FORT LEE SCHOOL DISTRICT
FORT LEE, NEW JERSEY

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

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? ☐ 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

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.

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**

FORT LEE SCHOOL DISTRICT
FORT LEE, NEW JERSEY

REQUEST FOR GIVING MEDICATION AT SCHOOL
FORM 02-D-18

This form is required for all over-the-counter and/or prescription medication(s) to be administered during school hours. The medication(s) will be supplied by the parents and brought to the school nurse in the original container appropriately labeled by the pharmacy and physician. **All medication must be picked up at the end of the school year.**

Student's Name: ____________________ Date of Birth: __________

Allergies: ______________ Grade: ______ Current Weight: __________

Diagnosis/Medical Condition: ______________________________

Name of Medication: ______________ Dose to be administered: __________

Route: ________ Time to be administered: ____________ am/pm (please circle)

Possible side effects of medication: ______________________________

Intervention to be rendered for an adverse reaction: ______________________

____

Dates to be dispensed (Please check): ☐ School year ______ to _______ ☐ Half days ☐ Field Trips (including overnight trips) ☐ Other prescribed time period: ____________

x ______________________ ____________
PHYSICIAN SIGNATURE DATE

x ______________________
PHYSICIAN PRINTED NAME

PHYSICIAN STAMP
(TO INCLUDE ADDRESS & PHONE NUMBER)

This section is to be completed by the Parent/ Legal Guardian

Please initial the following:

- I hereby give the school nurse/school physician permission to administer the above stated medication. Initial: __________
- I also, give the school nurse/school physician permission to contact my child's physician regarding the ordered medication, as needed. Initial: __________

______________________ ______________________ ______________
Parent/ Guardian Signature Emergency contact number Date

Received by school and reviewed by ______________________________ **School Nurse-teacher**
Name **School Doctor**

On

FORT LEE SCHOOL DISTRICT
FORT LEE, NEW JERSEY

SCHOOL YEAR 2019-2020

SELF-ADMINISTRATION OF MEDICATION REQUEST FOR OTHER POTENTIALLY LIFE – THREATENING ILLNESSES
FORM 02-D-34-B

To be completed by the examining physician and parent and returned to the School Nurse/Teacher.

Permission is effective only for the school year for which it is granted and must be renewed annually. Medication must be in ORIGINAL container, appropriately labeled by the pharmacy or physician.

Student's Name ________________________________ DOB____________ Grade __________
(Last) (First)

A. TO BE COMPLETED BY THE PHYSICIAN:

DIAGNOSIS ____

NAME OF THE MEDICATION: ____________________________________

BRAND NAME_________________MANUFACTURER__________EXPIRATION DATE_____

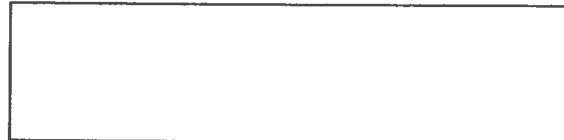
DOSAGE ____

FREQUENCY ____

FOLLOW – UP INSTRUCTIONS ____________________________________

The above named student is permitted to keep / carry the said medication and is capable of self-administering the medication as needed. I certify that the student has been instructed by me and understands the purpose and appropriate method and frequency of use of this medication.

_______________________ _______________
Physician Signature **Date**



____
Physician Printed Name

PHYSICIAN STAMP
(TO INCLUDE ADDRESS & PHONE NUMBER)

B. TO BE COMPLETED BY THE PARENT/GUARDIAN:

I hereby request that my child be allowed to carry/keep and self-administer the above medication as indicated by the physician. I verify that my child knows how to correctly administer the medication.

I understand that the district and its employees or agents shall incur no liability as a result of injury arising from the self-administration of medication by the student to himself/herself or other persons as a result of misuse. I indemnify and hold harmless the district and its employees or agents against any claims arising out of self-administration or non-administration of medication by the student.

________________________________ _______________
Parent/Guardian Signature **Date**

____
Parent/Guardian Printed Name

C. TO BE COMPLETED BY HEALTH SERVICES STAFF:

Form reviewed ____________________________ (Date) __________________

Quick Reference Emergency Plan

for a Student with Diabetes

Hypoglycemia
(Low Blood Sugar)

Photo

Student's Name

Grade/Teacher — Date of Plan

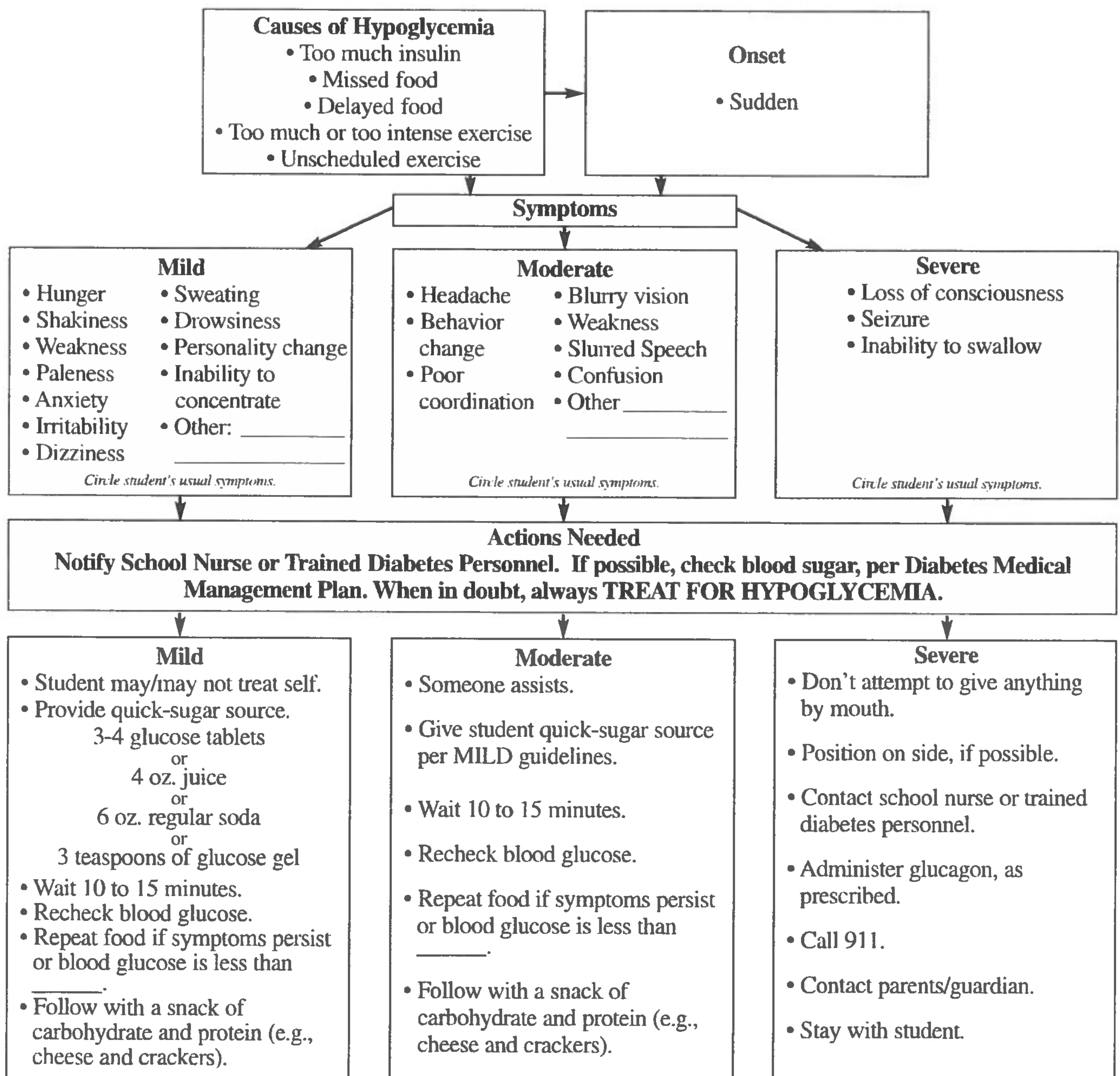
Emergency Contact Information:

Mother/Guardian — Father/Guardian

Home phone — Work phone — Cell — Home phone — Work phone — Cell

School Nurse/Trained Diabetes Personnel — Contact Number(s)

Never send a child with suspected low blood sugar anywhere alone.



Causes of Hypoglycemia
- Too much insulin
- Missed food
- Delayed food
- Too much or too intense exercise
- Unscheduled exercise

Onset
- Sudden

Symptoms

Mild
- Hunger
- Shakiness
- Weakness
- Paleness
- Anxiety
- Irritability
- Dizziness
- Sweating
- Drowsiness
- Personality change
- Inability to concentrate
- Other: ________

Circle student's usual symptoms.

Moderate
- Headache
- Behavior change
- Poor coordination
- Blurry vision
- Weakness
- Slurred Speech
- Confusion
- Other ________

Circle student's usual symptoms.

Severe
- Loss of consciousness
- Seizure
- Inability to swallow

Circle student's usual symptoms.

Actions Needed

Notify School Nurse or Trained Diabetes Personnel. If possible, check blood sugar, per Diabetes Medical Management Plan. When in doubt, always TREAT FOR HYPOGLYCEMIA.

Mild
- Student may/may not treat self.
- Provide quick-sugar source.
  - 3-4 glucose tablets
  - or
  - 4 oz. juice
  - or
  - 6 oz. regular soda
  - or
  - 3 teaspoons of glucose gel
- Wait 10 to 15 minutes.
- Recheck blood glucose.
- Repeat food if symptoms persist or blood glucose is less than ______.
- Follow with a snack of carbohydrate and protein (e.g., cheese and crackers).

Moderate
- Someone assists.
- Give student quick-sugar source per MILD guidelines.
- Wait 10 to 15 minutes.
- Recheck blood glucose.
- Repeat food if symptoms persist or blood glucose is less than ______.
- Follow with a snack of carbohydrate and protein (e.g., cheese and crackers).

Severe
- Don't attempt to give anything by mouth.
- Position on side, if possible.
- Contact school nurse or trained diabetes personnel.
- Administer glucagon, as prescribed.
- Call 911.
- Contact parents/guardian.
- Stay with student.

Quick Reference Emergency Plan
for a Student with Diabetes

Hyperglycemia
(High Blood Sugar)

Photo

Student's Name

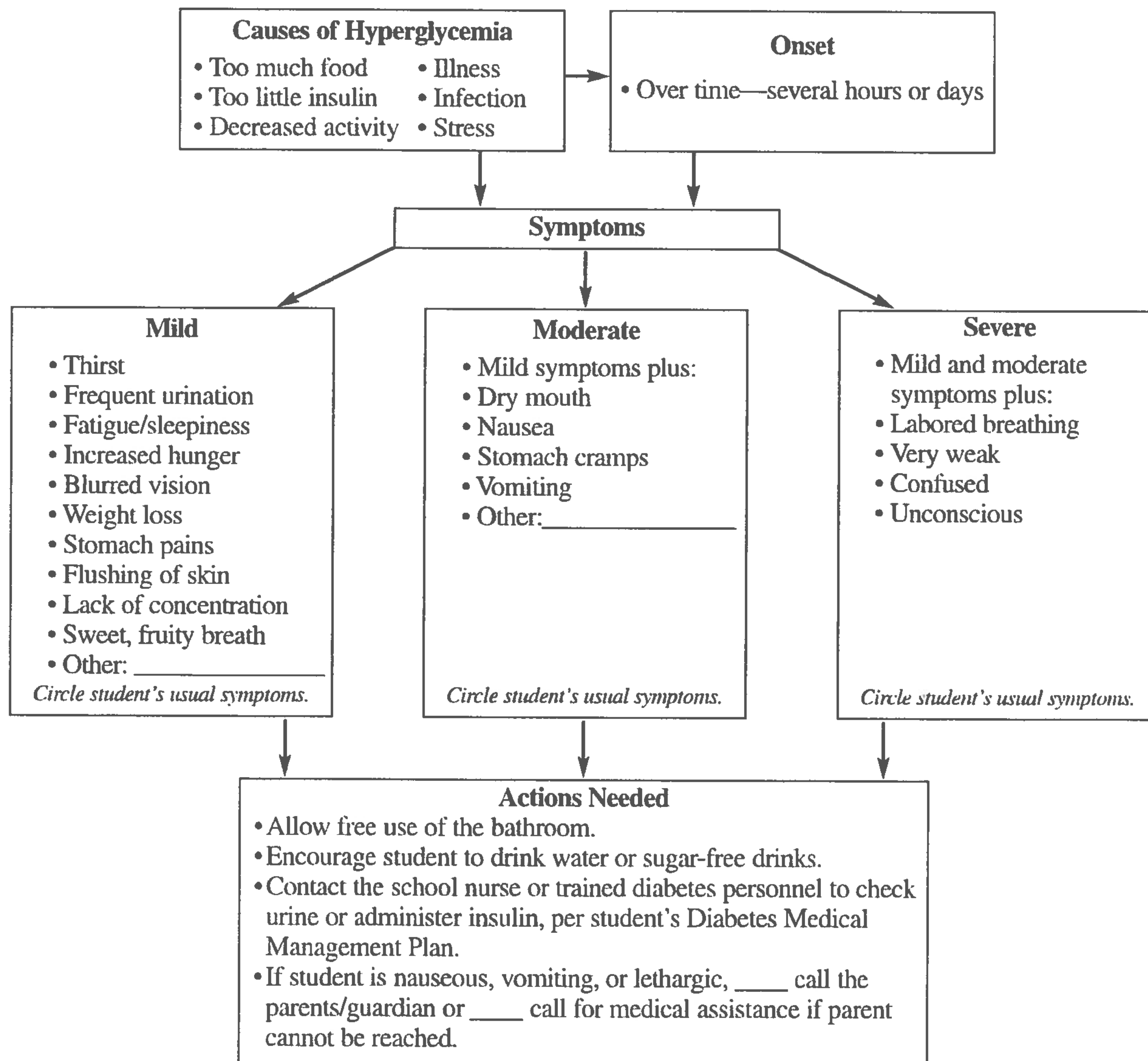
Grade/Teacher — Date of Plan

Emergency Contact Information:

Mother/Guardian — Father/Guardian

Home phone — Work phone — Cell — Home phone — Work phone — Cell

School Nurse/Trained Diabetes Personnel — Contact Number(s)



Causes of Hyperglycemia
- Too much food
- Too little insulin
- Decreased activity
- Illness
- Infection
- Stress

Onset
- Over time—several hours or days

Symptoms

Mild
- Thirst
- Frequent urination
- Fatigue/sleepiness
- Increased hunger
- Blurred vision
- Weight loss
- Stomach pains
- Flushing of skin
- Lack of concentration
- Sweet, fruity breath
- Other: ____________

Circle student's usual symptoms.

Moderate
- Mild symptoms plus:
- Dry mouth
- Nausea
- Stomach cramps
- Vomiting
- Other:____________

Circle student's usual symptoms.

Severe
- Mild and moderate symptoms plus:
- Labored breathing
- Very weak
- Confused
- Unconscious

Circle student's usual symptoms.

Actions Needed
- Allow free use of the bathroom.
- Encourage student to drink water or sugar-free drinks.
- Contact the school nurse or trained diabetes personnel to check urine or administer insulin, per student's Diabetes Medical Management Plan.
- If student is nauseous, vomiting, or lethargic, ____ call the parents/guardian or ____ call for medical assistance if parent cannot be reached.