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

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.

Sample 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**

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 in which case, this needs to be signed for each 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**

MONMOUTH COUNTY VOCATIONAL SCHOOLS

Quick Reference Emergency Plan

for a Student with Diabetes

Hypoglycemia (Low Blood Sugar)

Photo

Student's Name

Grade/Teacher Date of Plan

Emergency Contact Information:

Mother/Guardian			**Father/Guardian**		
Home phone	Work phone	Cell	Home phone	Work phone	Cell

School Nurse/Trained Diabetes Personnel **Contact Number(s)**

Never send a child with suspected low blood sugar anywhere alone.

Causes of Hypoglycemia
- Too much insulin
- Missed food
- Delayed food
- Too much or too intense exercise
- Unscheduled exercise

Onset
- Sudden

Symptoms

Mild
- Hunger
- Shakiness
- Weakness
- Paleness
- Anxiety
- Irritability
- Dizziness
- Sweating
- Drowsiness
- Personality change
- Inability to concentrate
- Other: _____ _____

Circle student's usual symptoms.

Moderate
- Headache
- Behavior change
- Poor coordination
- Blurry vision
- Weakness
- Slurred Speech
- Confusion
- Other _____ _____

Circle student's usual symptoms.

Severe
- Loss of consciousness
- Seizure
- Inability to swallow

Circle student's usual symptoms.

Actions Needed

Notify School Nurse or Trained Diabetes Personnel. If possible, check blood sugar, per Diabetes Medical Management Plan. When in doubt, always TREAT FOR HYPOGLYCEMIA.

Mild
- Student may/may not treat self.
- Provide quick-sugar source.
  3-4 glucose tablets
  or
  4 oz. juice
  or
  6 oz. regular soda
  or
  3 teaspoons of glucose gel
- Wait 10 to 15 minutes.
- Recheck blood glucose.
- Repeat food if symptoms persist or blood glucose is less than _____.
- Follow with a snack of carbohydrate and protein (e.g., cheese and crackers).

Moderate
- Someone assists.
- Give student quick-sugar source per MILD guidelines.
- Wait 10 to 15 minutes.
- Recheck blood glucose.
- Repeat food if symptoms persist or blood glucose is less than _____.
- Follow with a snack of carbohydrate and protein (e.g., cheese and crackers).

Severe
- Don't attempt to give anything by mouth.
- Position on side, if possible.
- Contact school nurse or trained diabetes personnel.
- Administer glucagon, as prescribed.
- Call 911.
- Contact parents/guardian.
- Stay with student.

Excerpted from: Helping the Student with Diabetes Succeed: A Guide for School Personnel. Published by National Diabetes Education Program: A Joint Program of the National Institutes of Health and the Centers for Disease Control and Prevention

MONMOUTH COUNTY VOCATIONAL SCHOOLS

Quick Reference Emergency Plan

for a Student with Diabetes

Hyperglycemia (High Blood Sugar)

Photo

Student's Name

Grade/Teacher Date of Plan

Emergency Contact Information:

Mother/Guardian			**Father/Guardian**		
Home phone	Work phone	Cell	Home phone	Work phone	Cell

School Nurse/Trained Diabetes Personnel **Contact Number(s)**

Causes of Hyperglycemia

- Too much food
- Too little insulin
- Decreased activity
- Illness
- Infection
- Stress

Onset

- Over time—several hours or days

Symptoms

Mild

- Thirst
- Frequent urination
- Fatigue/sleepiness
- Increased hunger
- Blurred vision
- Weight loss
- Stomach pains
- Flushing of skin
- Lack of concentration
- Sweet, fruity breath
- Other: _____

Circle student's usual symptoms.

Moderate

- Mild symptoms plus:
- Dry mouth
- Nausea
- Stomach cramps
- Vomiting
- Other:_____

Circle student's usual symptoms.

Severe

- Mild and moderate symptoms plus:
- Labored breathing
- Very weak
- Confused
- Unconscious

Circle student's usual symptoms.

Actions Needed

- Allow free use of the bathroom.
- Encourage student to drink water or sugar-free drinks.
- Contact the school nurse or trained diabetes personnel to check urine or administer insulin, per student's Diabetes Medical Management Plan.
- If student is nauseous, vomiting, or lethargic, ____ call the parents/guardian or ____ call for medical assistance if parent cannot be reached.

Excerpted from: Helping the Student with Diabetes Succeed: A Guide for School Personnel. Published by National Diabetes Education Program: A Joint Program of the National Institutes of Health and the Centers for Disease Control and Prevention

Monmouth County Vocational School District

PHYSICIAN CERTIFICATION FOR SELF-MEDICATION BY A STUDENT WITH A LIFE-THREATENING ILLNESS/ALLERGIC REACTION

In accordance with P.L. 2007, c.57, _____ (print name of physician) certify that I am the physician of _____ (print name of student). This patient suffers from _____ (print name of illness), a potentially life-threatening illness/allergic reaction, and is capable of, and has been instructed in, the proper method of self-administration of medication for this illness/allergic reaction.

_____(print name of student) is physically fit to attend school and is free of contagious disease **and** would not be able to attend school if the medication is not administered during school hours.

Name of Medication: _____

Dose and Route: _____

Time: _____

Side Effects: _____

Period of time to be administered:_____

Additional Instructions: _____

_____

_____	_____	_____
Signature of Physician/Stamp	Telephone	Date

Reviewed and approved by:

_____	_____
Signature of School Physician	Date

Revised 12/22/15

Monmouth County Vocational School District

SELF-MEDICATION PERMISSION FORM FOR A STUDENT WITH A LIFE-THREATENING ILLNESS/ALLERGIC REACTION

In accordance with P.L. 2007, c.57, this form must be signed by the parents or guardians of any student who wishes to self-administer and is capable of and has been instructed in the proper method of medication for a life-threatening illness or is subject to a life-threatening illness allergic reaction.

We, _____ and _____ (print names of parents/guardians), are the parents or guardians of _____ (print name of student) a student in the Monmouth County Vocational School District. As required by law, this form provides to the Monmouth County Vocational School District Board of Education our written authorization for our child to self-administer medication for a life-threatening illness or is subject to a life-threatening illness allergic reaction. By signing this form, we release the Monmouth County Vocational School District Board, its employees and agents, from any liability as a result of any injury from the self-administration of medication by our child and we expressly agree to defend, protect, indemnify, and hold harmless the Monmouth County Vocational School District, and its employees or agents, from all losses, costs, suits or claims which may result from the self-administration of medication by our child.

Attached to this form is the written certification of our physician verifying the diagnosis of my child as potentially life-threatening and the provision of medication instructions. Permission for our child to self-administer medication is effective upon approval and notification by the Monmouth County Vocational School District Board of Education. Permission remains effective only for the present school year.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of School Physician Date

_____ _____

Signature of School Nurse Date

_____ _____

Signature of Principal Date

Revised 8/6/09