iLearn Health Office

Diabetes Medical Management Plan (DMMP), Individual Health Plan (IHP) (8 pages total)

School Year July 1, 20____ - June 30, 20____

Student: _____ School: _____

Date: _____ Grade: _____ HR Teacher: _____

Dear Parent/Guardian:

Attached are the Diabetes Medical Management Plan (DMMP), Individual Health Plan (IHP) and Individualized Emergency Healthcare Plan that will be developed by you, your physician and the school nurse. These plans are essential to ensure that your child's diabetes is effectively managed while in school. These will be shared with your child's teacher and appropriate school staff. Please contact us immediately if any of the information changes or your child is experiencing erratic or uncontrollable blood sugar levels. Thank you for your cooperation in this matter.

Below is an explanation of how to complete this form:

Diabetes Medical Management Plan/Individualized Healthcare Plan/Individualized Emergency Healthcare Plan

Part A: **Individualized Healthcare Plan/Individualized Emergency Healthcare Plan/Diabetes Management Plan** must be completed by the healthcare provider, and signed by parent and school nurse. A copy will be provided to your child's teacher(s).

Part B: **Glucagon Delegate Orders** must be completed by a physician..

Part C: **Authorizations for Services and Sharing of Information/Release of Information** must be signed by the parent/guardian

Part D: **Emergency Contact Information for Diabetes Medical Management Plan (DMMP)** must be completed by the student's physician or advanced practice nurse.

Part E: **Student Diabetes Supplies** must be signed by the parent/guardian

If you have any questions, you may contact me anytime.

Sincerely,

School Nurse

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Part B – Glucagon Delegate Orders – Individualized Emergency Healthcare Plan (IEHP)

Student's Name: _____ Date of Birth: _____

School _____ Grade: _____ Homeroom Teacher: _____

If the above student is suspected of having low blood sugar (hypoglycemia), if possible, check blood sugar. Refer to symptoms on the back of this sheet.

Child specific symptoms of low blood sugar are:

_____

Never send a child with suspected low blood sugar anywhere alone. When in doubt, always treat for hypoglycemia as follows:

1. Provide quick-sugar source (check what applies):
   - 3-4 glucose tabs
   - 4 oz. juice
   - 6 oz. regular soda
   - 3 tsp. glucose gel
2. Inform the school nurse.
3. Wait 10-15 minutes and recheck blood glucose (if possible).
4. If symptoms persist, give a repeat dose of a quick-sugar source.
5. Follow with a snack of carbohydrates and protein.

If any of the following symptoms of severe hypoglycemia occur:

- Loss of consciousness
- Seizure
- Inability to swallow
  1. Do not attempt to give anything by mouth
  2. Position on the side, if possible
  3. Contact a school nurse or trained diabetes personnel
  4. If a nurse is unavailable, the trained delegate will administer glucagon _____ dose
  5. Preferred site by injection: ____ arm ____ thigh
  6. Call 911
  7. Contact parents/guardian
  8. Stay with student

Physician's Stamp:

_____ _____

Physician's Signature Physician's Date:

Parent/Guardian signature: _____ Date: _____

Delegate's signature: _____ Date: _____

Nurse's signature: _____ Date: _____

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9Part C – Authorization for Services and Release of Information

Student's Name: _____ Date of Birth: _____

School _____ Grade: _____ Homeroom Teacher: _____

Physician's Name: _____ Phone Number: _____

Physician's Address: _____ Town: _____

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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.

_____	_____	_____
Parent/Guardian Signature	Print name	Date

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Permission for Glucagon Delegate/Immunity from Liability

I give permission to the trained glucagon delegate 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.

_____	_____	_____
Parent/Guardian Signature	Print name	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	Print name	Date

School Year July 1, 20____ - June 30, 20____

Part D - Emergency Contact Information Form
Diabetes Medical Management Plan (DMMP)

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

Date of Plan: _____ This plan is valid for the current school year: _____ - _____

Student's Name: _____ Date of Birth: _____

Date of Diabetes Diagnosis: _____ □ type 1 □ type 2 □ Other_____

School _____ Grade: _____ Homeroom Teacher: _____

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PART E - STUDENT DIABETES SUPPLIES

Student's Name: _____ Date of Birth: _____

School _____ Grade: _____ Homeroom Teacher: _____

Parents are responsible for providing all necessary diabetes supplies.

Please check below:

Insulin Supplies

- Insulin bottle(s) ☐
- Insulin syringes ☐
- Alcohol wipes/antiseptic wipes (optional) ☐
- Insulin pen(s) with cartridge loaded ☐
- Pen needles ☐
- Alcohol wipes (optional) ☐

Ketone Supplies

- Urine ketone test strips ☐

Insulin Pump ☐ Pump Type _____

- Insulin pump supplies _____ ☐

Blood Sugar Testing Supplies

- Blood glucose meter and manufacturer's instructions ☐
- Test strips (with code information, if needed) ☐
- Fingerstick device ☐
- Lancets ☐
- Continuous Glucose Monitor (GCM) if ordered ☐ GCM type _____
- Student cell phones for GCM screening purposes only ☐

Hypoglycemia/Food Supplies ☐

- Please indicate supplies given (glucose tablets, juice, and carbohydrate/protein snack or other)
  - _____

Please provide adequate supplies to be given to designated staff in case of an emergency.

_____ _____ _____

Parent/Guardian Signature Print name Date