



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 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	<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:

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Preferred snack foods:

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Foods to avoid, if any:

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Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event):

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### **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: \_\_\_\_\_

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Treatment of hypoglycemia: \_\_\_\_\_

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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: \_\_\_\_\_

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Treatment of hyperglycemia: \_\_\_\_\_

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Urine should be checked for ketones when blood glucose levels are above \_\_\_\_\_ mg/dl.

Treatment for ketones: \_\_\_\_\_

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### **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:**

\_\_\_\_\_ Date  
 Student's Physician/Health Care Provider

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:**

\_\_\_\_\_ Date  
 Student's Parent/Guardian

\_\_\_\_\_ Date  
 Student's Parent/Guardian