Diabetes Medical Management Plan

Date of Plan:_____ School:_____This plan is valid for the current school year _____-_____

Name	Date of Birth	Diagnosis: ☐ Diabetes type I ☐ Diabetes type II
Healthcare Provider Name:	Parent/Guardian Name:	Emergency Contact Name:
Healthcare Provider Phone Number/Fax Number:	Parent/Guardian Phone Number:	Emergency Contact Phone Number:

Target range of blood glucose level:

Check blood glucose level:

☐ Before breakfast ☐After Breakfast ☐ ____Hours after breakfast ☐ 2 hours after a correction dose
☐ Before lunch ☐ After lunch ☐ ____Hours after lunch ☐ Before dismissal
☐Mid-Morning ☐ Before PE ☐ After PE ☐ Other:_____
☐ As needed for signs/symptoms of low or high blood glucose ☐ PRN signs of illness
Preferred site of testing: ☐ side of fingertip ☐ other:_____

Student's self-care blood glucose checking skills:
☐ Independently checks own blood glucose ☐ May check blood glucose with supervision
☐ Requires a school nurse or trained school staff to check blood glucose
☐ Uses a smartphone or other monitoring technology to track blood glucose values

Continuous Glucose Monitoring ☐Yes ☐ No
If yes, see page 2.

Insulin Therapy

Insulin delivery device: ☐ Syringe ☐ Insulin Pen ☐ Insulin Pump
Type of insulin therapy at school: ☐ Adjustable (basal-bolus) insulin ☐ Fixed insulin therapy ☐ No insulin

Adjustable (Basal-bolus) Insulin Therapy **Name of Insulin:**_____

Carbohydrate coverage
Insulin to carbohydrate ratio:_____

- Breakfast: 1 unit of insulin per___grams of carbohydrates
- Lunch:1 unit of insulin per ____ grams of carbohydrates
- Snack:1 unit of insulin per ____ grams of carbohydrates

Carbohydrate Dose Calculation Example

Total Grams of Carbohydrate to Be Eaten = ____Units of Insulin
Insulin-to-Carbohydrate Ratio

Correction dose:

- Blood glucose correction factor (insulin sensitivity factor)= _____
- Target blood glucose=____mg/dL

Correction Dose Calculation Example

Current Blood Glucose-Target Blood Glucose=____Units of Insuliin
Correction Factor

Correction dose scale (instead of calculation to determine insulin dose)
Blood glucose_____to _____mg/dL, give_____units
Blood glucose_____to _____mg/dL, give_____units
Blood glucose_____to _____mg/dL, give_____units
Blood glucose_____to _____mg/dL, give_____units

When to administer insulin:
Breakfast: ☐ Carbohydrate coverage only ☐ Carbohydrate coverage plus correction dose when blood glucose is greater than____mg/dL and ____ hours since last insulin dose ☐ Other:_____
Lunch: ☐ Carbohydrate coverage only ☐ Carbohydrate coverage plus correction dose when blood glucose is greater than____mg/dL and ____ hours since last insulin dose ☐ Other:_____
Snack: ☐ No coverage for snack ☐ Carbohydrate coverage only ☐Carbohydrate coverage plus correction dose when blood glucose is greater than____mg/dL and ____ hours since last insulin dose ☐ Correction dose only: For blood glucose greater than____mg/dL AND at least ____hours since last insulin dose ☐other:_____

Fixed Insulin Therapy Name of insulin:_____
☐_____units of insulin given before breakfast daily ☐____units of insulin given before lunch daily
☐ units of insulin given before snack daily ☐ Other:

Parent/Guardian Authorization to Adjust Insulin Dose
☐ Yes ☐ No Parent/guardian authorization should be obtained before administering a correction dose
Student's self-care insulin administration skills:
☐ Independently calculates and gives own injections ☐ May calculate/give own injections with supervision
☐ Requires school nurse or trained personnel to calculate dose and student can give own injection with supervision
☐ Requires school nurse or trained diabetes personnel to calculate dose and give the injection

Insulin Pump Information

Brand/Model of Pump:	**Type of insulin pump:**
Basal rates during school: Time:_____ Basal rate:_____ Time:_____ Basal rate:_____ Time:_____ Basal rate:_____ Time:_____ Basal rate:_____ Time:_____ Basal rate:_____ Time:_____ Basal rate:_____	
Other pump instructions:	
Type of infusion set:	**Appropriate infusion site:**

□ For blood glucose greater than _____ mg/dL that has not decreased within ____ hours after correction, consider pump failure or infusion site failure. Notify parent/guardian.
□ For infusion site failure: Insert new infusion set and/or replace reservoir or give insulin by syringe or pen.
□ For suspected pump failure: Suspend or remove pump and give insulin by syringe or pen

Physical Activity

May disconnect from pump for sports activities: □ Yes, for ____hours □ No
Set a temporary basal rate: □ Yes, ____% temporary basal for____ hours □ No
Suspend pump use: □ Yes, for ____ hours □ No

Student's Self-Care Pump Skills	**Independent?**	
Counts carbohydrates	□ Yes	□ No
Calculates correct amount of insulin for carbohydrates consumed	□ Yes	□ No
Administers correction bolus	□ Yes	□ No
Calculates and sets basal profiles	□ Yes	□ No
Changes batteries	□ Yes	□ No
Disconnects pump	□ Yes	□ No
Reconnects pump	□ Yes	□ No
Reconnects pump to infusion set	□ Yes	□ No
Prepares reservoir, pod, and/or tubing	□ Yes	□ No
Inserts infusion set	□ Yes	□ No
Troubleshoots alarms and malfunctions	□ Yes	□ No

Other Diabetes Medications			
Medication	**Dose**	**Route**	**Times Given**

Meal Plan

Meal/Snack	**Time**	**Carbohydrate Content (gram)**
Breakfast		
Mid-morning snack		
Lunch		
Mid-afternoon snack		

Other times to given snacks and content/amount:_____

Instructions for when food is provided to the class:_____

_____

Special event/party food permitted: □ Parent's/Guardian's discretion □ Student's discretion

Physical activity and sports

A quick-acting source of glucose such as □ glucose tabs and/or □ sugar-containing juice must be available at the site of physical education activities and sports.

Student should eat □ 15 grams of carbohydrates □ 30 grams of carbohydrates □ Other:_____
□ Before □ Every 30 minutes during □ Every 60 minutes during □ After vigorous physical activity □ other:_____

If most recent blood glucose is less than ____mg/dL, student can participate in physical activity when blood glucose is corrected and above ____mg/dL.
Avoid physical activity when blood glucose is greater than ____mg/dL or if urine ketones are moderate to large. (see insulin therapy dosing if ketones are present)

Hypoglycemia Treatment

Student's usual symptoms of hypoglycemia:_____

_____

_____

- If exhibiting symptoms of hypoglycemia, OR if blood glucose is less than____mg/dL, give a quick acting glucose product equal to____ grams of carbohydrate.
- Recheck blood glucose in 15 minutes and repeat treatment if blood glucose level is less than ____mg/dL.
- Additional treatment:_____

_____

If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movement):

- Position the student on his/her side to prevent choking
- **Give Glucagon (patient will need rx for this)**
  Dose: □ 1mg □ 1/2mg □ Other:_____
  Route: □ Subcutaneous □ Intramuscular **Preferred Site for Injection**:□ Buttocks □ Arm □ Thigh □ Other:_____
- Call 911
- Contact the student's parent/guardian

Hyperglycemia Treatment

Student's usual symptoms of hyperglycemia:_____

_____

_____

- Check urine ketones every ____ hours when blood glucose levels are above ____mg/dL
- For blood glucose greater than ____mg/dL AND at least ____ hours since last insulin dose, give correction dose of insulin (see correction dose orders).
- Notify parent/guardian if blood glucose is over ____mg/dL.
- For insulin pump users: see Insulin Pump Information
- Allow unrestricted access to the bathroom
- Give extra water and/or non-sugar-containing drinks (not fruit juices):____ounces per hour.

Additional treatment for ketones:_____

_____

If the student has symptoms of hyperglycemia emergency (dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, drowsiness or lethargy, or a decrease in level of consciousness) call 911 and contact the student's parent/guardian.

This diabetes medical management plan has been approved by:

Student's Healthcare Provider Signature Healthcare Provider Printed Name Date

I, (parent/guardian) _____, give permission to the school healthcare staff, or trained school staff to carry out the diabetes care tasks as outlined in (student)_____diabetes medical management plan. I also consent to the release of the information contained in this diabetes medical management plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school healthcare staff to contact my child's healthcare provider.

Acknowledged and received by:

Student's Parent/Guardian's Signature Parent/Guardian Printed Name Date