**PUBLIC SCHOOLS OF**
**Pemberton Township**

One Egbert Street, Pemberton, NJ 08068
Phone: 609-893-8141 1-1008 Fax: 609-894-0585
Mike Gorman, Superintendent
Barbara Greco, Director of Student Personnel Services

## Diabetes Medical Management Plan

Date_____

To the Parent /Guardian of _____

The state of New Jersey has approved the law which regulates the administration of glucagon to diabetic students in schools starting February 1, 2010. The law requires that a trained designee be available for any student who may require the emergency administration of glucagon by injection when the school nurse is not available. In addition, you need to have a completed "Diabetes Medical Management Plan" on file in the Health Office.

The school nurse or school physician is responsible for delegating the administration of glucagon to school personnel in the event of an emergency. A delegate shall be trained according to the "Glucagon Training" for the emergency administration of glucagon developed by Pemberton Township School District.

This protocol has been developed to assist your child in an emergency situation. The following forms need to be completed by you and your physician:

Page 1 - **Diabetes Medical Management Plan Contact Information** (Parent)

Page 2 - 5 **Diabetes Medical Management Orders** (Doctor)

Page 6 & 7 **Individual Emergency Care Plan for Diabetes (including Hypo/Hyperglycemia)** (Parent & doctor)

Page 8 **Parent Signature Page** (Sign 4 Times) (Parent)

Page 9 & 10 **Individualized Healthcare Plan** (Parent & Nurse)

*Please sign the highlighted line on page 9 that you have reviewed and agree with the Individual Healthcare Plan for you child. This may be done at a later date after the nurse reviews the doctor's orders and can prepare an individualized plan for your child. It would be page 10.

Please have the above forms completed and return to the school nurse as soon as possible. If you have any questions I can be reached at 609-893-8141, ext.
Sincerely,

**PEMBERTON TOWNSHIP SCHOOLS**
**P.O. Box 228**
**Pemberton, NJ 08068**

## DIABETES MEDICAL MANAGEMENT PLAN CONTACT INFORMATION

**Effective Dates:**_____

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.

Student's Name:_____

Date of Birth:_____ Date of Diabetes Diagnosis:_____

Grade:_____ Homeroom Teacher:_____

Physical Condition: _____Diabetes type 1 _____Diabetes type 2

## CONTACT INFORMATION

Mother/Guardian:_____

Address:_____

Telephone: Home_____ Work_____ Cell_____

Father/Guardian:_____

Address:_____

Telephone: Home_____ Work_____ Cell_____

Student's doctor/Health Care Provider:

Name:_____

Address:_____

Telephone:_____ Emergency Number:_____

Other /Emergency Contacts:

Name:_____

Relationship:_____

Telephone: Home_____ Work_____ Cell_____

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

_____

**PEMBERTON TOWNSHIP SCHOOLS**
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## DIABETES MEDICAL MANAGEMENT ORDERS FOR INSULIN SYRINGE AND PEN

**ame:**_____ **Physician:**_____

**DOB:**_____ **Date: of Diagnosis:**_____

**Target Range:**_____

| | | |
|---|---|---|
| Can student give own injection? | _____Yes | _____No |
| Can student determine correct amount of insulin? | _____Yes | _____No |
| Can student draw correct dose of insulin? | _____Yes | _____No |
| Can student perform own blood glucose checks? | _____Yes | _____No |

Exceptions:_____

Your student is under our care for diabetes.

Please check (or let the student check) the glucose level:

a. ___whenever he/she thinks it is too low or too high, or exhibits signs/symptoms of high or low BS
b. ___every day before lunch
c. ___treat any glucose <70 with _____ grams carbohydrate ( add protein if student will not be eating within an hour)
d. ___please maintain a record of BS values and send it home weekly
e. ___if the student becomes unconscious please administer glucagon, 1 mg SC or IM --- or 0.5 mg if student is less than 44 pounds, (FYI – high and low glucose can be treated in school; students should not be sent home unless ill)
f. ___student my provide self treatment in any area of school/school grounds
g. ___check urine ketones if B/S >300 or if student feels ill. Call parent if ketones moderate/large.

Treatment for ketones:_____

h. ___Please allow the student free access to the water fountain or use of a water bottle in class
i. ___Please allow the student free, unlimited access to the bathroom

Usual lunchtime dose:_____

This student's lunchtime scale for:_____ insulin SC is:
(type of insulin)

| Glucose | Insulin to give | | |
|---|---|---|---|
| Under 200 | **NONE** | | 1 unit for every _____gms of carbohydrate, |
| 200-250 | _____units | | AND |
| 251-300 | _____units | | 1 unit for every _____mg/dl over _____mg/dl |
| 301-350 | _____units | **OR** | Round numbers down |
| 351-400 | _____units | | May use preprinted scales ("cheat Sheet") |
| Over 400 | _____units | | |

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.

**For Students Taking Oral diabetes Medications**

Type of medication:_____Timing:_____
Other medications:_____Timing:_____

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## DIABETES MEDICAL MANAGEMENT ORDERS FOR INSULIN PUMP

**Name:**_____ **Physician:**_____

**DOB:**_____ **Date: of Diagnosis:**_____

**Target Range:**_____

| | | |
|---|---|---|
| Can student give own injection? | _____Yes | _____No |
| Can student determine correct amount of insulin? | _____Yes | _____No |
| Can student draw correct dose of insulin? | _____Yes | _____No |
| Can student perform own blood glucose checks? | _____Yes | _____No |

Exceptions:_____

Your student is under our care for diabetes.

Please check (or let the student check) the glucose level:

a. ___whenever he/she thinks it is too low or too high, or exhibits signs/symptoms of high or low BS
b. ___every day before lunch
c. ___treat any glucose <70 with _____ grams carbohydrate (add protein if student will not be eating within an hour)
d. ___please maintain a record of BS values and send it home weekly
e. ___please administer glucagon, 1 mg SC or IM, if the student becomes unconscious (high and low glucose can be treated in school; students should not be sent home unless ill)
f. ___check urine ketones if B/S >300 or if student feels ill. Call parent if ketones moderate/large.

Treatment for ketones:_____

g. ___Please allow the student free access to the water fountain or use of a water bottle in class
h. ___Please allow the student free, unlimited access to the bathroom

**For Students With Insulin Pumps**

Type of pump:_____ Basal rates:_____ 12am 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 carbohydrate 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 |
| Troubleshooting alarms and malfunctions | _____Yes | _____No |

**(Please turn over and complete order on back of page)**

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## DIABETES MEDICAL MANAGEMENT ORDERS FOR INSULIN PUMP (continued)

In the event of Pump Malfunction follow this scale:

This student's lunchtime scale for:_____ insulin s.c. is:
(type of insulin)

| Glucose | Insulin to give |
|---|---|
| Under 200 | **NONE** |
| 200-250 | _____units |
| 251-300 | _____units |
| 301-350 | _____units |
| 351-400 | _____units |
| Over 400 | _____units |

**OR**

1 unit for every _____gms of carbohydrate,
AND
1 unit for every_____mg/dl over_____mg/dl
Round numbers down
May use preprinted scales ("cheat sheet")

## DIABETES MEDICAL MANAGEMENT ORDERS

### 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

Please allow the student to participate in all activities. □ Yes □ No
A fast acting carbohydrate such as _____ should be available at the site of exercise or sport.
Restrictions on activity, if any: _____
Students should not exercise if blood glucose level is below _____mg/dl or above _____mg/dl or if moderate to large urine ketones are present
Check all that applies to exercise

- □ check BS before exercise
- □ check BS after exercise
- □ only check when student exhibits symptoms of hyper or hypo glycemia

### Transportation

Blood Glucose needs to be checked before getting on bus □ Yes □ No
Blood Glucose before getting on bus must be greater than: _____
Date of notification to school bus driver _____
School bus driver trained on:

1. How to treat hypoglycemia
2. Who to contact in an emergency; call 911
3. Provided contact information

### Special Instructions for Field Trips □ Yes □ No

_____

_____

_____

## DIABETES MEDICAL MANAGEMENT ORDERS

### Parent Responsibilities

1. Parent/Guardian to keep school nurse informed of all current and/or changes in Diabetes Management Program/Insulin Scales.
2. Parent to provide school nurse with updated emergency contact information.
3. Parent will notify the school nurse regarding before school and after school activities such as programs, clubs and sports at least 1 week before attending.
4. Parent to provide the following supplies to be kept at school:

____Blood glucose meter, blood glucose test strips, batteries for meter
____ Lancet device, lancets, gloves, etc.
____ Urine ketone strips
____ Insulin vials and syringes
____ Bottled water
____ Insulin pump and supplies
____ Insulin pen, pen needles, ____insulin cartridges
____Carbohydrates containing snack
____ Glucagon emergency kit
____Emergency to go kit (juice box, carbohydrate snack, glucose tablets, glucagon) *to travel with student

**Hypoglycemia (Low Blood Sugar)**

Usual symptoms of hypoglycemia: See emergency plan_____

_____

Treatment of hypoglycemia: _____

_____

Glucagon should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow. Route ____, Dosage_____, site for glucagon injection: _____arm, _____ thigh, _____ other.

If Glucagon is required, administer it promptly. Then call 911 (or other emergency assistance).

**Hyperglycemia (High Blood Sugar)**

Usual symptoms of hyperglycemia: See emergency plan_____

_____

Treatment of hyperglycemia: _____

_____

Urine should be checked for ketones when blood glucose levels are above _____mg/dl.

Treatment for ketones_____

**These Diabetes Medical Management Orders have been approved by:**

_____ Date_____

**Physician's Signature**

**Physician's Office Stamp:** ⇨

**Physician's Contact Information:**

Phone #:_____ Fax #:_____

Days and times at this office:_____

Office Address:_____

Emergency Availability number if different from above:_____

**These Diabetes Medical Management Orders have been reviewed by:**

School Nurse:_____ Date:_____

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## Diabetes Emergency Healthcare Plan - Hypoglycemia (Low Blood Sugar)

Name:_____ Date of Birth:_____

**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
- ☐ Dizziness
- ☐ Sweating
- ☐ Drowsiness
- ☐ Personality change
- ☐ Inability to concentrate
- ☐ Irritability
- ☐ Other__

**Moderate**
- ☐ Headache
- ☐ Behavior Change
- ☐ Poor Coordination
- ☐ Confusion
- ☐ Blurry Vision
- ☐ Weakness
- ☐ Slurred Speech
- ☐ Other__

**Severe**
- ☐ Loss of consciousness
- ☐ Seizure
- ☐ Inability to swallow

**Actions Needed**
**Notify School nurse or Trained Diabetes Personnel. If possible, check blood sugar, per diabetes Medial Management plan. When in doubt, always TREAT FOR HYPOGLYCEMIA.**

**Mild**
- ☐ Student may/may not treat self
- ☐ Provide quick-sugar source
- ☐ Seizure
- ☐ 3-4 glucose tablets
  or
- ☐ 4 oz. juice
  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.i., 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 glucagons, as prescribed
- ☐ **Call 911**
- ☐ **Contact parents/guardian**
- ☐ **Stay with student**
- ☐ Above or equal to 44 pounds – give 1 mg IM/IV/SC
- ☐ Below 44 pounds or below 6-8 yrs of age give 0.5mg IM/IV/SC (may repeat 1 dose after 15 mins. if no response while waiting for emergency assistance)

****During emergency Evacuations, "To-Go" Kit required to remain with student (Teacher or Student may carry)**

| | | | |
|---|---|---|---|
| *Physician Stamp* | *Date* | *Parent/Guardian Signature* | *Date* |
| *Physician Signature* | *Date* | *Designated Staff* | *Date* |
| *School Nurse Signature* | *Date* | *Bus Driver Signature* | *Date* |
| *Other* | *Date* | *Other* | *Date* |

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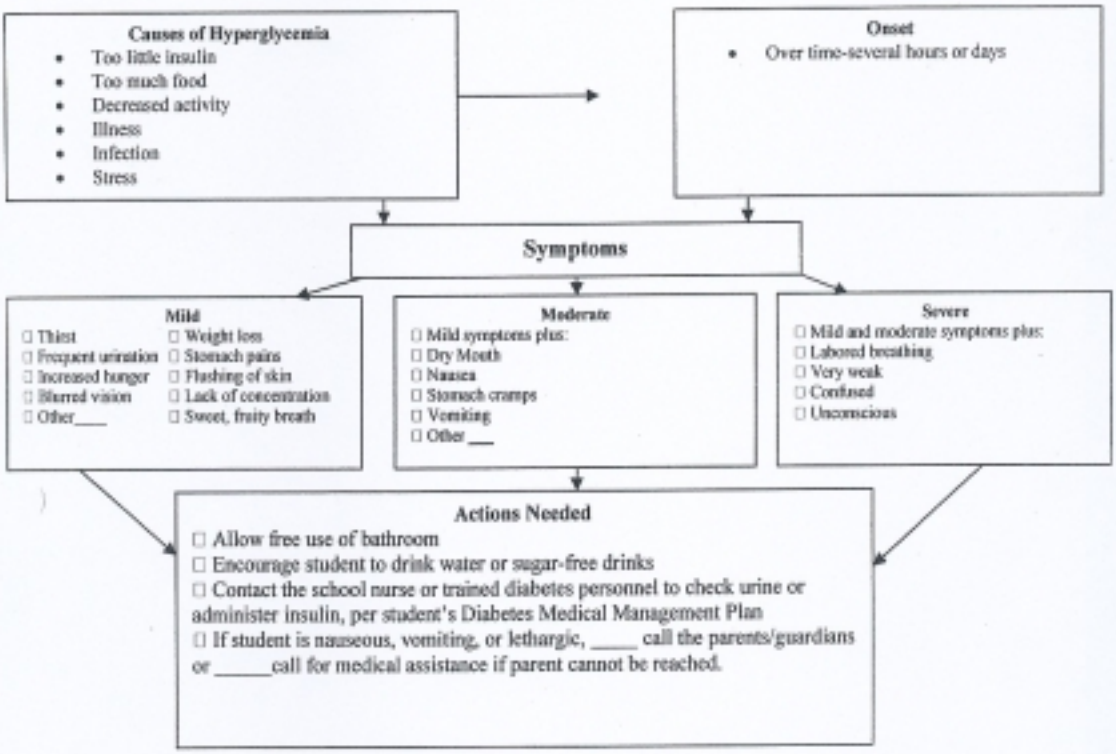
## Diabetes Emergency Healthcare Plan - Hyperglycemia (High Blood Sugar)

Name:_____ Date of Birth:_____




| | | | |
|---|---|---|---|
| *Physician Stamp* | *Date* | *Parent/Guardian Signature* | *Date* |
| *Physician Signature* | *Date* | *Designated Staff* | *Date* |
| *School Nurse Signature* | *Date* | *Bus Driver Signature* | *Date* |
| | *Date* | *Other* | *Date* |

## Parent Signatures for Authorization for Services, Release of Information Permission for Care and Acknowledgement of No Liability

### *Parent Approval for Services, DMMPO, IHP and IEHP*

I give permission to the school nurse to perform and carry out the diabetes care tasks outlined in the Diabetes Medical Management Plan/Orders (DMMPO), 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 _____ and _____ to serve as the trained Gucagon 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. **Note: A student may have more than one or two delegates in which case, this needs to be signed for each delegate.**

_____ _____

Parent/Guardian Signature Date

### *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.

_____ _____

Parent/Guardian Signature Date

### *Acknowledgement of No Liability*

I have been informed that "no school employees, including the school nurse, bus driver, bus aide or other officer or agent of the board of education shall be held liable for any good faith act or omission consistent with the provisions of this act nor shall any 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 (trained delegate) by the school nurse pursuant to the law." [State of NJ Department of Education – Guidelines for the Care of Students with Diabetes in the School Setting/Frequently Asked Questions]

_____ _____

Parent/Guardian Signature Date

**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/Orders.

## INDIVIDUALIZED HEALTHCARE PLAN SERVICES AND ACCOMODATIONS AT SCHOOL AND SCHOOL-SPONSORED EVENTS

Student's Name:_____ DOB:_____

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
Case Manager if yes:_____

Does this child have a 504 Plan? [ ] Yes [ ] No

Does this child have a Glucagon Designee [ ] Yes [ ] No
If yes, name and phone number :_____

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Does this student participate in any of the following activities? Check all programs that apply:

[ ] Before School Program
Date Before School Program was notified of Emergency Plan:_____

[ ] After School Program or Clubs -Name of Club:_____
Date After School Program/Club was notified of Emergency Plan:_____

[ ] After School Sports
Date After School Sports/coach was notified of Emergency Plan:_____

See attached Individual Health Care Plan developed by: _____ _____
School Nurse Signature Date

Individual Health Care Plan reviewed and agreed by Parent: _____ _____
Parent Signature Date