



Student Name: _____

DOB: _____

Name:	DOB:	Grade:
Parent/Guardian:	Phone #:	School:
MD/Endocrinologist:	Phone #	fax#

Medical Diagnosis: Diabetes Type 1 or Type 2 (please circle one)

Diabetic History:

Age of diagnosis: _____ Routine Management Target Blood Glucose Range _____ to _____

Emergency Notification

Notify parents of the following conditions.

- Loss of Consciousness or seizure (convulsion)* Call parent immediately after Glucagon given & 911 called
- Blood sugars over _____ mg/dl
- Moderate to large Urine Ketones
- Abdominal pain, nausea/vomiting, diarrhea, fever, altered breathing or altered level of consciousness
- Other: _____

*If unable to reach parent/guardian call emergency contact number: _____

Blood Glucose Monitoring:

Continuous Glucose Monitoring Yes No details: _____

Blood Glucose Monitoring: Yes No Meter: _____

If yes, can student perform own blood glucose checks? Yes No Needs Supervision: Yes No

Student Interprets results: Yes No Document result and send copy home weekly Yes No

Times to be performed: Before Breakfast Before PE/Activity _____

Mid-morning: before snack After PE/Activity _____

Before Lunch Mid-afternoon _____

Dismissal As needed for signs/symptoms of low/high blood glucose

Place to be performed: Classroom Clinic/ Health Room Other _____

Call parent if blood glucose values are below _____ or above _____.

Insulin/Medications at School:

Insulin Injections during school: Yes No

If Yes: Can Student -Determine correct dose? Yes No Draw Up own dose? Yes No

-Give own injections? Yes No Need Supervision? Yes No



Insulin Delivery: Pen Pre-Drawn syringe Syringe/via Pump

*for dosing see insulin dosing guidelines

For Students with Insulin Pumps:

Type of pump: _____ Basal Rates: _____ from _____ to _____
 _____ from _____ to _____
 _____ from _____ to _____

Type of insulin in pump: _____

Type of infusion set: _____

Insulin/Carbohydrate ratio: _____ Correction Factor: _____

Student Pump Abilities/ Skills	Needs Assistance (circle)	
Count Carbohydrates.....	yes	no
Bolus Correct amount for carbohydrates consumed	yes	no
Calculate and administer corrective bolus.....	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
Trouble shoot alarms and malfunctions.....	yes	no

Other routine Diabetes medications at school: Yes No

Name of Medication: _____	Dose: _____	Time: _____	Route: _____
_____	_____	_____	_____
_____	_____	_____	_____

Sliding Scale: Blood Glucose Correction and Insulin Doseage using (Rapid Acting) Insulin:

Blood Glucose Range _____ mg/dl Administer _____ units

Blood Glucose Range _____ mg/dl Administer _____ units

Blood Glucose Range _____ mg/dl Administer _____ units

Blood Glucose Range _____ mg/dl Administer _____ units and check ketones

Blood Glucose Range _____ mg/dl Administer _____ units and check ketones

Blood Glucose Range _____ mg/dl Administer _____ units and check ketones



Blood Glucose Range _____ mg/dl Administer _____ units and check ketones

Insulin to Carbohydrate Ratio _____ unit(s) for every _____ grams of carbohydrates (or to be) eaten

▷ Parent/guardian authorized to increase or decrease sliding scale +/-2 units of insulin.

▷ Parent/guardian authorized to increase or decrease insulin to carbohydrate count with the following range: 1 unit per prescribed grams of carbohydrates +/-5 grams of carbohydrates.

Meals and Snacks Eaten at School:

Meals/Snacks: 1 Carb serving= 15 grams of carbohydrates

- Student can independently count carbohydrates
- Needs assistance with carbohydrate counting for snacks and meals

Morning & Snack Plan

	<input type="checkbox"/> Carb servings or <input type="checkbox"/> Carbohydrate Grams eaten at meal or snack	
Meal/ Snack	Amount:	Time:
Breakfast		
Mid-morning snack		
Lunch		
Mid-afternoon snack		

In addition to the above meal plan the student may require an extra snack:

- Before gym after gym only when needed

Location where snacks are kept: _____

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 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.



Hypoglycemia (Low Blood Sugar):

Usual symptoms of hypoglycemia: _____

Treatment of hypoglycemia: _____

Glucagon administration:

Glucagon should be given if the student is unconscious, having a seizure, or unable to swallow.

Route: _____ Dosage: _____ Site: _____

If glucagon is required, administer it promptly. Then call 911 and the guardian/ parents.

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: _____

Diabetes Care Supplies:

While in school or at school- sponsored activities, the student is required to have available the following diabetic supplies (check all that apply):

- Blood Glucose Meter, test strips, batteries for meter
- Lancet Device, lancets
- Urine Ketone Strips
- Insulin Pump and Supplies
- Glucagon Emergency Kit
- Other (Please Specify) _____
- Insulin Pen, pen needles, insulin cartridges, syringes
- Fast-Acting source of glucose
- Carbohydrate containing snack
- Bottled Water

The school district will supply gloves for caregivers and a sharps box



PHYSICIAN CONSENT FOR DIABETES MANAGEMENT DMMP

I have reviewed and approved the Diabetes Management IHP and have included any recommended modification. I understand that specialized physical health care services for Diabetic Medical Management Plan will be performed by trained personnel. This consent is for a maximum of one year.

This school plan will expire on: _____

Practitioner Name (Print): _____

Practitioner Signature: _____ Date: _____

Signatures:

As parent/guardian of the above named student, I give permission to the school nurse and other designated staff to perform and carry out the diabetes tasks outlined in the Individualized Health Plan (IHP) and for my child's healthcare provider to share information with the school health coordinator for the completion of this plan. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the school nurse whenever there is any changes in the student's health status or care. Parents/Guardian and student are responsible for maintaining necessary supplies, snack, blood glucose monitor, medications and equipment.

Student's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

School Nurse Or Designee: Signature: _____ Date: _____

This document follows guidelines and principles outlined by the American Diabetes Association.