

WOODSTOWN-PILESGROVE REGIONAL SCHOOL DISTRICT

Woodstown, New Jersey 08098

Diabetes Medical Management Plan/Individualized Healthcare Plan

Part A: Contact Information must be completed by 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: 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 _____

E-mail address: _____

Student's Physician/Healthcare Provider

Name: _____

Address: _____

Telephone: _____

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**

Wears medical alert identification ___ Yes ___ No

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 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

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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bolus correct amount for carbohydrates consumed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculate and administer corrective bolus	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculate and set basal profiles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculate and set temporary basal rate	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Disconnect pump	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reconnect pump at infusion set	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prepare reservoir and tubing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Insert infusion set	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Troubleshoot alarms and malfunctions	<input type="checkbox"/> Yes	<input type="checkbox"/> 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. 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. Accommodations for school trips, after-school activities, class parties, and other school-related activities: _____

11. If student requires more specific educational accommodations, please see: _____

12. 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 emergency kit

Glucagon emergency kit

Bottled water

Other (please specify) _____

Location of diabetic school supplies: _____

13. Education

Personnel trained in the symptoms and treatment of low and high blood sugar, including when to call for assistance, dates of training: _____

This Diabetes Medical Management Plan has been approved by:

Signature: Student's Physician/Healthcare Provider

Date

Student's Physician/Healthcare Provider Contact Information:

Signature: Parent/Guardian

Date

This Diabetes Medical Management Plan has been reviewed by:

School Nurse

Date

Part C. Authorization for 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