PART A: Diabetes Medical Management Plan Contact Information

Student's Name: _____ Gender_____

Date of Birth: _____

Date of Diabetes Diagnosis:_____

Grade: _____ Homeroom Teacher: _____

Parent/Guardian #1:_____

Address: _____

_____

Telephone: Home _____ Work: _____

Cell_____

E-mail Address

_____

Parent/Guardian #2: _____

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: _____

Part B: Diabetes Medical Management Plan. Physicians Orders. 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

Humalog/Novolog /Regular insulin at lunch (circle type of rapid-/short-acting insulin used)

_____ 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/ _____ grams carbohydrate.

Use of other insulin at lunch: (circle type of insulin used): intermediate/NPH/lente or

Basal/Lantus/Ultralente _____ units.

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

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.

Humalog/Novolog /Regular insulin at lunch (circle type of rapid-/short-acting insulin used)

_____

_____

_____ units/ _____ grams carbohydrate.

Changes must be faxed to the school nurse at _____.

If parameters outlined above do not apply in a given circumstance: Call the student's healthcare provider is not available, consult with the school physician for immediate actions to be taken. Notify parent.

4. Students with Insulin Pumps Type of pump: _____

Type of infusion set:_____

Insulin/carbohydrate ratio: _____ Correction factor:_____

Basal rates: _____ _____ to _____

_____ _____ to _____

_____ _____ to _____

_____ _____ to _____

_____ _____ to _____

_____ _____ to _____

_____ _____ to _____

_____ _____ to _____

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

Name of medication: _____ 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)

_____

_____

Glucagon should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow.

Glucagon Dosage _____

Preferred site for glucagon injection: arm thigh buttock

Once administered, call 911 and notify the parents/guardian.

9. Hyperglycemia (High Blood Sugar)

_____

_____

_____

_____

Urine should be checked for ketones when blood glucose is > _____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 and test strips,

☐ Lancet device and lancets

☐ Urine ketone strips

☐ Insulin pump and supplies

☐ Insulin pen,

☐ Pen needles,

☐ Syringes

☐ Fast-acting source of glucose

☐ Carbohydrate containing snack

☐ Bottled Water

☐ Other (please specify)

This Diabetes Medical Management Plan has been approved by:

_____ _____

Signature: Student's Physician/Healthcare Provider Date

Provider's stamp

_____ _____

Reviewed by School Nurse 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.*

_____ _____

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**