

TOMS RIVER REGIONAL SCHOOLS

Diabetes Medical Management Plan/Individualized Healthcare Plan

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

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.

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.

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

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

<i>Meal/Snack</i>	<i>Time</i>	<i>Food content/amount</i>
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.

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

Data	Nursing Diagnosis	Student Goals	Nursing Interventions and Services	Expected Outcomes
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This individualized Healthcare Plan has been developed by:

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

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.

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