Howell Township Public Schools

PROUD OF OUR SCHOOLS CONCERNED FOR OUR CHILDREN

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 _____

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

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 (if applicable)

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.

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? ☐ Yes ☐ No

If yes, who is the child's case manager?

Does this child have a 504 plan? ☐ Yes ☐ No

Does this child have a glucagon designee? (if applicable) ☐ Yes ☐ 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**

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 (if applicable)

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.

Parent Refusal for non-medical person (delegate) to administer glucagon to my child when nurse is unavailable. I understand that EMS 911 will be activated immediately.

_____ _____

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**

Howell Township Public Schools

PROUD OF OUR SCHOOLS CONCERNED FOR OUR CHILDREN

BUS TRANSPORT EMERGENCY MEDICAL PLAN

NAME:_____

ADDRESS:_____

ROUTE #:_____

1. _____ has a history of **diabetes**.

2. Diabetes is a serious chronic disease that impairs the body's ability to use food and must be managed 24 hours a day in order to avoid the potentially life-threatening consequences of blood sugars that are either too low (hypoglycemia) or too high (hyperglycemia).

3. Mild to moderate symptoms of hypoglycemia, which are different for each student and may vary from episode to episode, can include: shakiness, sweating, hunger, paleness, headache, blurry vision, sleepiness, dizziness, confusion, disorientation, irritability, lack of coordination, personality change, inability to concentrate, weakness, lethargy and changed behavior.

4. Severe symptoms of hypoglycemia may include: inability to swallow, seizure and loss of consciousness.

5. If _____ shows any of the symptoms of mild to moderate hypoglycemia, is alert and can speak and swallow, they should immediately eat a snack provided by parent and carried in their backpack. Radio transportation director so the student's parent/emergency contact can be alerted to the situation.

6. If _____shows any signs of severe hypoglycemia noted above:

   A. Radio for help. Ask for 911 emergency response to meet you at your location. Tell the dispatcher: "I am transporting a _____ year old child with a history of diabetes with a possible low blood sugar. His/her symptoms are _____.
   B. Stay with the child, speak calmly, and reassure him/her that people are coming to help.
   C. When _____ is to be transported to the hospital, send this form with emergency telephone numbers with him/her.
   D. Make sure that your bus company contacts the parents and the school to explain the reaction and to which hospital the child has been transported.
   E. Fill out any accident/incident report that is required.
   F. If you have any questions, please contact the school nurse at _____. Also, please keep in close communication with me throughout the year with any changes that may occur with the bus run as the year progresses.

7. The student will be seated at the front of the bus to the right of the bus driver. _____ _____
   Accept *Decline*

_____ _____ _____ _____

Certified School Nurse *Date* *Bus Driver* *Date*

_____ _____

Parent/Guardian Signature *Date*

EMERGENCY CONTACTS

1. *Name:*_____ *Relationship:*_____ *Phone No:*_____

2. *Name:*_____ *Relationship:*_____ *Phone No:*_____

(1/ 2013)

Howell Township Public Schools

PROUD OF OUR SCHOOLS CONCERNED FOR OUR CHILDREN

Dear Parent/Guardian,

Should it be necessary for your child to receive medication during school hours, you must present **this form** or an order from your personal physician, stating medication, **dosage**, **time of administration,** and the length of time your child will be on medication. This includes Tylenol, Motrin, cough drops and **all** over-the-counter medications. Any changes in these directions must be verified by a call to the school nurse, as well as a written note from the physician.

Any dangerous condition being experienced by a child on medication should be spelled out in detail with procedures to follow should a reaction occur. **Medicine must be properly labeled and in the original container, with the child's name, dosage, etc., on the pharmacist's label. The parent/guardian must transport all medication to and from school, unless a child has a doctor's signed permission to self-medicate and therefore carry an emergency medication (inhaler, pre-filled auto-injector mechanism).**

Sincerely,

Dorothea Fernandez

Dorothea Fernandez
Director of Pupil Services

Request for Administration of Medication

Student_____Homeroom_____Date _____

Diagnosis_____

Name of Medication_____Dosage _____Time of Administration _____

Daily or PRN: _____to be given_____ minutes before physical education or recess

To begin on _____ and conclude on _____

Possible side effects to be observed: _____

Special Instructions _____

Is this medication needed during field trips? Yes _____ No _____

Is this medication to be given on early dismissal day? Yes _____ No _____

Is child on any other medication? _____

Physician's Signature _____ Parent/Guardian Signature_____

School Physician's Approval _____ _____

Signature of Principal/Approval

PLEASE NOTE: If your child has permission from their physician to self-medicate with an emergency medication such as an asthma inhaler or a pre-filled auto-injector mechanism, please obtain the self-medication order form from your school nurse or download it from the district website.

Physician's Stamp

(2/2017)

Howell Township Public Schools

PROUD OF OUR SCHOOLS CONCERNED FOR OUR CHILDREN

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Name of Medication_____Dosage _____Time of Administration _____

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Special Instructions _____

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Is this medication to be given on early dismissal day? Yes _____ No _____

Is child on any other medication? _____

Physician's Signature _____ Parent/Guardian Signature_____

School Physician's Approval _____ _____

Signature of Principal/Approval

PLEASE NOTE: If your child has permission from their physician to self-medicate with an emergency medication such as an asthma inhaler or a pre-filled auto-injector mechanism, please obtain the self-medication order form from your school nurse or download it from the district website.

Physician's Stamp

(2/2017)

HOWELL TOWNSHIP SCHOOL DISTRICT
EMERGENCY CARE PLAN for
STUDENTS WITH DIABETES

Student: _____ Date: _____
Birthdate: _____
Preferred hospital in case of emergency: _____
Physician: _____ Phone#: _____
GLUCAGON DELEGATE: _____

Contact Information:

Parent /Guardian: 1._____ 2. _____	**Home Phone:** _____ **Work:** _____ **Cell:** _____ **Work:** _____ **Cell:** _____
Emergency Contact:	**Home Phone:** _____ **Work:** _____ **Cell:** _____

STUDENT -SPECIFIC EMERGENCIES

If You See This	*Do This*
1. If student complains of	**1. Send student to the Health Office with another student. Allow student to eat glucose tabs or snack if requested. If nurse is unavailable, call parent.** **Extra snacks in _____.**
2. If student complains of feeling shaky, fast heart rate, sweating, dizziness, impaired vision, severe headache, weakness or irritability	**2. Call nurse immediately. Allow student to eat glucose tabs or snack. If nurse is unavailable and snack does not alleviate symptoms, call "glucagon delegate"_____; notify parent and administrator.**
3. If student is unresponsive or unconscious	**3. Call nurse immediately. If nurse is unavailable, call 911, call "glucagon delegate" to administer glucagon _____; notify parent and administrator.**

If an emergency occurs:

1. If the emergency is life-threatening, immediately call 9-1-1.
2. Stay with student or designate another adult to do so.
3. Call or designate someone to call the principal and/or the school nurse.
   State who you are, state where you are and state the problem.

School Nurse: _____ Phone: _____
Parent Signature: _____ Date: _____
Copy to: _____ _____

(1/2013)