American Diabetes Association®
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DISABILITY RIGHTS EDUCATION & DEFENSE FUND

Community Unit School District No. 300

Diabetes Medical Management Plan

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.

Effective Dates: _____

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 Monitoring

Target 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 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

_____ 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: _____

Student Pump Abilities/Skills:	*Needs Assistance*	
Count 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: _____ Timing: _____

Other medications: _____ Timing: _____

Meals and Snacks Eaten at School

Is student independent in carbohydrate calculations and management? ☐ Yes ☐ No

Meal/Snack	*Time*	*Food content/amount*
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 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 _____, 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

_____ _____

Student's Parent/Guardian Date

COMMUNITY UNIT SCHOOL DISTRICT 300
AUTHORIZATION FOR THE
ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name:_____ Date of Birth:_____

Address:_____

School _____Grade:_____

I hereby confirm my primary responsibility to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize Community Unit School District 300 and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described. **I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICATIONS TO MY CHILD TO BE PERFORMED BY AN INDIVIDUAL OTHER THAN A CERTIFIED SCHOOL NURSE AND SPECIFICIALLY CONSENT TO SUCH PRACTICES.** I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

For parent(s)/guardian(s) of students who Self-Administer Asthma Medications or may use an Epinephrine Auto-Injector for Anaphylaxis:
I authorize the School District and its employees and agents, to allow my child or ward to possess and use his or her medication (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property. Illinois law requires the School District to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration of medication (105 ILCS 5/22-30). Beginning fall 2010 a physician's signature is not required for Asthma Inhalers and Epinephrine Auto-Injectors if the health office has a copy of the pharmacy labeled container for the medication(s). *If you agree please initial*: _____

Parent(s)/Guardian(s) Signature:_____Date:_____

Phone: Home:_____ Work:_____Cell:_____

PHYSICIAN'S ORDERS (to be completed by student's physician)

Medication:_____

Dosage:_____Frequency:_____Administration Time:_____

Diagnosis Requiring Medication:_____

Possible Side Effects:_____

Special Instructions:_____

Signature:_____Date of Signature:_____

Physician's Printed Name:_____

Office Address:_____

Office Phone:_____ Fax Number:_____

COMMUNITY UNIT SCHOOL DISTRICT 300
PROCEDURE FOR ADMINISTRATION OF MEDICATION

Prior to the District's administration of any medication, the District shall have on file a medication program for the involved student prepared by the student's attending licensed prescriber in compliance with CUSD #300 procedures and signed by the student's parent/guardian.

Whenever possible, the parent/guardian should make arrangements for medication to be administered at home, before and/or after school hours. In situations when a student's health could be compromised by not receiving medication during school hours, school district policy and procedures must be followed for administering all medications.

1. Medication is defined as prescription or non-prescription (over the counter) drugs, including vitamins and supplements.

2. Administration of **any** medication requires both a physician's written order and signed parental permission. ***Beginning fall 2010 a physician's signature is not required for Asthma Inhalers and Epinephrine Auto-Injectors if the health office has a copy of the pharmacy labeled container for the medication(s).***

3. Prescription medication must be in a pharmacy or physician labeled container. Over the counter medication must be brought in with the original manufacturers label, clearly marked with the student's name.

4. It is the parent's/guardian's responsibility to bring the medication to school.

5. All medications to be taken during school hours will be kept in the nurse's office. It is the responsibility of the student to report to the nurse's office at the proper time to receive his/her medication. Students are allowed to carry and self-administer asthma medication or may use an Epinephrine Auto-Injector for anaphylaxis only after the school is notified and the student's parent/guardian and physician have signed the appropriate authorization form.

6. The parent/guardian must assume responsibility for informing the school (in writing) of any change in the student's health or change in medication. A physician's order must accompany any medication change.

7. Medication must be picked up by a parent/guardian on or before the last day of school. Medication not picked up will be discarded.

8. The school district will reject requests for administration of medication if it does not receive all of the required information on the authorization form.

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