

FREEHOLD REGIONAL HIGH SCHOOL DISTRICT

Parents/Guardian of _____

In order to comply with **N.J.S.A. 18A:40-12.11-21**, which addresses the care of the diabetic student in the school setting, the attached packet must be completed to ensure that students with diabetes are able to manage their disease while at school or at school-related activities.

An important component of this law is to provide for the safety and well-being of all diabetic students by employing the assistance of a volunteer staff delegate. This delegate will be trained by the school nurse in the administration of glucagon to a student who experiences severe hypoglycemia when the school nurse is not physically present.

Part A – Contact Information (completed by parent/guardian)

Part B – Authorization for Services and Release of Information (completed by parent/guardian)

Part C – Diabetic Medical Management Plan (completed by the student's physician or advanced practice nurse who provides the medical orders)

Part D – Individualized Healthcare Plan (completed by the school nurse in consultation with the student's parent/guardian and healthcare provider and reflects the orders outlined in the DMMP)

New documentation will be required at the beginning of each school year.

Please return this packet the first day of school with the necessary snacks and supplies.

If you have any questions, please contact your child's health office.

Thank you for your cooperation.

FREEHOLD REGIONAL HIGH SCHOOL DISTRICT

Diabetes Medical Management Plan/Individualized Healthcare Plan

PART A: CONTACT INFORMATION (must be filled out by parent/guardian)

Student's Name: _____ Grade: _____

Date of Birth: _____ Date of Diabetes Diagnosis: _____

Mother/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell _____

Father/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell _____

EMERGENCY CONTACT (In the event a parent/guardian cannot be reached)

Name: _____ Relationship: _____

Address: _____

Telephone: Home _____ Work _____ Cell _____

Student's Physician/Healthcare Provider

Name: _____

Address: _____

Telephone: _____

Hospital you prefer to transport your child to in the event of an emergency:

Part B: 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 Managed Plan (DMMP), Individualized Health Care Plan (IHP), and Individualized Emergency Health Care Plan (IEHP) designed for my child, _____. I understand that no school employee, school bus driver, or any other agent or officer of the Freehold Regional High School District, 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 the school nurse to train one or more VOLUNTEER school employees, school bus driver, or any other agent or officer of the Freehold Regional High School District to serve as a trained glucagon delegate for my child, _____ in the event that the school nurse is not physically present at the scene. I understand that any trained delegate shall not 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

OR

I do not give permission for glucagon delegation for my child _____ as per N.J.S.A. 18A:40-12.14.

Parent/Guardian Signature

Date

Release of Information:

I authorize the sharing of medical information about my child, _____ between my child’s physician, advanced practice nurse and other healthcare providers in 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.

Parent/Guardian Signature

Date

Part C: Diabetic 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 (Individual Healthcare Plan) and IEHP (Individual Emergency Healthcare Plan).

Student 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.

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.**

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: _____

4. Student Pump Abilities/ Skills

Needs Assistance

Count carbohydrates	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bolus correct amount for carbohydrates consumed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculate and administer corrective bolus	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculate and set basal profiles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculate and set temporary basal rate	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Disconnect pump	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reconnect pump at infusion set	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prepare reservoir and tubing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Insert infusion set	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Troubleshoot alarms and malfunctions	<input type="checkbox"/> Yes	<input type="checkbox"/> 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) _____

This Diabetes Medical Management Plan has been approved by:

Signature: Student's Physician/Healthcare Provider

Date

Student's Physician/Healthcare Provider Stamp (Including address and phone number)

This Diabetes Medical Management Plan has been reviewed by:

School Nurse

Date

Part D: Individualized Healthcare Plan. This must be completed by the school nurse in consultation with the student's parent/guardian and healthcare provider and reflects the orders outlined in the DMMP.

**Individualized Healthcare Plan
Services and Accommodations at School and School-Sponsored Events**

Part A: STUDENT INFORMATION (Parent, please fill out this section):

Student's Name: _____ Birth date: _____

Address: _____

Phone: _____ Grade: _____

Parent/Guardian: _____

Physician/Healthcare Provider: _____

Physician Telephone: _____

Does your child have an IEP? Yes No

If yes, who is your child's case manager? _____

Does your child have a 504 plan? Yes No

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Part B. Reserved for School Use:

Date IHP Initiated: _____

Dates Amended or Revised: _____

IHP developed by: _____

Does this child have a glucagon designee? Yes No

If yes, name and phone number: _____

(Signature of School Nurse (developer of IHP))

Data	Nursing Diagnosis	Student Goals	Nursing Interventions and Services	Expected Outcomes
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See Attached

