HS Form # 31

EDISON TOWNSHIP PUBLIC SCHOOLS

DIVISION OF HEALTH SERVICES

Diabetes Medical Management Plan

Part A: Contact Information must be completed by the parent/guardian

Part B: Authorization for Services and Sharing of Information must be signed by the parent/guardian.

Part C: Diabetes Medical Management Plan (DMMP) must be completed by the student's physician or advanced practice nurse and provides the medical "orders" for the student's care. This section must be signed and dated by the medical practitioner.

Part D: Individualized Healthcare Plan (IHP) must be completed by the school nurse in consultation with the student's parent/guardian and healthcare provider. It focuses on services and accommodations needed by the student at school or during school-sponsored activities.

PART A: Contact Information

Student's Name:________________________________ Gender: _________________

Date of Birth:___________________Date of Diabetes Diagnosis: ___________________

Grade: ______ Homeroom Teacher: ______________________________________

Mother/Guardian: ____

Address: ____

____

Telephone: Home ___________________ Work __________________ Cell____________

E-mail Address____

Father/Guardian: ____

Address: ____

____

Telephone: Home __________________ Work ___________________ Cell ____________

E-mail Address____

Student's Physician/Health Care Provider:

Name: ____

Address: ____

Telephone: _________________________ Fax: ____________________________

Emergency Contact:

Name: ____

Relationship to Student: ____

Telephone: Home____________________ Work___________________ Cell ___________

Part B: Authorization for Services and Release of Information

Permission for Care

I give permission to the school nurse to perform and carry out the diabetes care tasks outlined in the Diabetes Medical Management Plan (DMMP), Individualized Health Care Plan (IHP), and Individualized Emergency Health Care Plan (IEHP) designed for my child. I understand that no school employee, including a school nurse, a school bus driver, a school bus aide, or any other officer or agent of a board of education, shall be held liable for any good faith act or omission consistent with the provisions of *N.J.S.A 18A:40-12-11-21.*

_______________________________ _____________________
Student's Parent/Guardian Date

Permission for Glucagon Delegate

I give permission to ______________________ to serve as the trained glucagon delegate(s) for my child in the event that the school nurse is not physically present at the scene. I understand that no school employee, including a school nurse, a school bus driver, a school bus aide, or any other officer or agent of a board of education, shall be held liable for any good faith act or omission consistent with the provisions of N.J.S.A. 18A:40-12-11-21.

_____________________________ ______________________
Student's Parent/Guardian Date

Note: A student may have more than one delegate, in which case, this needs to be signed for each delegate

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Release of Information

I authorize the sharing of medical information about my child between my child's physician or advanced practice nurse and other healthcare providers in the school.
I also consent to the release of information contained in this plan to school personnel who have responsibility for or direct contact with my child, and who may need to know this information to maintain my child's health and safety.

_______________________________ _____________________
Student's Parent/Guardian Date

Parent Acknowledgement

1. I understand that as per NJ state law every effort will be made to secure a trained delegate to administer glucagon to my child in the absence of a school nurse. If no nurse or delegate is available (including class trips and school-sponsored activities/events), 911 will be called.
2. I will contact the school if my child is attending any school-sponsored activity outside of regular school hours without an accompanying parent/guardian.

______________________________ _______________________
Student's Parent/Guardian Date

Part C: Diabetes Medical Management Plan. This section must be **completed by the student's physician or advanced practice nurse** and provides the medical "orders" for the student's care. This section must be signed and dated by the medical practitioner. The information in the DMMP is used to develop the IHP and the IEHP

Student's Name:____

Effective Dates of Plan: ____________________________________

Physical Condition: ☐ **Diabetes type 1** ☐ **Diabetes type 2**

1. Blood Glucose Monitoring

Target range for blood glucose is ☐ 70-150 ☐ 70-180 ☐ Other: ___________

Usual times to check blood glucose____

____

Times to do extra blood glucose checks (*check all that apply*)

☐ Before exercise

☐ After exercise

☐ When student exhibits symptoms of hyperglycemia

☐ When student exhibits symptoms of hypoglycemia

☐ Other (explain): ____

Can student perform own blood glucose checks? ☐ Yes ☐ No

Exceptions: ____

____

Type of blood glucose meter used by the student: ______________________________

____

2. Insulin

Usual Lunchtime Dose

Base dose of Humalog/Novolog /Regular insulin at lunch (circle type of rapid-/short-acting insulin used)

☐ _____ units **or**

☐ Flexible dosing using _____ units/ _____ grams carbohydrate.

Use of other insulin at lunch: (circle type of insulin used):

☐ Intermediate/NPH/lente _____ units **or**

☐ Basal/Lantus/Ultralente _____ units.

3. Insulin Correction Doses

Authorization from the student's physician or advanced practice nurse must be obtained before administering a correction dose for high blood glucose levels except as noted below.

Changes must be faxed to the school nurse at _________________________.

_____ 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 determine correct amount of insulin? ☐ Yes ☐ No

Can student draw correct dose of insulin? ☐ Yes ☐ No

If parameters outlined above do not apply in a given circumstance:

- **a.** call parent/guardian and request immediate faxed order from the student's physician/healthcare provider to adjust dosage.
- **b.** If the student's healthcare provider is not available, consult with the school physician for immediate actions to be taken.

4. For Students with Insulin Pumps

Type of pump: ______________________ Basal rates: _______ 12 am to _____

_______ _____ to _____

_______ _____ to _____

Type of insulin in pump: ____

Type of infusion set: ____

Insulin/carbohydrate ratio: _______________________ Correction factor: _________

Student Pump Abilities/Skills:	***Needs Assistance***	
Count carbohydrates	☐ Yes	☐ No
Bolus correct amount for carbohydrates consumed	☐ Yes	☐ No
Calculate and administer corrective bolus	☐ Yes	☐ No
Calculate and set basal profiles	☐ Yes	☐ No
Calculate and set temporary basal rate	☐ Yes	☐ No
Disconnect pump	☐ Yes	☐ No
Reconnect pump at infusion set	☐ Yes	☐ No
Prepare reservoir and tubing	☐ Yes	☐ No
Insert infusion set	☐ Yes	☐ No
Troubleshoot alarms and malfunctions	☐ Yes	☐ No

5. For Students Taking Oral Diabetes Medications

Type of medication: ______________________________________ Timing: ____________

Other medications: ______________________________________ Timing: ____________

6. Meals and Snacks Eaten at School

Is student independent in carbohydrate calculations and management? ☐ Yes ☐ No

Meal/Snack	***Time***	***Food content/amount***
Breakfast		
Mid-morning snack		
Lunch		
Mid-afternoon snack		
Dinner		

Snack before exercise? ☐ Yes ☐ No Snack after exercise? ☐ Yes ☐ No

Other times to give snacks and content/amount: _________________________________

Preferred snack foods: ____

Foods to avoid, if any: ____

Instructions for class parties and food consuming events: _________________________

____

7. Exercise and Sports

A fast-acting carbohydrate such as ____
should be available at the site of exercise or sports.

Restrictions 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.

8. Hypoglycemia (Low Blood Sugar)

Usual symptoms of hypoglycemia: ____

____

Treatment of hypoglycemia: ____

____

Hypoglycemia: Glucagon Administration

Glucagon should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow.

Glucagon dosage____________

Preferred site for glucagon injection: ☐ arm ☐ thigh ☐ buttock

Once administered, call 911 and notify the parents/guardian.

***Please note-In the absence of a school nurse, if available, a trained delegate will give glucagon. IF NO NURSE OR DELEGATE AVAILABLE, 911 WILL BE CALLED IMMEDIATELY.**

9. **Hyperglycemia (High Blood Sugar)**

Usual symptoms of hyperglycemia: ____

____

Treatment of hyperglycemia: ____

____

Urine should be checked for ketones when blood glucose levels are above ______ mg/dl.

Treatment for ketones: ____

____

10. Diabetes Care Supplies

While in school or at school-sponsored activities, the student is required to carry the following diabetic supplies (check all that apply):

- ☐ Blood glucose meter, blood glucose test strips, batteries for meter
- ☐ Lancet device, lancets, gloves
- ☐ Urine ketone strips
- ☐ Insulin pump and supplies
- ☐ Insulin pen, pen needles, insulin cartridges, syringes
- ☐ Fast-acting source of glucose
- ☐ Carbohydrate containing snack
- ☐ Glucagon emergency kit
- ☐ Bottled water
- ☐ Other (please specify)

This Diabetes Medical Management Plan has been approved by:

____ ____________________

Student's Physician/Health Care Provider **Date**

Student's Physician/Healthcare Provider Contact Information:

This Diabetes Medical Management Plan has been reviewed by:

____________________________ ____________________

School Nurse's Signature **Date**

Part D: Individualized Healthcare Plan. This must be completed by the school nurse in consultation with the student's parent/guardian and healthcare provider. It focuses on services and accommodations needed by the student at school or during school-sponsored activities. It uses the nursing process to document needed services. **This plan should reflect the orders outlined in the Diabetes Medical Management Plan.**

☐ Attached is the Individual Healthcare Plan (IHP)

Individualized Healthcare Plan
Services and Accommodations at School and School-Sponsored Events

Student's Name: ______________________________Birth date:________________

Address:____________________________________ Phone: _________________

Grade: ________ Homeroom Teacher: ____________________________________

Parent/Guardian: ____

Physician/Healthcare Provider: ____

Date IHP Initiated: ____

Dates Amended or Revised: ____

IHP developed by: ____

Does this student have an IEP? ☐ Yes ☐ No
If yes, who is the child's case manager?

Does this child have a 504 plan? ☐ Yes ☐ No

Does this child have a glucagon designee? ☐ Yes ☐ No
If yes, name and phone number:

Data	Nursing Diagnosis	Student Goals	Nursing Interventions and Services	Expected Outcomes

This Individualized Healthcare Plan has been developed by:

_______________________________ School Nurse

___________________ Date

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