TRI COUNTY AREA SCHOOLS

Diabetes Medical Management Plan

20___-20___

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 distributed to authorized personnel at the beginning of each school year or any time deemed necessary due to changes in the student's health.

Student's Name: ____

Date of Birth:______________Date of Diabetes Diagnosis:____________________________________

Grade:____________________Homeroom Teacher:____

_____Diabetes Type I _____Diabetes Type II _____ Other___________________

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:___________________________________

Fax:____

Other Emergency Contacts:

Name:_________________________________Relationship: ____________________________________

Telephone: ________________(home)________________________(work)___________________(cell)

Notify parents/guardians or emergency contact in the following situations:

____

____

Blood Glucose Monitoring:

Target range for blood glucose is _____70-150 _____70-180 _____Other_______________________

Times to check blood glucose level: (*check all that apply)*

___Before lunch

___ (___) Hours after lunch

___ (___) Hours after correction dose

___ Before Physical Education class

___ After Physical Education class

___ 30 minutes before bus ride home

___Other (please explain)

____

**In addition, the student's blood glucose will be checked anytime necessary based on symptoms, or at the recommendation of the school nurse or the student's parents.*

Student's self-care blood glucose checking skills:

___ Independently checks own blood glucose

___ May check blood glucose with supervision

___ Requires school nurse or trained diabetes personnel to check blood glucose

Continuous Glucose Monitor (CGM) ___Yes ___No

Brand/Model: ____________________________________ Alarms set for: ___ low and ___ high

**Note: Confirm CGM results with blood glucose meter before taking action on sensor blood glucose level. If student has symptoms or signs of hypoglycemia, check blood glucose level regardless of CGM.*

HYPOGLYCEMIA TREATMENT

Student's usual symptoms of hypoglycemia (list below):

____

____

If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than _____ mg/dL, give a quick-acting glucose product equal to _____ grams of carbohydrates.

Re-check blood glucose in 10-15 minutes and repeat treatment if blood glucose level is less than _____ mg/dL.

Additional treatment: ____

Follow physical activity and sports orders (see page 6).

- If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions (jerking movements), give:
- Glucagon: ___ 1 mg ___ 0.5 mg Route: ___ Sub-q ___ IM (Arm/Thigh/Other______)
- Call 911 the student's parents/guardian and the school nurse.
- Contact student's health care provider.

HYPERGLYCEMIA TREATMENT

Student's usual symptoms of hyperglycemia (list below):

Check for ketones when blood glucose levels are above ___ mg/dL.
For blood glucose greater than ___ mg/dL AND at least ___ hours since last insulin dose, five correction dose of insulin (see below).
For insulin pump users: see additional information for student with insulin pump.
Give extra water and/or non-sugar containing drinks (not fruit juices).
Follow physical activity and sports orders (see page 6).

- Notify parents/guardian of onset of hyperglycemia and/or presence of ketones in urine.
- If the student has symptoms of a hyperglycemic emergency, including dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy, or depressed level of consciousness: Call 911, the student's parents/guardian and the school nurse.
- Contact the student's health care provider.

Insulin Therapy:

Insulin delivery device: ___ syringe ___ insulin pen ___ insulin pump

<u>Adjustable Insulin Therapy:</u>

- Carbohydrate Coverage:
  - Insulin to Carbohydrate Ratio:
    - Lunch: 1 unit of insulin per _____ grams of carbohydrate
    - Snack: 1 unit of insulin per _____ grams of carbohydrate

Carbohydrate Dose Calculation Example:

Grams of carbohydrate in meal or snack / Insulin to Carbohydrate Ratio = _________ units of insulin

- Correction Dose:
  - Blood Glucose correction Factor/Insulin Sensitivity Factor = ________
  - Target Blood Glucose = ________ mg/dL

Correction Dose Calculation Example:

Actual Blood Glucose – (minus) Target Blood Glucose / Blood Glucose Correction Factor/Insulin Sensitivity Factor = _____ units of insulin

Correction Dose Scale: (use instead of calculation above to determine insulin correction dose):

________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

Fixed Insulin Therapy:

_____ units of insulin given pre-lunch daily
_____ units of insulin given pre-snack daily
_____ other ____

Parental Authorization to Adjust Insulin Dose:

Yes No Parent/guardian authorization should be obtained before administering a correction dose each and every time.
Yes No Parents/guardians are authorized to increase or decrease correction dose scale.
Yes No Parents/guardians are authorized to increase or decrease insulin to carbohydrate ratio.
Yes No Parents/guardians are authorized to increase or decrease fixed insulin dose.

Student's self-care insulin administration skills:

Yes No Independently calculates and gives own injections

Yes No May calculate/give own injections with supervision

Yes No Requires school nurse or trained diabetes personnel to calculate/give injections

For students with insulin pumps:

Type of pump:________________ Basal rates: ______ 12:00 am to _________ am/pm

______ ______ am/pm to _________am/pm

______ ______ am/pm to__________am/pm

Type of insulin in pump:____

Type of insulin set: ____

Insulin/carbohydrate ratio: ______________________Correction Factor: ______________________

Consider pump failure when blood glucose has not decreased with 2 hours after correction. Contact parent/guardian immediately upon suspicion of pump failure.

Student Pump Abilities/Skills:	Needs Assistance:	
Count Carbohydrates:	Yes	No
Bolus correct amount for carbohydrates consumed:	Yes	No
Calculate and administer correction bolus:	Yes	No
Calculate and set basal profiles:	Yes	No
Calculate and set temporary basal rate:	Yes	No
Change batteries:	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 Medication:

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 (if consistent)
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 (example: 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. (parents/guardian to provide)

Student should eat _____ grams of carbohydrates ___ before ___every 30 minutes during ___after ___other__________________ vigorous physical activity.

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 may disconnect insulin pump for physical activities. Yes No*

Supplies to be kept at School (and provided by parents/guardians):

_____Blood glucose meter	_____Blood glucose test strips	_____Extra batteries for meter
_____Lancet device	_____Extra lancets	_____Gloves
_____Urine ketone strips	_____Insulin vials and syringes	_____Insulin pump and supplies
_____Insulin pen	_____Insulin pen needles	_____Insulin pen cartridges
_____Fast-acting glucose source	_____Carbohydrate snack	_____Glucagon 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 Tri County Area Schools to perform and carry out the diabetes care tasks as outlined by this Diabetes Medical Management Plan. I also consent to the release of the information contained in this plan to all staff members and other adults who take care of my child and who may need to know this information to maintain my child's health and safety. I also give permission for Tri County Area Schools to contact my child's physician if any questions or concerns should arise regarding the medical condition to which this plan relates.

Acknowledged and received by:

Student's Parent/Guardian Date

Student's Parent/Guardian Date

District Nurse Date