Date of Plan:

Cleveland School District Health Services
Diabetes Medical Management Plan

Effective Dates: _____

Student's Name: _____

Date of Birth: _____ Date of Diabetes Diagnosis: _____

Grade: _____ Homeroom Teacher: _____

Physical Condition: _____

Contact Information

Mother/Guardian: _____

Address: __ _____

Telephone: Home _____ Work _____ Cell _____

Student's Doctor/Health Care Provider:_____

Name: _____

Address:_____

Telephone: _____Emergency Number: _____

Other Emergency Contacts:

Name: _____

Relationship: _____

Telephone: Cell _____

Notify parents/guardian or emergency contact in the following situations:

_____

_____

_____

Blood Glucose Monitoring

Target range for blood glucose is **80-150**

Usual times to check blood glucose _lunch and as needed

Times to do extra blood glucose checks:

*when student exhibits symptoms of hyperglycemia

*when student exhibits symptoms of hypoglycemia

other (explain): _____

Can student perform own blood glucose checks? **Yes**

Exceptions: _____

_____

Type of blood glucose meter student uses: -_____

Insulin:_____

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?

____x___ Parents are authorized to adjust the insulin dosage under the following circumstances: _____

For Students Taking Oral Diabetes Medications

Type of medication: _____Timing: __

Other medications: _____ Timing: _____

Meals and Snacks Eaten at School

Is student independent in carbohydrate calculations and management?

Meal/Snack Time Food content/amount

Breakfast _____

Mid-morning snack _____ _____

Lunch _____

Mid-afternoon snack _____

_____

Dinner _____ _____

Other times to give snacks and content/amount: _

Preferred snack foods: _____

Foods to avoid, if any: _ _____

Exercise and Sports

A fast-acting carbohydrate such as _____ should be available at the site of exercise or sports.

Restrictions on activity, if any: _____ 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 (convulsion), or unable to swallow.

Route _IM/SQ_____, Dosage _1mg_____, site for glucagon injection: ___x_arm, ____x___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 _300_mg/dl.

Treatment for ketones: __If large amount of ketones present, then student must go home and call the doctor. _____

Supplies to be kept at School

___x____Blood glucose meter, blood glucose test strips, batteries for meter

__x_____ Lancet device, lancets, gloves, etc.

___x____Urine ketone strips

___x____Fast-acting source of glucose

___x____Carbohydrate containing snack

___x____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

_____ _____

School Nurse Date