Northern Valley Regional High School at Demarest
Diabetes Medical Management Plan

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**

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**