WARREN HILLS REGIONAL SCHOOL DISTRICT
Washington, NJ 07882

HEALTH OFFICES

Middle School – 908-689-0750 ext. 2020 **High School – 908-689-3050 ext. 2**
MS FAX – 908-835-0570 **HS FAX – 908-835-8511**

Diabetes Medical Management Plan/Individualized Healthcare Plan

Part A: Contact Information must be completed by the **parent/guardian**. Page 1

Part B: 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. Pages 2 - 6

Part C: Individualized Healthcare Plan 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. Page 7

Part D: Authorizations for Services and Sharing of Information must be signed by the **parent/guardian** and the **school nurse**. Page 8

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 _____
Email Address _____

Student's Physician/Healthcare Provider
Name: _____
Address: _____
Telephone: _____ Emergency Number: _____

Other Emergency Contacts:
Name: _____
Relationship: _____
Telephone: Home _____ Work _____ Cell _____

Part B: 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) is _____ units or does 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 _____.

Glucose levels ☐ Yes ☐ No
_____ 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. 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. 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 physical activity: _____
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. If glucagon is required and the school nurse is not physically available to administer it, the student's delegate is:
Name: _____ Title:_____ Phone: _____
Name: _____ Title: _____ Phone: _____
Glucagon Dosage _____
Preferred site for glucagon injection: ☐arm ☐thigh ☐buttock
Once administered, call 911 and notify the parents/guardian.

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:

_____ _____
Signature: Student's Physician/Healthcare Provider **Date**

Student's Physician/Healthcare Provider Contact Information:

This Diabetes Medical Management Plan has been reviewed by:

_____ _____
School Nurse **Date**

Part C: 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.

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**

_____ _____
School Nurse **Date**

Part D. 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**

Release of Information

I authorize the sharing of medical information about my child, _____, between my child's physician or advanced practice nurse and other health care providers in the school. I also consent to the release of information contained in this plan to school personnel who have responsibility for or 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**

If you want a non-medical professional to be trained to act as a glucagon delegate for your child please contact the school nurse for additional information.