

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 Monitoring

Target range for blood glucose is 70-150 70-180 Other _____

Usual times to check blood glucose _____

Times to do extra blood glucose check (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 check? 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 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: _____ 12am to _____
 _____ to _____
 _____ to _____

Type of insulin in pump: _____
 Type of infusion set: _____
 Insulin/carbohydrate ratio: _____ Correction factor: _____

Student Pump Abilities/Skills:

- Count carbohydrates
- Bolus correct amount for carbohydrates consumed
- Calculate and administer corrective bolus
- Calculate and set basal profiles
- Calculate and set temporary basal rate
- Disconnect pump
- Reconnect pump at infusion set
- Prepare reservoir and tubing
- Insert infusion set
- Troubleshoot alarms and malfunctions

Needs Assistance

- Yes No
- Yes No
- Yes No
- Yes No
- Yes No
- Yes No
- Yes No
- Yes No
- Yes No
- 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

| <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 moderate to large urine ketones are present.

Hypoglycemia (Low Blood Sugar)

Usual symptom 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 91 1 (or other emergency assistance) and the parents/guardian.

Hyperglycemia (High Blood Sugar)

Usual symptom 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 task 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

Quick Reference Emergency Plan for a Student with Diabetes

Photo

Hypoglycemia (Low Blood Sugar)

Student's Name _____

Grade/Teacher _____

Date of Plan _____

Emergency Contact Information:

Mother/Guardian _____

Father/Guardian _____

Home phone _____

Work phone _____

Cell _____

Home phone _____

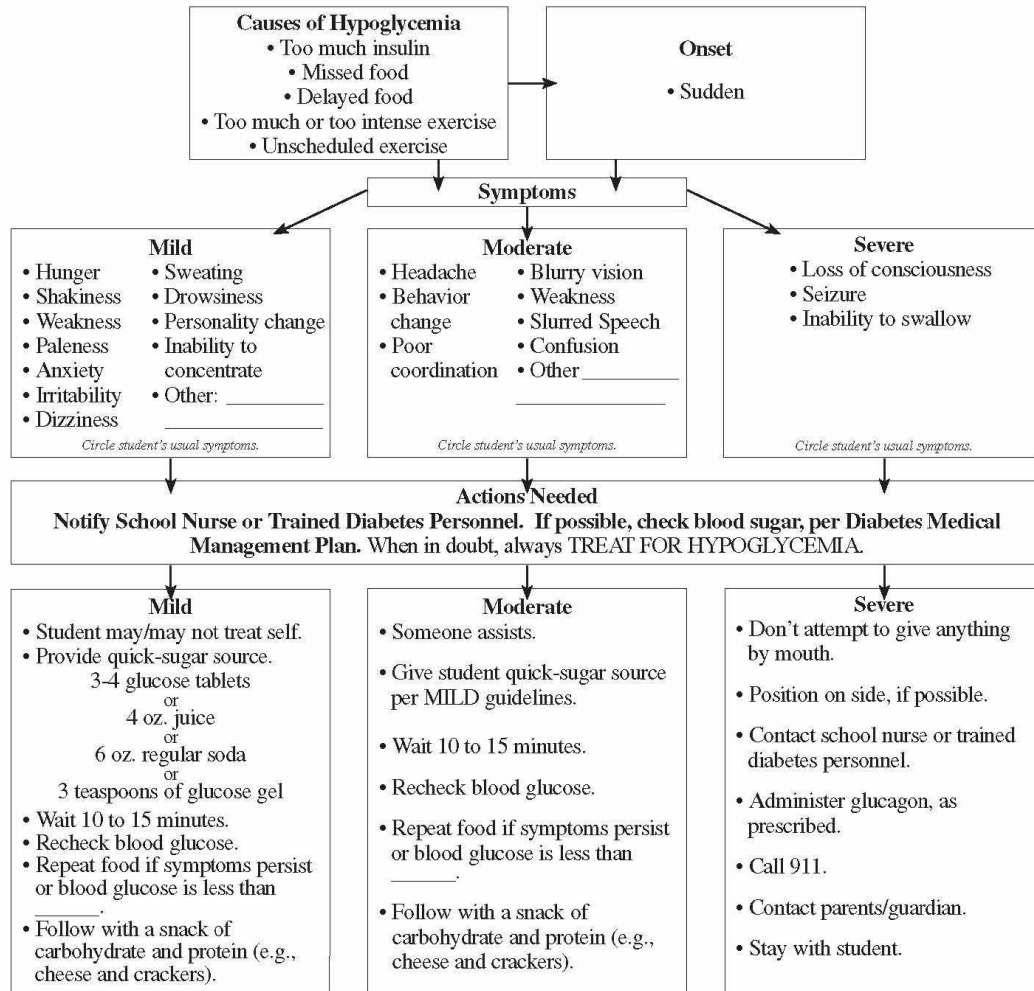
Work phone _____

Cell _____

School Nurse/Trained Diabetes Personnel _____

Contact Number(s) _____

Never send a child with suspected low blood sugar anywhere alone.



TOOLS

Quick Reference Emergency Plan for a Student with Diabetes

Hyperglycemia (High Blood Sugar)



Student's Name _____

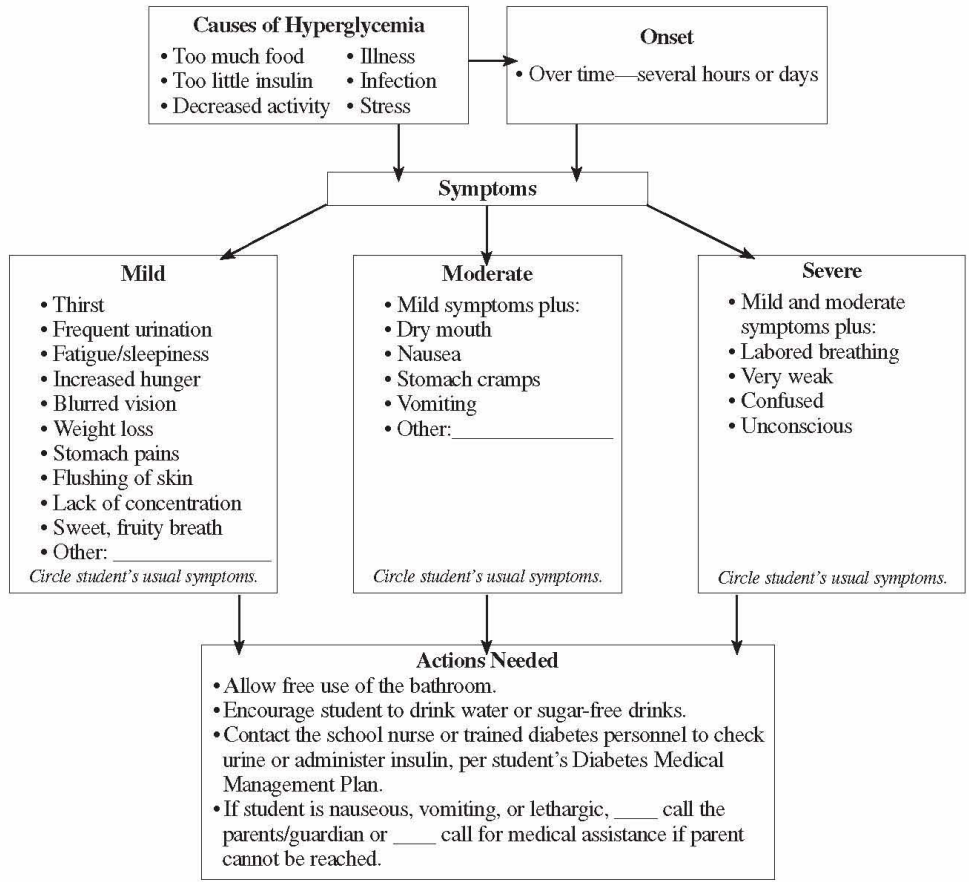
Grade/Teacher _____ Date of Plan _____

Emergency Contact Information:

| Mother/Guardian | | | Father/Guardian | | |
|-----------------|------------|------|-----------------|------------|------|
| Home phone | Work phone | Cell | Home phone | Work phone | Cell |
| | | | | | |

School Nurse/Trained Diabetes Personnel _____

Contact Number(s) _____



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