American Diabetes Association. | Safe at School®

Individual Health Plan

2025 - 2026

(Add student photo here.)

AUSTIN Independent School District

Student Last Name: First Name: DOB:

School Name: School Phone #: School Fax #: Grade:

Home Room: School Point of Contact Name and E-mail Address: Contact Phone #:

DEMOGRAPHIC INFORMATION (PARENT/GUARDIAN)

Student's Cell #: Diabetes Type: Date Diagnosed: Month: Year:

STUDENT'S SCHEDULE Arrival Time: Dismissal Time:

Travels to school by (check all that apply):
- ☐ Foot/Bicycle
- ☐ Car
- ☐ Bus
- ☐ Attends Before-School Program

Meal Times:
- ☐ Breakfast
- ☐ AM Snack
- ☐ Lunch
- ☐ PM Snack
- ☐ Pre-Dismissal Snack

Physical Activity Days/Times:
- ☐ Gym
- ☐ Recess
- ☐ Sports
- ☐ Additional information:

Travels to:
- ☐ Home ☐ After-School Program
- ☐ Other
- Via: ☐ Foot/Bicycle ☐ Car ☐ Student Driver ☐ Bus

Parent/Guardian #1 (contact first): Relationship:

Cell #: Home #: Work #:

Email Address:

Indicate Preferred Contact Method:

Parent/Guardian #2: Relationship:

Cell #: Home #: Work #:

Email Address:

Indicate Preferred Contact Method:

Has your child lost consciousness, experienced a seizure, or required glucagon in the last two years: ☐ No ☐ Yes If yes, date of last event

Has your child experienced DKA or hospitalization for diabetes in the last two years: ☐ No ☐ Yes If yes, date of last event

INSULIN DELIVERY/DOSE CALCULATION DEVICES (SELECT ALL THAT APPLY)

- ☐ Multiple Daily Injections (MDI)
  - ☐ Insulin Syringe ☐ Insulin Pen
  - ☐ Smart Pen
  - ☐ Injection via i-Port
- ☐ Insulin Pump (Specify Brand and Model)
  - ☐ Insulin pump is an automated insulin delivery (AID) system
  - ☐ Insulin pump is an open-sourced (OS-AID) system
- ☐ Bolus Calculator App
- ☐ Other

List self-carry supplies:

Name of Health Care Provider/Clinic: Contact #: Fax #:

Email Address (non-essential communication): Other:

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Individual Health Plan 202 - 202

STUDENT LAST NAME: FIRST NAME: DOB:

GLUCOSE MONITORING AT SCHOOL

Monitor Glucose: ☐ Before Meals (Default) ☐ With Physical Complaints/Illness (Default, Include Ketone Testing) ☐ High or Low Glucose Symptoms ☐ Before/After Physical Activity ☐ Before Leaving School ☐ Other:

CONTINUOUS GLUCOSE MONITORING (CGM) ☐ **N/A**

Specify Brand and Model:

Perform finger stick if:

- Symptoms do not match the sensor reading
- Sensor reading is unavailable, tracing is inconsistent or there is no trend arrow
- Sensor is still reading below 70 mg/dL 15 minutes following low treatment
- Sensor reading < 70 mg/dL or > 300 mg/dL

MEALTIME INSULIN TIMING GUIDELINES (SELECT ALL THAT APPLY)

Insulin Administration Guidelines

Insulin Delivery Timing:

Ensure substitution carbohydrates are consumed when student does not complete their meal.

☐ **Prior to Meal:** Recommended 10–15 minutes for rapid-acting insulin.

☐ **At the Time of the Meal:** Recommended for students using ultra-rapid insulin or the iLet insulin pump.

☐ **May Advance:** Administer insulin prior to meal when student demonstrates consistent eating patterns.

☐ **Partial Dose Prior to Meal:** Recommended for unpredictable eating, using pumps. Calculate pre-meal dose using grams of carbohydrates Follow pre-meal dose for additional grams of carbohydrate consumed, within 20 minutes (active AID: additional carbs N/A if ≥ 30 minutes late)

☐ **After Meal as Soon as Possible:** Recommended for students that refuse food on pumps or unpredictable eating, using MDI. For MDI calculate dose based on pre-meal glucose, carbs consumed, and administer dose following meal. Pumps give correction before eating and enter grams of carbs consumed within 30 minutes of start of meal.

LOCATION OF SUPPLIES

Insulin	
Fast Acting Carbohydrates/Snacks	
Glucometer Supplies	
Emergency Medicine	
Misc. Supplies	

My child is knowledgeable in the management of his/her diabetes and it is my wish that he/she can be allowed to manage his/her diabetes independently while at school or at an off campus event. My child will seek assistance from the school nurse or diabetes care attendant as needed or in the event of a medical emergency.

PARENT SIGNATURE: _____ **DATE:** _____

STUDENT SIGNATURE: _____ **DATE:** _____

PARENT AUTHORIZATION SIGNATURE

As parent/guardian of the above named student, I give permission for use of this health plan and for the school nurse to contact my child's healthcare provider(s) regarding the above condition.

I also give permission to the School Nurse, the Unlicensed Diabetes Care Assistant (UDCA) and any other designated staff members of my child's school to perform and carry out the diabetes care tasks as outlined by child's Diabetes Management Treatment Plan/Physician's Orders. I also consent to the release of the information contained in this Diabetes Management Treatment Plan to all staff member's and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

I agree to provide the school with all the supplies and medication(s) necessary to carry out the treatment plan for my child as indicated by my child's physician/healthcare provider.

I also agree to notify the school should there be any changes to my child's treatment plan at any time throughout the school year.

Under HB 984, an Unlicensed Diabetes Care Assistant may only administer diabetes care and management services if the student's parent/guardian authorizes an Unlicensed Diabetes Care Assistant to assist the student and confirms his or her understanding that an Unlicensed Diabetes Care Assistant is immune from liability for civil damages under section 22.0511 of the Texas Education Code.

Parent/Guardian Signature: Printed Name: Date:

School Nurse/Designee Signature: Printed Name: Date: