SCHOOL HEALTH SERVICES
Diabetes Medical Management Plan

Parent/Guardian:

Please complete the following information along with your child's diabetic healthcare provider to assist the school nurse in developing an individualized health plan for your child. If you would like to discuss the plan, please call the school nurse.

Student Name: _____ DOB: _____ Grade: _____
Age of Diabetes Diagnosis: _____ Diabetes Type: □ Type 1 □ Type 2

Contact Information

Mother/Guardian: _____
Name
Phone: (h) _____ (w) _____ (cell) _____

Father/Guardian: _____
Name
Phone: (h) _____ (w) _____ (cell) _____

Physician/Healthcare Provider: _____
Name
Phone: _____ emergency number _____

Other Emergency Contacts:
1. _____ _____
Name relationship
Phone: _____

2. _____ _____
Name relationship
Phone: _____

Notify parent/guardian or emergency contact in following situations:
_____
_____

Diabetes Management Plan for: _____

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 readings *(check all that apply)*

- □ Before exercise
- □ After exercise
- □ When student exhibits symptoms of hypoglycemia
- □ When student exhibits symptoms of hyperglycemia
- □ Other (explain) _____

Can student perform own blood glucose checks? □ Yes □ No
Exceptions: _____
Where do you prefer student to do blood glucose checks?
□ Health Office □ Classroom □ Other _____
Type of glucose monitor used by student _____

Insulin

Usual Lunchtime Dose:

Rapid/short acting insulin - Humalog/Novalog/Regular *(circle type)*
Base dose _____ units - or - flexible dosing _____units/_____grams/carbohydrate
Use of other insulin *(circle type and note amount)*
Intermediate/HPH/lente _____units
Basal/Lantus/Ultralente _____units

Insulin Correction Doses:

_____ 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
Is parental authorization required before administering correction dose? □ Yes □ No
Can student give own injections? □ Yes □ No
Can student draw correct dose of insulin? □Yes □ No
□ Parents are authorized to adjust insulin dosage under the following circumstances: _____
_____

For Student with Insulin Pump

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 Management Plan for: _____

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
Disconnect pump	□ Yes □ No
Reconnect pump at infusion set	□ Yes □ No
Prepare reservoir and tubing	□ Yes □ No
Insert infusion pump	□ Yes □ No
Troubleshoot alarms and malfunctions	□ Yes □ No

For Students Taking Oral Diabetes Medications

Type of medication: _____ Times: _____
Other medications: _____ Times: _____

School Snacks

Is student independent in carbohydrate calculations and management? □Yes □ No
(If no, complete following snack information)

Snack	*Time*	*Food content/amount*
Mid-morning	_____	_____
Mid-afternoon	_____	_____

Snack before exercise? □ Yes □ No
Snack after exercise? □ Yes □ No
Other times for snacks and content/amount: _____
Preferred snack foods: _____
Foods to avoid, if any: _____
Instructions for food in class (e.g. as part of 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.

Hypoglycemia (Low Blood Sugar)

Usual symptoms of hypoglycemia: _____
_____
Treatment of hypoglycemia: _____
_____
Glucagon should be given if the student is unconscious, having a seizure, or unable to swallow.
Route _____, Dosage _____, site for glucagon injection: □ arm □ thigh □ other
If glucagon is required, administer it promptly. Then call 911 and parent(s)/guardian.

Diabetes Management Plan for: _____

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, test strips, battery
- ☐ Lancet device and lancets
- ☐ Urine ketone strips
- ☐ Insulin vials and syringes
- ☐ Insulin pump and supplies
- ☐ Insulin pen, pen needles, insulin cartridges
- ☐ Fast-acting source of glucose
- ☐ Carbohydrate containing snack
- ☐ Glucagon emergency kit *(Note: must be accompanied by MD script)*

Signatures
This Diabetes Medical Management Plan has been approved by:

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

I give permission to the school nurse and other designated staff members of Hampton Township School district to perform and carry out diabetes care tasks as outlined by this Diabetes Medical Management Plan. I also consent to the release of the information contained in 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.

_____ _____
Student's Parent/Guardian **Date**