

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON
DIABETES MEDICAL MANAGEMENT PLAN

Appendix F-5A

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PART I TO BE COMPLETED BY PARENT OR GUARDIAN

Student _____ Date of Birth _____ Date of Diagnosis _____

School _____ Grade/ Teacher _____

Physical Condition: *check all that apply* 1 epyt setebaiD 2 epyt setebaiD

Contact Information

Mother/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell _____

Father/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell _____

Licensed Health Care Provider:

Name: _____

Address: _____

Telephone: _____ Fax _____ Emergency _____

Emergency Contacts:

Name: _____ Relationship _____

Telephone: Home _____ Work _____ Cell _____

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

Blood glucose less than _____ mg/dl

Blood glucose greater than _____ mg/dl

Insulin pump problems

Vomiting or feeling ill

Presence of urine ketones

Other: _____

PART II TO BE COMPLETED BY LICENSED HEALTH CARE PROFESSIONAL

BLOOD GLUCOSE MONITORING

Type of blood glucose meter student uses: _____

Target range for blood glucose is 07 -150 07 -180 _____ rehtO

Usual times to check blood glucose _____

(Blood Glucose Monitoring continued)

Times to do extra blood glucose checks (*check all that apply*)

- esicrexe erofeB
- esicrexe retfA
- aimecylgrepyh fo smotpmys stibihxe tneduts nehW
- aimecylgopyh fo smotpmys stibihxe tneduts nehW
- _____ :nialpxe(rehtO

Can student perform own blood glucose checks? seY oN

Exceptions: _____

Student may test discreetly in the classroom setting Yes No

Student must test in the school health room Yes No

Type of blood glucose meter student uses: _____

Blood glucose Management

Refer to appropriate treatments as indicated on Parts A and B Quick Reference Emergency Plan

FOR STUDENTS TAKING ORAL DIABETES MEDICATIONS

Type of medication: _____ Timing: _____

Other medications: _____ Timing: _____

INSULIN

Administration of insulin during school-sanctioned activities requires complete, appropriate, Medication Authorization forms.

Usual Lunchtime Dose

Base dose of, (*select appropriate type*)

- | | | | | | |
|----------------|-------------------------|---------------------|-------------------------|-------------------|-------------------------|
| Regular | insulin is _____ Units. | Intermediate | insulin is _____ Units. | Basal | insulin is _____ Units. |
| Novolog | insulin is _____ Units. | NPH | insulin is _____ Units. | Lantus | insulin is _____ Units. |
| Humalog | insulin is _____ Units. | Lente | insulin is _____ Units. | Ultralente | insulin is _____ Units. |

Insulin Correction Doses

Parental authorization required before administering a correction dose for high blood glucose levels.

seY oN

- _____ 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? seY oN

Can student determine correct amount of insulin? seY oN

Can student draw correct dose of insulin? seY oN

Parents are authorized to adjust the insulin dosage under the following circumstances _____

FOR STUDENTS WITH INSULIN PENS

Type of pen: _____

Insulin / carbohydrate ratio: _____

Correction factor: _____

Special instructions, if any: _____

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: _____

Special instructions if any: _____

Student Pump Abilities/Skills

Needs Assistance

- 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

- seY oN
- seY oN
- seY oN
- seY oN
- seY oN
- seY oN
- seY oN
- seY oN
- seY oN
- seY oN

MEALS AND SNACKS EATEN AT SCHOOL

Is student independent in carbohydrate calculations and management? seY oN

Meal/Snack

Time

Food content/amount

Breakfast _____

Mid-morning snack _____

Lunch _____

Mid-afternoon snack _____

Dinner _____

Snack before exercise? seY oN

Snack after exercise? seY oN

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

Check blood glucose levels prior to PE/activity Yes No
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 will carry a fast-acting carbohydrate such as _____ to the site of exercise.

Restrictions on activity, if any: _____

Other considerations: _____

HYPOGLYCEMIA (Low Blood Sugar)

Complete Part A of Diabetes Medical Management Plan

Usual symptoms of hypoglycemia: _____

Treatment of hypoglycemia: _____

GLUCAGON

Administration of Glucagon during school-sanctioned activities requires complete appropriate Medication Authorization forms.

ogaculG n is to be given if the student is unconscious, having a seizure (convulsion), or unable to swallow.

Route _____ Dosage _____ Site: mra hgih .rehto

If Glucagon is required, administer it promptly. Call 911 and the parents/guardian.

HYPERGLYCEMIA (High Blood Sugar)

Complete Part B of Diabetes Medical Management Plan

Usual symptoms of hyperglycemia: _____

Treatment of hyperglycemia: _____

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

Treatment for ketones: _____

DISASTER PLANNING

Special considerations, if any

OTHER CONSIDERATIONS FOR THE PLAN

PARENTAL PROVIDED SUPPLIES TO BE KEPT AT SCHOOL

- spirits tset dna retem esoculg doolB
- retem rof seirettaB
- stecnal dna ecived tecnaL
- spirits enotek enirU
- segnirys dna slaiv nilusnI
- pmup nilusnI
- pmup rof seirettaB
- seilppus dna tes noisufnI
- segdirtrac nilusni ,seldeen nep ,nep nilusnI
- Fast-acting source of glucose
- kcans gniniatnoc etardyhobraC
- tik ycnegreme nogaculG
- 3 days supply of food and drink (disaster preparedness)

Signatures

This Diabetes Medical Management Plan has been formulated and approved by:

 Licensed Health Care Provider Telephone _____ 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:

 Parent/Guardian Date _____

PART III TO BE COMPLETED BY PRINCIPAL OR REGISTERED NURSE

ACTION PLAN CHECK LIST FOR SCHOOL PERSONNEL

• Diabetes Medical Management Plan pages 1-5 completed					yes	no		
• Quick Reference Emergency Plan Part A and B completed					yes	no		
• Medication authorization complete					yes	no		
• Medication maintained in school-designated area					yes	no		
• Expiration date of medication (s)								_____
• Parental provided supplies maintained in school					yes	no		
• Staff trained in medication administration					yes	no		
• Staff trained in Diabetes education					yes	no		
• Copies of plan provided to:	Educational	yes	no	n/a	After school	yes	no	n/a
	Athletic	yes	no	n/a	Food service	yes	no	n/a

Full Diabetes Action Plan has been implemented

 Principal or Registered Nurse Date _____
 Source: U.S. Department of Health and Human Resources, National Diabetes Education Program. (June 2003). *Helping the Student with Diabetes Succeed: A Guide for School Personnel*. NIH Publication No. 03-5217,