BARNEGAT TOWNSHIP SCHOOL DISTRICT
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Dr. Brian Latwis
Superintendent

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Business Administrator/Board Secretary

Diabetes Medical Management Plan/Individualized Healthcare Plan

Part A: Contact Information must be completed by the parent/guardian.

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 ____________________ 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 (*circle 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

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 (circle 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, Date

Part C. 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

DECLINING OF GLUCAGON DELEGATE

I do not give permission for the school nurse to delegate a non-medical school employee to administer the Glucagon Emergency Kit in case of a severe hypoglycemic reaction. I understand that if a severe hypoglycemic reaction occurs, the school district will initiate the 911 protocol and notify me of such actions.

____

Student's Parent/Guardian, Date