WOODBRIDGE TOWNSHIP SCHOOL DISTRICT

P.O. Box 428, School Street
Woodbridge, NJ 07095

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 Health Care 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: _____ Type of Diabetes Diagnosis: _____

Grade: _____ Homeroom Teacher: _____

Mother/Guardian: _____

Address: _____

Phone #: Home: _____ Work: _____ Cell: _____

E-mail address: _____

Father/Guardian: _____

Address: _____

Phone #: Home: _____ Work: _____ Cell: _____

E-mail address: _____

Student's Physician/Healthcare Provider: _____

Address: _____

Phone #: _____

Emergency Contact Name: _____

Relationship to student: _____

Phone #: 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 additional 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 his/her 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: _____ units
   OR
   ☐ Flexible dosing using _____ units/ _____ grams carbohydrates

   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 administer his/her 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 physician/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 correct 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 site	☐ 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 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 of 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 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.

_____ _____

Print Name of Parent/Guardian of Student *Signature of Parent/Guardian of Student*

_____

Date

Permission for Glucagon Delegate

I give permission to _____ to serve as the 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.

_____ _____

Print Name of Parent/Guardian of Student *Signature of Parent/Guardian of Student*

_____

Date

Note: A student may have more than one delegate, in which case this section must be completed and signed for each delegate.

Release of Information

I authorize the sharing of medical information regarding 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.

_____ _____

Print Name of Parent/Guardian of Student *Signature of Parent/Guardian of Student*

_____

Date

WOODBRIDGE TOWNSHIP SCHOOL DISTRICT

AUTHORIZATION FOR GLUCAGON ADMINISTRATION BY NON-NURSE SCHOOL PERSONNEL

STUDENT'S NAME:_____ DATE OF BIRTH:_____

PARENT/GUARDIAN:_____

AUTHORIZED SCHOOL PERSONNEL:_____

I, _____
(Print name of Parent/Guardian)

hereby authorize _____
(Print name of Authorized School Personnel)

to administer glucagon in an emergency for my child,

_____
(Print Student's name)

Training to administer glucagon must comply with N.J.S.A. 18A:40-12.11-21 and be carried out by a physician, physician's assistant, advanced practice registered nurse, or registered nurse for the exclusive purpose of providing emergency care in the absence of my child's school nurse teacher.

Once training is completed appropriately, _____
(Authorized School Personnel)

will be authorized to administer glucagon to my child in the event of a hypoglycemic emergency in the absence of my child's school nurse teacher. This information should be included in my child's individualized emergency care plan which is monitored by his/her school nurse teacher.

_____ _____
Signature – Parent/Guardian *Date*