WATCHUNG HILLS
REGIONAL HIGH SCHOOL

ELIZABETH C. JEWETT, PHD
SUPERINTENDENT

TIMOTHY M. STYS, CPA
BUSINESS ADMINISTRATOR

WILLIAM J. LIBRERA
PRINCIPAL

Dear Parent/Guardian,

You have indicated in school records that your child has an ongoing health need that may require medication and/or treatment during the school day. Please see your physician to have the appropriate action plan completed and signed and submit it to the health office prior to the first day of school.

New Jersey State Law requires your healthcare provider's written order and parent/guardian authorization for a nurse to administer medications. Medications must be in pharmacy –prepared containers and labeled with the name of the student, name of the drug, strength, dosage, frequency, name of physician, date of original prescription. In the event of an emergency other staff may need to care for your child until medical personnel arrives. Please read and sign below if you agree to share medical information with WHRHS staff for your child.

I give permission to the school nurse, trained personnel, and other designated staff members of Watchung Hills Regional High School to perform and carry out the necessary care tasks as outlined by N.J.S.A 18A:40-12.11-21, referring to the administration of Glucagon, and N.J.S.A.18A:40-12.5 for the administration of epinephrine via a pre-filled auto-injector mechanism. I also consent to the release of information contained in this Medical Management Plan to all staff members and other adults who have custodial care of my child during the school day and during school sponsored events who may need to know this information to maintain my child's health and safety.

Please send/bring completed forms and any medications or equipment to the Health office prior to or on the first day of school. This information enables the healthcare team at WHRHS to provide optimal care to your child in the event of an emergency. Your immediate attention to these matters is greatly appreciated. If you have any further questions please do not hesitate to contact the nurses at 908-647-4800.
Thank You

The School Nurses

Acknowledged and Received by:

_____
Student's Parent/Guardian

Date _____

WATCHUNG HILLS
REGIONAL HIGH SCHOOL

Elizabeth C. Jewett
Superintendent

Timothy M. Stys, CPA
Business Administrator

George P. Alexis
Principal

Diabetes Medical Management Plan/Individualized Healthcare Plan

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**