

Date of Plan: _____

Diabetes Medical Management Plan

Effective Dates: _____

This plan should be completed by the student's personal health care team and parents/guardian. It should be reviewed with relevant school staff and copies should be kept in a place that is easily accessed by the school nurse, trained diabetes personnel, and other authorized personnel.

Student's Name: _____

Date of Birth: _____ Date of Diabetes Diagnosis: _____

Grade: _____ Homeroom Teacher: _____

Physical Condition: Diabetes type 1 Diabetes type 2

Contact Information

Mother/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell _____

Father/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell _____

Student's Doctor/Health Care Provider:

Name: _____

Address: _____

Telephone: _____ Emergency Number: _____

Other Emergency Contacts:

Name: _____

Relationship: _____

Telephone: Home _____ Work _____ Cell _____

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

Blood Glucose MonitoringTarget range for blood glucose is 70-150 70-180 Other _____

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: _____

Type of blood glucose meter student uses: _____

Insulin**Usual Lunchtime Dose**

Base dose of Humalog/Novolog /Regular insulin at lunch (circle type of rapid-/short-acting 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 DosesParental 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 NoCan student determine correct amount of insulin? Yes NoCan student draw correct dose of insulin? Yes No

_____ 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:

Student Pump Abilities/Skills:

Needs Assistance

- | | | |
|---|------------------------------|-----------------------------|
| Count carbohydrates | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bolus correct amount for carbohydrates consumed | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Calculate and administer corrective bolus | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Calculate and set basal profiles | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Calculate and set temporary basal rate | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Disconnect pump | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Reconnect pump at infusion set | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Prepare reservoir and tubing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Insert infusion set | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Troubleshoot alarms and malfunctions | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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? Yes No

| <i>Meal/Snack</i> | <i>Time</i> | <i>Food content/amount</i> |
|---------------------|-------------|----------------------------|
| Breakfast | _____ | _____ |
| Mid-morning snack | _____ | _____ |
| Lunch | _____ | _____ |
| Mid-afternoon snack | _____ | _____ |
| Dinner | _____ | _____ |

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:

Instructions for when food is provided to the class (e.g., as part of a 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

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 _____, Dosage _____, site for glucagon injection: _____ arm, _____ 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 _____ mg/dl.

Treatment for ketones: _____

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

_____ Fast-acting source of glucose

_____ Carbohydrate containing snack

_____ 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

Date