

Date of Plan:

Diabetes Medical Management Plan

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:

Diabetes Medical Management Plan *Continued*

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 (highlight type of rapid-/short-acting insulin used) is _____ units or doses flexible dosing using _____ units/ _____ grams carbohydrate.

Use of other insulin at lunch: (highlight 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:

Diabetes Medical Management Plan *Continued*

Student Pump Abilities/Skills:

Needs Assistance

Count carbohydrates	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bolus correct amount for carbohydrates consumed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculate and administer corrective bolus	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculate and set basal profiles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Calculate and set temporary basal rate	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Disconnect pump	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reconnect pump at infusion set	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prepare reservoir and tubing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Insert infusion set	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Troubleshoot alarms and malfunctions	<input type="checkbox"/> Yes	<input type="checkbox"/> No

For Students Taking Oral Diabetes Medications

Type of medication: _____ Timing: _____

Other medications: _____ Timing: _____

Meals and Snacks Eaten at School

Is the student independent in carbohydrate calculations and management? Yes No

<i>Meal/Snack</i>	<i>Time</i>	<i>Food content/amount</i>
Breakfast	_____	
Mid-morning snack	_____	
Lunch	_____	
Mid-afternoon snack	_____	
Dinner	_____	

Snack before 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

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.

Diabetes Medical Management Plan *Continued*

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

- | | |
|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| <input type="checkbox"/> Blood glucose meter, blood glucose test strips, batteries for meter | <input type="checkbox"/> Insulin pump and supplies |
| <input type="checkbox"/> Lancet device, lancets, gloves, etc. | <input type="checkbox"/> Insulin pen, pen needles, insulin cartridges |
| <input type="checkbox"/> Urine ketone strips | <input type="checkbox"/> Fast-acting source of glucose |
| <input type="checkbox"/> Insulin vials and syringes | <input type="checkbox"/> Carbohydrate containing snack |
| | <input type="checkbox"/> Glucagon emergency kit |

Signatures

This Diabetes Medical Management Plan has been approved by:

Student's Physician/Health Care Provider: _____ Date:

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

Student's Parent/Guardian: _____ Date: