes Care for Out-of-School-Hours Activities 8-2016

Student Name:		**School:**	**Grade:**
Program/Field Trip:			
Start Date:	**End Date:**	**Days of Week:**	**Hours:**

NOTE: see the student's *Alaska Individualized Healthcare Plan (IHP) for Diabetes* for care during normal school hours. Follow the algorithms for blood glucose results. Below is additional or supporting information needed for this program or field trip.

Monitor Blood Glucose as identified on the IHP. In addition, test… ☐ Before dinner ☐ After dinner ☐ Before bedtime ☐ Other_____

Insulin Dosing	Type of insulin (circle): ☐rapid acting (Humalog/Novalog/Apidra) ☐regular or ☐ Other:			
Insulin Delivery System (circle one)	Pen	Vial/Syringe	Pump Brand_____ Serial Number _____ Change site every____days Last pump site change _____Next site change due_____	
Continuous Glucose Monitor? Brand _____ Last site change_____ Next site change due_____			Temporary Basal Decrease: ____% or ____units for ____minutes or ☐duration of exercise	
Breakfast Dose: Insulin/Carb ratio: _____ Correction scale: _____	Lunch Dose: Insulin/Carb ratio: _____ Correction scale: _____	Dinner Dose: Insulin/Carb ratio: _____ Correction scale: _____	Bedtime Dose: Insulin/Carb ratio: _____ Correction scale: _____	Long acting insulin: _____ _____units given at_____ Snacks: Given at_____

Additional considerations or restrictions:

Healthcare provider signature: **Date:**

SCHOOL SECTION

Staff Training	Parental delegation of insulin/glucagon requested? ☐ Yes ☐ No		Authorization form completed?
IF YES:	Staff Name	Date Trained	Trained by:
IF NO: emergency action training completed			

Parent Signature _____**Date**_____ **School Nurse Signature**_____**Date**_____

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LOG	Breakfast			Initials	Lunch			Initials	Dinner			Initials	Bedtime			Initials	Other/Remarks
	Blood Glucose	Carbs	Insulin Dose		Blood Glucose	Carbs	Insulin Dose		Blood Glucose	Carbs	Insulin Dose		Blood Glucose	Carbs	Insulin Dose		
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Staff Name	Signature	Initials

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