Date of Plan: ______________________________

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 No.: ______________

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 ☐ when student exhibits symptoms of hyperglycemia

☐ after exercise ☐ 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 *(check 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 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.
☐ Insulin pen, pen needles, insulin cartridges
☐ Carbohydrate containing snack
☐ Urine ketone strips
☐ Insulin pump and supplies
☐ Fast-acting source of glucose
☐ 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*