WEST WINDSOR-PLAINSBORO REGIONAL SCHOOL DISTRICT

Date of Plan: _____

Diabetes Medical Management Plan

This plan should be completed by the student's personal health care team and parents/guardian. It should be reviewed with relevant school staff and copies should be kept in a place that is easily accessed by the school nurse, trained diabetes personnel, and other authorized personnel.

Effective Dates: _____

Student's Name: _____

Date of Birth: _____ Date of Diabetes Diagnosis: _____

Grade: _____ Homeroom Teacher: _____

Contact Information

Mother/Guardian: _____

Address: _____

Email _____

Telephone: Home _____ Work _____ Cell_____

Father/Guardian: _____

Address: _____

Email_____

Telephone: Home _____ Work _____ Cell _____

Other Emergency Contacts:

Name: _____

Relationship: _____

Telephone: Home _____ Work _____ Cell _____

Notify parents/guardian or emergency contact in the following situations: _____

_____

_____

To be completed by the Student's Doctor/ Health Care Provider:

Provider's Name: _____

Address: _____

Telephone: _____ Emergency Number: _____

Physical Condition: ☐ Diabetes type 1 ☐ Diabetes type 2

Blood Glucose Monitoring

Target range for blood glucose is ☐ 70-150 ☐ 70-180 ☐ Other _____

Can student perform own blood glucose checks? ☐ Yes ☐ No

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): _____

Insulin

Can student safely carry insulin pens/needles-syringes? ☐ Yes ☐ No

Can student determine correct amount of insulin? ☐ Yes ☐ No

Can student give own injections? ☐ Yes ☐ No

Can student draw correct dose of insulin? ☐ Yes ☐ No

Usual Lunchtime Dose

Dose of _____ insulin at lunch is _____ units or does flexible dosing using _____ units/ _____ grams carbohydrate.

Insulin Correction Doses

_____ 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

If blood glucose is outside of these parameters call:

☐ Healthcare Provider or ☐ Parent to adjust insulin dose.

(The District reserves the right to contact the student's physician for clarification as needed.)

For Students with Insulin Pumps

Type of pump: _____ Basal rates: _____ from _____ to _____

_____ from_____ to _____

_____ from_____ 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

For Students Taking Oral Diabetes Medications

Name /Dose of medication: _____ Timing: _____

Name/Dose of medication: _____ Timing: _____

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 when food is provided to the class (e.g., as part of a class party or food sampling event): _____

_____

Exercise and Sports

A fast-acting carbohydrate should be available at the site of exercise or sports.

Restrictions on activity, if any: _____ 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.

Hypoglycemia (Low Blood Sugar)

Usual symptoms of hypoglycemia: _____

_____

Treatment of Mild/Moderate Hypoglycemia: Please use the attached Quick Reference Emergency Plan for Hypoglycemia

Treatment of Severe Hypoglycemia: Glucagon should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow.

Route IM, Dosage _____, site for glucagon injection: thigh, arm or buttock

If glucagon is required, administer it promptly. Then, call 911 (or other emergency assistance) and the parents/guardian. If the student does not awaken in 15 min, administer a second dose of Glucagon.

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: _____

_____

Supplies to be Kept at School

The student may possess at any time the supplies or equipment necessary to monitor and care for the student's diabetes;

Signatures:

This Diabetes Medical Management Plan has been approved by:

_____ _____

Student's Physician/Health Care Provider Date

Permission for Care:

I give permission to the school nurse, trained diabetes personnel, and other designated staff members of _____ School to perform and carry out the diabetes care tasks as outlined by _____'s Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I hereby acknowledge my understanding 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 this act N.J.S.A. 18A:40-12.11-21, nor shall an action before the New Jersey State Board of Nursing lie against a school nurse for any such action taken by a person trained in good faith by the school nurse pursuant to this act. Good faith shall not include willful misconduct, gross negligence, or recklessness.

Acknowledged and received by:

_____ _____

Student's Parent/Guardian Date

DMMP Reviewed by:

_____ _____

School Nurse Date

Authorization of Delegate's Administration of Glucagon:

I understand that the school nurse shall have primary responsibility for the emergency administration of Glucagon. I authorize the school nurse to designate in consultation with the board of education, additional employees of the school district who volunteer to administer glucagon to my child who is experiencing severe hypoglycemia when a school nurse is not physically present at the scene. I hereby acknowledge my understanding 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 this act N.J.S.A. 18A:40-12.11-21, nor shall an action before the New Jersey State Board of Nursing lie against a school nurse for any such action taken by a person trained in good faith by the school nurse pursuant to this act. Good faith shall not include willful misconduct, gross negligence, or recklessness.

Acknowledged by:

_____ _____

Student's Parent/Guardian Date

DMMP Reviewed by:

_____ _____

School Nurse Date

Revised 5-15-10 cj