

WARREN HILLS REGIONAL SCHOOL DISTRICT  
Washington, NJ 07882

HEALTH OFFICES

Middle School – 908-689-0750 ext. 2020  
MS FAX – 908-835-0570

High School – 908-689-3050 ext. 2  
HS FAX – 908-835-8511

**Diabetes Medical Management Plan/Individualized Healthcare Plan**

**Part A: Contact Information** must be completed by the **parent/guardian**. Page 1

**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. Pages 2 - 6

**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. Page 7

**Part D: Authorizations for Services and Sharing of Information** must be signed by the **parent/guardian** and the **school nurse**. Page 8

**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 \_\_\_\_\_

**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.

### 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

<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. 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**

**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.

<b>Individualized Healthcare Plan Services and Accommodations at School and School-Sponsored Events</b>				
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**

\_\_\_\_\_  
**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**

**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**

**If you want a non-medical professional to be trained to act as a glucagon delegate for your child please contact the school nurse for additional information.**