Warren Township School District Diabetes IHCP

Date of Plan: _____

Diabetes Health 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: _____

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: _____

_____

_____

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 student uses: _____

_____

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

Parental authorization should be obtained before administering a correction dose for high blood 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

Parents are authorized to adjust the insulin dosage under the following circumstances:

_____

_____

For 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

In the event of pump malfunction follow this scale:

Type of Insulin_____

Glucose	**Insulin to give**		
Under 200	NONE		
200-250	_____ units		1 unit for every _____ gms of carb.
251-300	_____ units		AND
301-350	_____ units	**OR**	1 unit for every _____ mg/dl over
351-400	_____ units		_____ mg/dl
Over 400	_____ units		

For Students Taking Oral Diabetes Medications

Type of medication: _____ Timing: _____

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

_____

Special instructions for field trips _____Yes _____ No

_____

Exercise and Sports

A fast-acting carbohydrate such as _____ 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 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) and the parents/guardian.**

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

_____Blood glucose meter, blood glucose test strips, batteries for meter

_____ Lancet device, lancets, gloves, etc.

_____Urine ketone strips

_____Insulin pump and supplies

_____Insulin pen, pen needles, insulin cartridges

_____Fast-acting source of glucose

_____Carbohydrate containing snack

_____Glucagon emergency kit

Signatures

This Diabetes Health Management Plan has been approved by:

_____ _____

****Student's Physician/Health Care Provider** Date

****Physician Stamp**:

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 Health Management Plan. I also consent to the release of the information contained in this Diabetes Health 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.

Acknowledged and received by:

_____ _____

Student's Parent/Guardian Date

This Diabetes Health Management Plan has been reviewed by:

_____ _____ **School**

Nurse **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**

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.

_____ _____

Student's Parent/Guardian **Date**

Warren Township School District

Authorization for students to carry and self-administer Insulin

Name of Student: _____ Grade: _____ Year: _____

As per N.J.S.A. 18A:40-12.13 Boards of Education are authorized to permit self-administration by a pupil for the self-management and care of his/her diabetes with the written authorization by parent and MD or advanced practice nurse(APN). Furthermore, the MD or APN will provide written certification to the Board of Education that the student is capable of, and has been instructed in the management of his /her diabetes.

The privilege of self-administration of medication may be revoked if the pupil fails to comply with school policy and/or violates the tenets of the agreement to self-medicate. I understand and agree in making this request that neither Warren Township School District nor its staff shall incur liability as a result of any injury/reaction arising from the self-medication. This permission is effective for the current school year.

For MD completion:

The parents/guardians of _____ have designated me as his/her private physician. The student has been diagnosed with **DIABETES MELLITUS,** a potentially life-threatening illness. He/she is capable of, and has been instructed in, the proper method of self-administration of **INSULIN:** _____(exact type/name).

_____ _____

Physician's Signature Date

Physician's Stamp

For Parent/Guardian Completion:

I/we_____, the parents of _____

authorize the self-administration of **INSULIN** _____(exact type/name) during the _____school year as certified above by our physician. I/we recognize that the Warren Township BOE and its employees shall have no liability for any injury arising from the self-administration of this medication.

_____ _____

Parent/Guardian Signature Date

Revised: 11/11