**FREEHOLD REGIONAL HIGH SCHOOL DISTRICT**

Parents/Guardian of ___________________________________________________

In order to comply with **N.J.S.A. 18A:40-12.11-21,** which addresses the care of the diabetic student in the school setting, the attached packet must be completed to ensure that students with diabetes are able to manage their disease while at school or at school-related activities.

An important component of this law is to provide for the safety and well-being of all diabetic students by employing the assistance of a volunteer staff delegate. This delegate will be trained by the school nurse in the administration of glucagon to a student who experiences severe hypoglycemia when the school nurse is not physically present.

Part A – Contact Information (completed by parent/guardian)

Part B – Authorization for Services and Release of Information (completed by parent/guardian)

Part C – Diabetic Medical Management Plan (completed by the student's physician or advanced practice nurse who provides the medical orders)

Part D – Individualized Healthcare Plan ( completed by the school nurse in consultation with the student's parent/guardian and healthcare provider and reflects the orders outlined in the DMMP)

Part E - Self-Administration of Medication Request (completed by the parent/guardian if there is a request for the student to self-administer medication)

New documentation will be required at the beginning of each school year.
Please return this packet the first day of school with the necessary snacks and supplies.
If you have any questions, please contact your child's health office.

Thank you for your cooperation.

# FREEHOLD REGIONAL HIGH SCHOOL DISTRICT

## Diabetes Medical Management Plan/Individualized Healthcare Plan

**PART A: CONTACT INFORMATION (must be filled out by parent/guardian)**

Student's Name: ________________________________________ Grade: _________

Date of Birth: ________________ Date of Diabetes Diagnosis: _________________

Mother/Guardian: ______________________________________________________________

Address: ______________________________________________________________________

Telephone: Home ___________________ Work __________________ Cell_________________

**Father/Guardian:** _____________________________________________________________

Address: ______________________________________________________________________

Telephone: Home __________________Work ___________________Cell __________________

**EMERGENCY CONTACT (In the event a parent/guardian cannot be reached)**

Name: ___________________________________________ Relationship: ________________

Address: ______________________________________________________________________

Telephone: Home _________________ Work __________________Cell ____________________

**Student's Physician/Healthcare Provider**

Name: _________________________________________________________________________

Address: ______________________________________________________________________

Telephone: ____________________________________

Hospital you prefer to transport your child to in the event of an emergency:

______________________________________________________________________________

## 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 Managed Plan (DMMP), Individualized Health Care Plan (IHP), and Individualized Emergency Health Care Plan (IEHP) designed for my child, ___________________________________. I understand that no school employee, school bus driver, or any other agent or officer of the Freehold Regional High School District, 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.

_______________________________________ ___________________________

Parent/Guardian Signature Date

*****************************************************************************************

### ***Permission for Glucagon Delegate:***

**I give permission** to the school nurse to train one or more VOLUNTEER school employees, school bus driver, or any other agent or officer of the Freehold Regional High School District to serve as a trained glucagon delegate for my child, ________________________________________________________ in the event that the school nurse is not physically present at the scene. I understand that any trained delegate shall not be held liable for any good faith act or omission consistent with the provisions of N.J.S.A. 18A:40-12-11-21.

_______________________________________ ____________________________

**Parent/Guardian Signature** **Date**

**OR**

**I do not give permission** for glucagon delegation for my child ____________________________________ as per N.J.S.A. 18A:40-12.14.

_______________________________________ ____________________________

**Parent/Guardian Signature** **Date**

**********************************************************************************

### ***Release of Information:***

I authorize the sharing of medical information about my child, _______________________________________ between my child's physician, advanced practice nurse and other healthcare providers in 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.

_______________________________________ _________________

**Parent/Guardian Signature** **Date**

**Part C: Diabetic 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 (Individual Healthcare Plan) and IEHP (Individual Emergency Healthcare Plan).

**Student 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.

**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.**

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: ________________

**4. 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 Stamp (Including address and phone number)**

**This Diabetes Medical Management Plan has been reviewed by:**

______________________________________ ____________________

**School Nurse** **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 and reflects the orders outlined in the DMMP.

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

**Part A: STUDENT INFORMATION (Parent, please fill out this section):**

Student's Name: ________________________________________ Birth date: ___________

Address: ________________________________________________________________________

Phone: ___________________ Grade: ______________

Parent/Guardian: __________________________________________________________________

Physician/Healthcare Provider: _______________________________________________________

Physician Telephone: ____________________________________

Does your child have an IEP? ☐ Yes ☐ No

If yes, who is your child's case manager? ___________________________________________________

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

……………………………………………………………………………………………………

**Part B. Reserved for School Use:**

Date IHP Initiated: _____________________________________

Dates Amended or Revised: _____________ _______________ ________________ _______________

IHP developed by: __________________________________________________________________

Does this child have a glucagon designee? ☐Yes ☐ No

If yes, name and phone number: ________________________________________________________

_________________________________________________
(Signature of School Nurse (developer of IHP)

| **Data** | **Nursing Diagnosis** | **Student Goals** | **Nursing Interventions and Services** | **Expected Outcomes** |
|---|---|---|---|---|

See Attached

**Part E - Self-Administration of Medication Request** - completed by the parent/guardian if there is a request for the student to self-administer medication

FREEHOLD REGIONAL HIGH SCHOOL DISTRICT

REQUEST FOR STUDENT SELF-ADMINISTRATION OF MEDICATION

Student Name: ___________________ School: ___________________________Grade: ________

Date of Birth: ____________________ Age: __________ ID#: ____________________________

As per Board Policy and Regulation 5330, self-administration of medication by a student may be permitted for the treatment of asthma or other potentially life threatening illness, or a life threatening allergic reaction. A life threatening illness is defined as an illness or condition that requires an immediate response to specific symptoms and/or an after effect of disease or injury that if left untreated may lead to potential loss of life. All requests for self administration of medication are effective for one school year only and expire as of July 1st of each year.

****************************************************************************************************

SECTION ONE: To be completed by student's Private Physician

I certify that the student named above has a qualifying condition or illness that may require medication. I certify that the student has been instructed and is proficient in the proper method of self-administration of the prescribed medication, and is capable of self-carrying and self administration of the prescribed medication. I hereby request that the above named student be allowed to self-administer the following medication as prescribed by me:

Name of Medication: ___________________ Form of medication: ___________________

Diagnosis/Reason: _____________________ Purpose of medication: _________________

Dosage: ______________________________ Frequency: ___________________________

Time Medication to be Self-Administered:_____________________________________________

Special Instructions: ______________________________________________________________

_________________________________________________________________________________

Possible Side Effects: _____________________________________________________________

_________________________________________________________________________________

Date to Begin: ________________________ Date to Conclude:______________________

_____________________________________ _____________________________________

Physician's Name (Printed/Typed) Address

_____________________________________ ____________ __________________

Physician's Signature Date Telephone Number

(Stamp not acceptable)

******************************************************************************************************

SECTION TWO: To be completed by Parent(s)/Guardian(s)

I/We, as parent/guardian of __________________________________, provide our express authorization and permission for ____________________________________ to self-administer ___________________________ while in school and/or during school activities/athletics.

In accordance with Board Policy and Regulation 5330 and N.J.S.A. 18A:40-12.3, I/we have been advised, understand and acknowledge that the Board, the District and any of its employees or agents shall have no liability as a result of any injury to my child that is caused by or arises out of the self-administration of any medication.

I/We further understand and acknowledge that in accordance with N.J.S.A. 18A:40-12.3, I/we must indemnify and hold harmless the Board, the District and any of its employees or agents against any claims arising out of the self-administration.

I/We understand and acknowledge that the permission provided by this form is good for the current school year only and must be renewed for each subsequent school year.

______________________________ ____________ ________________________

Signature of Parent/Guardian Date Emergency Telephone number

**************************************************************************************

SECTION THREE: To be completed by school staff

After consultation with the School Nurse and School Medical Inspector, the request for self administering of medication by the student referenced above is hereby [**GRANTED/DENIED**] (select one).

__________________________________________ ________________________

Signature of School Principal Date

A copy of this completed form will be provided to the School Nurse and the student's parent(s)/ guardian(s).

In accordance with Board Policy and Regulation 5330, any request that is denied may be appealed to the Superintendent or his/her designee.