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:

_____

_____

_____

Diabetes Medical Management Plan *Continued*

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: _____

Diabetes Medical Management Plan *Continued*

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 vials and syringes
_____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

Diabetes Medical Management Plan *Continued*

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.

DIABETES EMERGENCY CARE PLAN

School: Charter School of Excellence School Health Services **School Year:**
Student Name:
Grade: **DOB:**
Emergency Contacts:

Name	Relationship	Home Phone	Work Phone	Cell Phone
1				
2				
3				

Physician: Phone:
Hospital: Phone:
Health Concern: **Allergies:**
Diabetic History:
Maintenance Regimen:

1. RECOGNIZE SIGNS OF ALTERED BLOOD SUGAR LEVELS

IF CHILD UNCONSCIOUS

- Activate EMS – 911
- Notify health office
- Nurse to administer glucagon if ordered
- Notify Primary Emergency Contact
- Stay with child and reassure until ambulance arrives

For any of the following symptoms send child with an escort to the Health Office for observation and treatment:

Hypoglycemia/low blood sugar	**Hyperglycemia/high blood sugar**
Shaky/trembling Difficulty with coordination	Increased thirst/urination Loss of appetite
Dizzy Confused/disoriented Weakness	Nausea and vomiting
Pale Severe headache	Abdominal pain Heavy/labored breathing
Irritable Impaired vision	Generalized aches
Weak/drowsy Sweaty	

2. TEST BLOOD SUGAR

- **Blood sugar below _____ follow Medical Management Plan and notify parent**
- **Blood sugar over _____ follow Medical Management Plan and notify parent**

In case of serious illness and I cannot be reached I authorize school personnel to contact:
Physician/Clinic:
or transport by ambulance to:
Hospital

I agree with this emergency care plan for my child. I give permission for this plan to be carried out and shared with pertinent staff during the current school year.

Parent Signature: **Date:**
Nurse Signature: **Date:**

Note: Per school district policy, signed physician prescription, parent authorization, and medication in the original container are required for any medication administration at school.

Insulin: Date received in health office:
Physician Orders: Date received in health office:
Glucagon: Date received in health office:

All Diabetic supplies in Health Office: Date received in health office:

Notes: