Diabetes Medical Management Plan/Individualized Healthcare Plan

This plan should be completed by the student's physician, personal diabetes healthcare team and parent/guardians. It should be reviewed with relevant school staff and copies should be kept in a place that can be assessed easily by school nurse and trained diabetes personnel.

This plan is valid for the current school year_____

Student Name_____

Date of birth_____ Grade_____ Building_____

Date of Diabetes diagnosis_____ Type I_____ Type II _____

School Nurse_____ Phone_____

Contact Information

Mother/Guardian_____

Address _____

Home phone_____ Work_____ Cell_____

Father/Guardian_____

Address _____

Home phone_____ Work_____ Cell_____

Student Physician/Health Care Provider

Name_____

Address _____

Phone_____ Emergency Number_____

Other Emergency Contact

Name_____ Relationship_____

Address_____

Home phone_____ Work_____ Cell_____

Diabetes Medical Management Plan

This section should be completed by student's physician or diabetic educator and provide medical "orders" for student's care. Their signature and date must be included.

Any changes may be faxed to school nurse at _____

Target range for blood glucose is:

_____70-130mg/dL _____70/180mg/dL _____Other

Times blood glucose levels should be checked (check all that apply)

_____Upon arrival to school

_____Mid AM before snack

_____Before Lunch

_____Mid PM before snack

_____Before leaving school

Times to do extra checks (check all that apply)

_____Before PE

_____After PE

_____After lunch, how many hours?_____

_____After correctional insulin dose, how many hours_____

_____When student exhibits symptoms of Hyperglycemia (high glucose)

_____When student exhibits symptoms of Hypoglycemia (low glucose)

_____Other (explain)

Can student perform own blood glucose checks? _____Yes _____No

Blood glucose testing should be supervised and blood glucose level verified:

_____No _____Yes (explain) _____

Brand/Model of glucose meter_____

Insulin delivery devise: _____Syringe _____Insulin pen _____Insulin pump

Can Student give own injection? _____Yes _____No

Can student draw up/dial up correct amount of insulin? _____Yes _____No

Name of Insulin using at lunch_____

Which of the following Adjustable Insulin Therapies does student use?

_____Carbohydrate Coverage:

Lunch: _____unit of insulin per _____grams of carbohydrate

Snack: _____unit of insulin per _____grams of carbohydrate

_____Sliding scale:

If blood glucose is _____to _____mg/dL give _____units

If blood glucose is _____to _____mg/dL give _____units

If blood glucose is _____to _____mg/dL give _____units

If blood glucose is _____to _____mg/dL give _____units

If blood glucose is _____to _____mg/dL give _____units

_____Insulin Pump:

Brand/Model of pump _____

Type of Insulin in pump_____

Type of Infusion set: _____

Basal rates: 12am: _____units/hr

____: _____units/hr

____: _____units/hr

____: _____units/hr

Insulin to carbohydrate ratio: _____

Correction factor: _____

Is student independent in the following self-care pump skills?

Count Carbohydrate's _____Yes _____No

Bolus correct amount for carb consumed _____Yes _____No

Calculate and administer corrective bolus _____Yes _____No

Calculate and set basal rate _____Yes _____No

Calculate and set temporary basal rate _____Yes _____No

Change batteries _____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

_____Oral diabetic medications

Name of medication_____

Time given: _____ Dose: _____

Hypoglycemia (Low Blood Sugar)

For this student low blood glucose level is less than _____

Usual symptoms Hypoglycemia for this student are _____
_____

Treat with _____grams of quick acting carbohydrates such as _____

Repeat glucose test in _____ minutes.

Repeat treatment if blood glucose level is less than _____.

Continue with above until students blood glucose is above_____.

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

This medication should be kept in the nurse's office.

Preferred site for injection _____

Make sure 911, nurse and parents/guardians are notified after administration**.**

Exercise/Sports

A fast acting carbohydrates such as _____should be available at the site of exercise/sports.

Restrictions on physical activity _____

Student should not exercise if blood glucose level is below_____ or above _____or if moderate to large ketones are present in urine.

Hyperglycemia (High Blood Sugar)

For this student high blood glucose level is greater than _____

Usual symptoms Hyperglycemia for this student are _____
_____

Test for ketones in _____urine or _____blood, if blood glucose level is

greater than _____mg/dL every _____ hour.

If ketones present _____ **<u>may</u>** participate in PE _____ **<u>may not</u>** participate In PE.

Administer the following correctional insulin_____

_____.

Recheck blood glucose level in _____.

Encourage student to drink _____ounces of water per hour.

Additional treatment for ketones_____

Notify parents if blood glucose level remains above _____ or_____ hours after correctional insulin has been given.

Supplies to be kept at school

_____ Blood glucose meter, glucose strips, batteries

_____ Lancet device and lancets

_____ Ketone strips and meter (if testing ketones in blood)

_____ Pump supplies for site changes (if using a pump)

_____ Insulin pen, pen needles, insulin cartridges, syringes

_____ Fast-acting source of glucose

_____ Carbohydrate containing snacks

_____ Glucagon emergency kit

_____ Other _____

Please feel free to attach any additional information that may be needed in the care of this student.

This Diabetes Medical Management Plan has been reviewed and approved by:

Student's Physician **Date**

Student's Diabetic Educator **Date**

Student's Parent/Guardian **Date**

Plan adapted from American Diabetes Association

Release for Students at Point and High School Only

_____ is a Type I diabetic. He/she is mature, accepting of their diabetic diagnosis and responsible.

_____ is fully able to manage his/her diabetes while at school. Please allow him/her to check their blood glucose levels at their locker or any other designated location and manage their own insulin doses.

_____ will follow the Diabetic Management Plan and Individual Healthcare Plan that is on file.

I agree to review this annually prior to the start of each school year.

Physician Signature Date

******MD will still need to submit a signed prescription stating that this student can manage their diabetes*******

I _____ feel that _____

Parent /Guardian Name Student name

Is mature, accepting of their diabetes diagnosis and responsible to manage his/her diabetes while at school. My son/daughter will follow the details of the plan on file, being sure to check, take the correct insulin and dispose of needles in a safe hard container. I also understand that if there are any issues with safety or deviations from the health plan this privilege can be revoked.

Parent/Guardian Signature Date

I,_____ feel I am mature, accepting of my diabetes and responsible to manage my diabetes at school. I will check my glucose regularly, take the correct amount of insulin, keep my items secure at all times, and dispose of needles in the appropriate container. I need to follow this plan to stay healthy. I know I can come to the Nurse's office at any time with concerns. I am also aware that if I pose any safety/health issues or deviate from my plan this privilege may be taken away from me for the remainder of the school year.

Student Signature Date

Revised May 2018

Authorization for Services

I authorize the school nurse or another qualified health care professional or trained diabetes personnel of College Community Schools to perform and carry out the diabetes care tasks as outlined in my child's Diabetes Medical Management Plan and Individualized Health Care Plan (DMMP&IHP). I understand that no employee, including the school nurse , health secretary, school bus driver or aide, or any other officer or agent of a board of education, shall be held liable for any good faith act or omission consent with the provisions of N.J.S.A. 18A: 40-12-12-11-21. I also consent to the release of the information contained in this DMMP&IHP to all staff members and other adults who have responsibility for my child and may need to know this information to maintain my child's health and safety.

Student name _____

Please Print

School Year_____ Grade_____ Building_____

Parent/Guardian Name_____

Please Print

Parent/Guardian Signature **Date**

Acknowledgment and receipt of completed plan:

_____

School Nurse **Date**

Revised May 2018