MERCER COUNTY TECHNICAL SCHOOLS

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_____
E-mail 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

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)

TO BE COMPLETED BY A PHYSICIAN

This Diabetes Medical Management Plan has been approved by:

_____ _____

Signature of Physician **Date**

Physician Phone Number: _____

TO BE COMPLETED BY THE SCHOOL NURSE

This Diabetes Medical Management Plan has been reviewed by:

_____ _____

Mercer County Technical 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.

MCTS 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? ___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:

_____ _____
MCTS 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*.

_____ _____

Parent/Guardian Signature **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.

_____ _____

Parent/Guardian Signature **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**