Diabetes Medical Management Plan *(1 of 5)*

Student _____ School _____

Date of Birth _____ Today's Date _____

Date of Diabetes Diagnosis: _____ Effective Dates: _____

Homeroom Teacher: _____ Grade: _____

Physical Condition: ⬡ Diabetes type 1 ⬡ Diabetes type 2

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.

Contact Info

Mother/Guardian: _____

Address: _____

Home Telephone: _____ Work: _____ Cell: _____

Contact Info

Father/Guardian: _____

Address: _____

Home Telephone: _____ Work: _____ Cell: _____

Contact Info

Student's Doctor/Health Care Provider:

Name: _____

Address: _____

Telephone: _____ Emergency Number: _____

Contact Info

Other Emergency Contacts:

Name: _____ Relationship: _____

Address: _____

Home Telephone: _____ Work: _____ Cell: _____

Notify parents/guardian or emergency contact in the following situations: _____

_____

_____

_____

Diabetes Medical Management Plan *(2 of 5)*

Student _____

Date _____

Blood Glucose Monitoring

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

Usual times to check blood glucose *(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 *(Please write in the rapid-/short-acting insulin used)*: _____
is _____ units or does flexible dosing using _____ units/ _____ grams carbohydrate.

Use of other insulin at lunch *(Please write in the type of insulin used)*: _____ 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 circumstance: _____

_____

_____

For Students with Insulin Pumps

Type of pump: _____

Basal rates: ____12 am to ____
____12 am to ____
____12 am to ____

Type of insulin in pump: _____

Type of infusion set: _____

Insulin/carbohydrate ratio: _____

Correction factor: _____

Diabetes Medical Management Plan *(3 of 5)*

Student Pump Abilities/Skills	Needs Assistance: Yes	Needs Assistance: No
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		

Student _____

Date _____

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)*: _____

Diabetes Medical Management Plan *(4 of 5)*

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.

Student _____

Date _____

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

check list

Diabetes Medical Management Plan *(5 of 5)*

Signatures

This Diabetes Medical Management Plan has been approved by:

Student's Physician/Health Care Provider: _____

Date: _____

Student

_____

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: _____