Diabetes Medical Management Plan/Individualized Healthcare Plan

Contact Information

Student's Name: ______________________________Gender:_____________________

Date of Birth: ________ Date of Diabetes Diagnosis: __________ Grade: __________

Address: ____

Parent/Guardian Phone Number:

Mother # : ________________ Father #: _______________

Other Emergency Contact Name and Phone#: _________________________________

Student's Physician/Healthcare Provider

Name:____

Address: ____

Telephone: _________________________

Diabetes Medical Management Plan:

Physical Condition: (Circle) Diabetes type 1 Diabetes type 2

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 their 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 at _______________________.

Glucose levels
_____ 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

Yes/ No 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

5. Students Taking Oral Diabetes Medications

Needs Assistance

Yes/ No

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

T***ime***

Food content/amount

____ Snack after exercise? Yes No

Other times to give snacks and content/amount: ____

Foods to avoid, if any: ____

Instructions for class parties and food-consuming events:
____

7. Exercise and 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 for this student:
____

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 _______

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 (circle 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
Student's Physician/Healthcare Provider Contact Information:

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), 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 for PJMS Staff 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

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**