Diabetes Management Plan

Effective Dates: ______________________________

Student	Date of Birth	Parent/Guardian
Date		Phone Number
Grade		Parent/Guardian
Teacher/Advisor	School Year	Phone Number
Transportation to and from school	Bus Car Walk	Bus #
Emergency Contact #1 Name/Relationship/ Phone #		Emergency Contact #2 Name/Relationship/ Phone #

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 Where? ______________________________

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 ______________________________

PLEASE DO NOT WRITE ABOVE THIS LINE - FOR MAGNUS HEALTH USE ONLY

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:

FAX		MAIL
(877) 447-9530 Outside of the United States? Please fax to (978) 244-8894	-OR-	**Magnus Health Does Not Accept Mailed Forms**

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 _____

_____ _____ to _____

_____ _____ 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

	Needs Assistance	
Counting 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
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
Troubleshoot alarms and malfunctions	☐ Yes	☐ No

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? ☐ Yes ☐ No

Will student be eating lunch or snacks purchased from school? ☐ Yes ☐ No

Meal/Snack	*Time*	*Food content/amount*
Breakfast	______________	______________________
Mid-morning snack	______________	______________________
Lunch	______________	______________________
Mid-afternoon snack	______________	______________________

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? ☐ Yes ☐ No

Snack after exercise? ☐ Yes ☐ No

Other times to give snacks and content/amount:

____

Preferred snack foods: ____

Foods to avoid, if any: ____

Extra snacks will be stored in ☐ School Nurse's office ☐ Backpack ☐ Classroom ☐ 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? ☐ Yes ☐ 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>80 mg/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 ______________________'s 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:

______________________________ ______________________

______________________________ ______________________

______________________________ ______________________

______________________________ ______________________