WOODBRIDGE TOWNSHIP SCHOOL DISTRICT

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 – This must be completed by the parent/guardian.

Student's Name: _____ Gender _____

Date of Birth: _____ Date of Diabetes Diagnosis: _____

Grade: _____ Homeroom Teacher: _____

Mother/Guardian: _____

Address: _____

Phone Number: Home _____ Work _____ Cell _____

E-mail Address: _____

Father/Guardian: _____

Address: _____

Phone Number: Home _____ Work _____ Cell _____

E-mail Address: _____

Student's Physician/Healthcare Provider

Name: _____ Phone Number: _____

Address: _____

Emergency Contact Name: _____

Relationship to student: _____

Phone Number: 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

- ☐ Rapid-/short-acting insulin used) is _____ units **or**
- ☐ Flexible dosing using _____ units/ _____ grams carbohydrate.

Use of other insulin at lunch: (check 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 injection? ☐ 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 _____ 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 parent/guardian.

9. Hyperglycemia (High Blood Sugar)

Usual symptoms of hyperglycemia:_____

Treatment of hyperglycemia:_____

Urine should be checked for ketones when blood glucose level is 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:

Name:_____

Address:_____

Phone Number: _____

This Diabetes Medical Management Plan has been reviewed by: School Nurse

_____ _____

Print School Nurse's Name *School Nurse's Signature*

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 order outlines in the diabetes Medical Management Plan.

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

Student's Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

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 student's case manager? _____

Does this student have a 504 Plan? ☐ Yes ☐ No

Does this student have glucagon designees? ☐ 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:

_____ _____

Print School Nurse's Name *School Nurse's Signature*

Date: _____