## Diabetes Management Plan

**Effective Dates: ______________________

<table>
<thead>
<tr>
<th>Student</th>
<th>Date of Birth</th>
<th>Parent/Guardian</th>
<th>Date</th>
<th>Phone Number</th>
<th>Parent/Guardian</th>
<th>Phone Number</th>
<th>Grade</th>
<th>School Year</th>
<th>Parent/Guardian</th>
<th>Phone Number</th>
<th>Teacher/Advisor</th>
<th>School Year</th>
<th>Transportation to and from school</th>
<th>Bus</th>
<th>Car</th>
<th>Walk</th>
<th>Bus #</th>
</tr>
</thead>
<tbody>
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</table>

**Parent/Guardian**: Complete this plan with the assistance of your child's Health Care provider and the School Nurse. The diabetes care plan requires the signature of the student's parent/guardian and the Health Care provider. Return the completed, signed plan to Cannon School. Attach other instructions/forms if needed.

**Health Care Provider**: Review this diabetes care plan and make any necessary changes or additions. Sign and return the plan to the parent/guardian or school.

**Diabetes Care Managers @ school & location**: ______________________

**Location of Diabetes supplies at school**: ______________________

**Does the student wear a medic alert?** Yes No

**Physical Condition**:  
- Diabetes type 1
- Diabetes type 2

### Student’s Doctor/Health Care Provider

- **Name**: ______________________
- **Address**: ______________________
- **Telephone**: ______________________
- **Emergency Number**: ______________________
- **Fax Number**: ______________________

### Blood Glucose Testing

- **Target range for blood glucose** is _____ to _____
- **Type of blood glucose meter**: ______________________
- **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**: ______________________

**Contact parent if blood sugar is below or above other**: ______________________

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American Diabetes Association

Cure • Care • Commitment®

CANNON SCHOOL
DIABETES ACTION PLAN FORM

This coversheet is **ONLY** for the form and student listed above and **MUST BE RECEIVED** for processing.

**DO NOT** use staples or paperclips!

Please print and complete this form then submit all pages including this coversheet via:

<table>
<thead>
<tr>
<th>FAX</th>
<th>MAIL</th>
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</thead>
<tbody>
<tr>
<td>(877) 447-9530</td>
<td>Magnus Health Does Not Accept Mailed Forms</td>
</tr>
</tbody>
</table>

Outside of the United States? Please fax to (978) 244-8894
Insulin

Usual Lunchtime Dose
My child's insulin is administered via ☐ needle/syringe ☐ insulin pen ☐ insulin pump ☐ other
Base dose of Humalog/Novolog /Regular/Apidra insulin at lunch (circle type of 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.

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
Where is insulin kept at school? ____________________________________________________________
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 ___

Type of insulin in pump: _____________________________
Type of infusion set: _____________________________
Insulin/carbohydrate ratio: _____________________________ Correction factor: _____________________________
User's manual for insulin pump will be provided to the school nurse ☐ Yes ☐ No
Back-up means of insulin administration: ______________________________________________________

Student Pump Abilities/Skills

<table>
<thead>
<tr>
<th>Needs Assistance</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Counting carbohydrates</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Bolus correct amount for carbohydrates consumed</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Calculate and administer corrective bolus</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Calculate and set basal profiles</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Calculate and set temporary basal rate</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Disconnect pump</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Reconnect pump at infusion set</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Prepare reservoir and tubing</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Insert infusion set</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Troubleshoot alarms and malfunctions</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
For Students Taking Oral Diabetes Medications

Type of medication: ____________________ Time Given: ____________
Other medications: ____________________ Time Given: ____________

Meals and Snacks Eaten at School

Is student independent in carbohydrate calculations and management? 0 Yes 0 No
Will student be eating lunch or snacks purchased from school? 0 Yes 0 No

<table>
<thead>
<tr>
<th>Meal/ Snack</th>
<th>Time</th>
<th>Food content/ amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast</td>
<td></td>
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<tr>
<td>Mid-morning snack</td>
<td></td>
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<tr>
<td>Lunch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mid-afternoon snack</td>
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</tbody>
</table>

If student requires assistance counting carbs when he/she brings a bag lunch from home, parents are responsible for writing down the number of carbs that they packed and sending a note with the student with that information included.

Student will carry a snack in his/her backpack and be permitted to eat a snack in the classroom and/or on the bus as needed.

Snack before exercise? 0 Yes 0 No
Snack after exercise? 0 Yes 0 No
Other times to give snacks and content/amount:

Preferred snack foods: ____________________________________________________________
Foods to avoid, if any: ____________________________________________________________
Extra snacks will be stored in 0 School Nurse’s office 0 Backpack 0 Classroom 0 other

The child with Diabetes can participate in parties just as other children do. The teacher will notify the parent/guardian when a party or other activity will take place and include information about the foods that will be served so that parents can decide with their child what he/she will plan to eat.

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event):

Bathroom

Allow bathroom privileges without restriction.

Exercise and Sports

PE days and time(s): ____________________ ____________________
Does student require a snack prior to exercise? 0 Yes 0 No
A fast-acting carbohydrate such as ____________________ should be available at the site of exercise or sports.
My child participates on the following sports team(s) at school: ____________________
My child participates in the following Cannon School after school activities:
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.

Field Trip

The child’s meter, insulin, Glucagon, and a sugar source should always accompany the child with Diabetes on any field trip.
Are there any necessary field trip accommodations for this child? Please list:


Hypoglycemia (Low Blood Sugar)

» Student should be sent to the School Nurse accompanied by an adult if symptomatic and BS<80mg/dl

» Test blood sugar-if blood glucose meter not available, treat symptoms.

» For BS<80mg/dl and symptomatic: Treat with 10-15 grams carbohydrates. Recheck BS in 15-20 minutes.

» Mild symptoms: Treat with juice, glucose tabs etc. Recheck and retreat blood glucose every 15-20 minutes until BS>80mg/dl

» Moderate symptoms: if unable to drink juice: Administer glucose gel. Recheck and retreat blood sugar every 15-20 minutes until BS>80mg/dl.

» Severe symptoms (which may include seizures or unconsciousness) or unable to take juice or gel. Administer Glucagon ___ mg(s) IM by trained staff and call 911. Disconnect pump and contact parent/guardian.

» Do not bolus for carbohydrates given to treat low blood sugar.

Usual symptoms of hypoglycemia: ___________________________________________

If the student exhibits signs/symptoms of low blood sugar, he/she should immediately check blood sugar and/or be accompanied to the School Nurse for assessment.

Additional treatment of hypoglycemia:

Hyperglycemia (High Blood Sugar)

» BS>300 mg/dl with ketones or 2 consecutive unexplained BS>250mg/dl (with or without ketones), may indicate a malfunctioning pump. Student may require insulin via injection and/or new infusion set.

» Contact parent, then healthcare provider if necessary, for bolus instructions. An order for insulin specific to the incident may be faxed from healthcare provider. Verbal orders may be taken only by the RN and only in the event a fax is unavailable.

» Check ketones if BS > ___ mg/dl. If ketostix not available, bolus according to pump and give water. Recheck in 1 hour.

» If ketones, call parents, provide water and student should not exercise. No exercise for BS>300mg/dl without ketones.

» It is recommended that the student be sent home from school when having symptoms of nausea and vomiting in order to be treated and monitored more closely by parent/guardian.

Usual symptoms of hyperglycemia: ___________________________________________

Additional treatment of hyperglycemia:

Notify parent/guardian if fsbs > ___ mg/dl.

Notify parent/guardian if + ketones.

Student should be encouraged to drink water and allowed to have water bottle in classroom.

Supplies to be Kept at School

___ Blood glucose meter, blood glucose test strips, batteries for meter

___ Lancet device, lancets, gloves, etc.

___ Urine ketone strips

___ Insulin pump and supplies

___ Insulin pen, pen needles, insulin cartridges/vials, syringes

___ Fast-acting source of glucose

___ Carbohydrate containing snack

___ Glucagon emergency kit
If student is to care for Diabetes independently:

☐ I give permission for my child to determine the correct time of administration, calculate amount of carbohydrates consumed, calculate the dose of insulin and administer his/her own insulin.

☐ I will instruct my child to notify an adult (parent, teacher and school nurse) whenever his/her blood sugar is below or above target blood sugar level.

Parent signature

Date

This Diabetes Medical Management Plan has been approved by:

Student’s Physician/Health Care Provider Signature and Printed Name

Date

I give permission to the school nurse, trained diabetes personnel, and other designated staff members of Cannon School to perform and carry out the diabetes care tasks as outlined by the Diabetes Management Plan. I agree that I am responsible for providing information included on this form to the school nurse and my child’s Health Care Provider. I am also responsible for providing blood sugar testing supplies, insulin administration supplies, back-up supplies for pump users, ketone testing supplies, if necessary, and instructions and supplies for treating low and high blood sugar including snacks, juice and water bottle for class. I understand insulin vials and/or insulin pens must be discarded and replaced after 30 days once opened. 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

School Nurse’s Signature

Date

Trained School Staff Member Signature:

Date: