

MONMOUTH COUNTY VOCATIONAL 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** _____

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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.

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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: _____

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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:

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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 _____ or BAQSIMI™ 3 mg Nasal Powder

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: _____

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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**

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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?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, who is the child's case manager?				
Does this child have a 504 plan?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Does this child have a glucagon designee?		<input type="checkbox"/> Yes	<input type="checkbox"/> 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

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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

Quick Reference Emergency Plan

for a Student with Diabetes



Hypoglycemia (Low Blood Sugar)

Student's Name _____

Grade/Teacher _____ Date of Plan _____

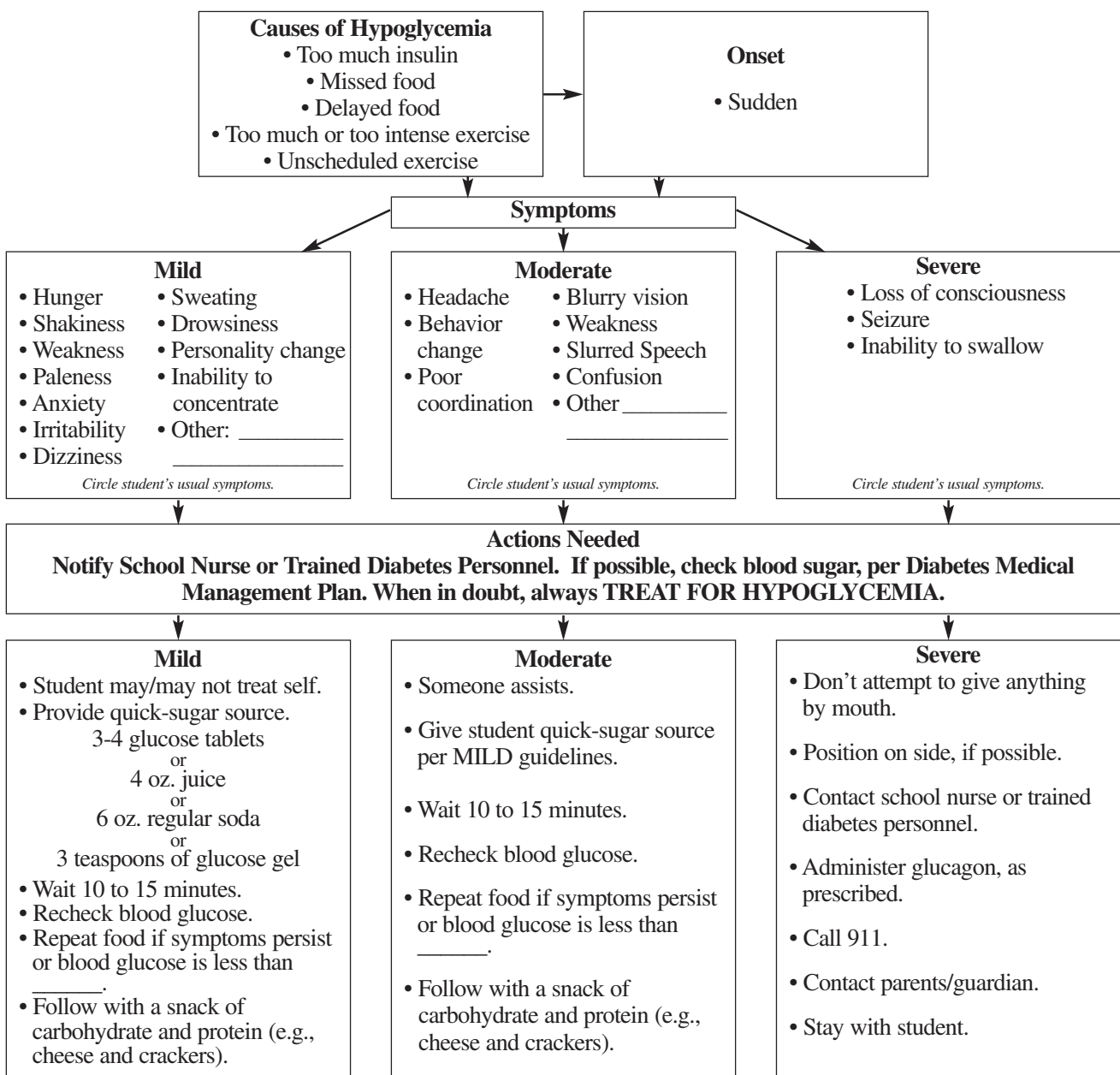
Emergency Contact Information: _____

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.



TOOLS

Quick Reference Emergency Plan

for a Student with Diabetes

Hyperglycemia (High Blood Sugar)



Student's Name _____

Grade/Teacher _____

Date of Plan _____

Emergency Contact Information:

Mother/Guardian

Father/Guardian

Home phone _____

Work phone _____

Cell _____

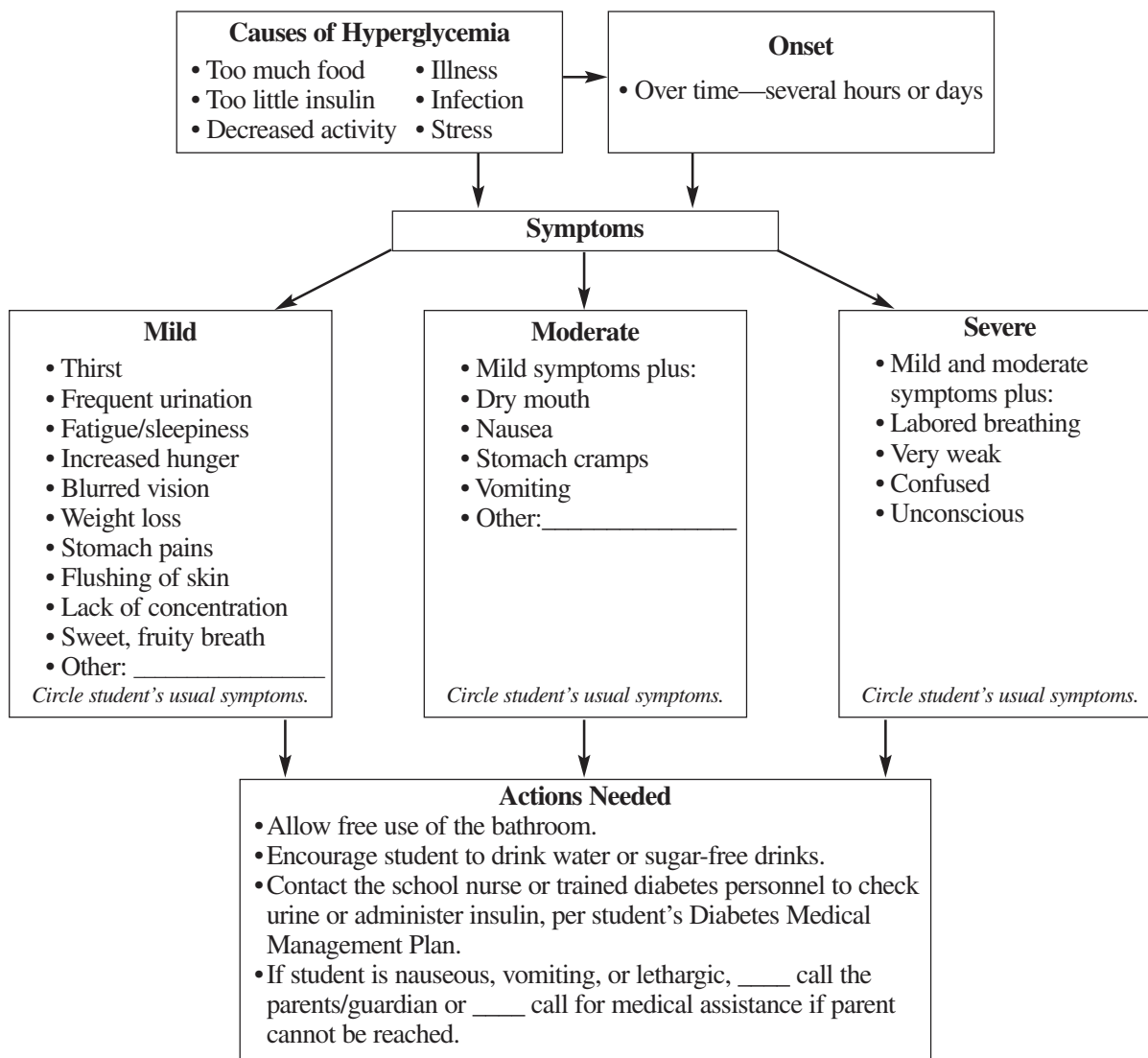
Home phone _____

Work phone _____

Cell _____

School Nurse/Trained Diabetes Personnel

Contact Number(s)



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

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**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