OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON
DIABETES MEDICAL MANAGEMENT PLAN

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* Diabetes type 1 Diabetes type 2

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 Contact other than listed above:
Name: ____ Relationship _________________
Telephone: Home _____________________ Work _________________ Cell _________________________

Notify parents/guardian or emergency contact in the following situations:
Blood glucose less than ___________ mg/dl
Insulin pump problems
Presence of urine ketones
Blood glucose greater than ___________ mg/dl
Vomiting or feeling ill
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 70-150 70-180 Other____________________________
Usual times to check blood glucose ____

(Blood Glucose Monitoring continued)

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: ____
Student may test discreetly in the classroom setting Yes No
Student must test in the school health room Yes No

Blood Glucose Management

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

FOR STUDENTS TAKING ORAL DIABETES MEDICATIONS

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

Type of medication: ____ Timing: ___________________
Other medications: ____ Timing: ___________________

INSULIN

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

Type of insulin therapy at school

Adjustable Insulin Fixed Insulin No insulin

Usual Lunchtime Dose

Base dose

_______________**(name of insulin)** ______ units by ____________(route)

Insulin Correction Doses

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

Yes No

Carbohydrate Coverage / Correction Dose

Name of insulin _____________

Carbohydrate Coverage / Insulin to Carbohydrate ratio

Lunch: 1 unit of insulin per _____ grams of carbohydrate
Snack: 1 unit of insulin per _____ grams of carbohydrate

Grams of Carb in meal / Insulin to Carb ratio	= ___units of insulin

Correction Dose

Blood glucose correction factor / insulin sensitivity factor = ______
Target blood glucose = _____

Actual blood glucose – Target blood glucose / Blood glucose correction factor/insulin sensitivity factor	= ___units of insulin

- _____ 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 PENS

Type of pen: ________________________________

Insulin / carbohydrate ratio: ____________________ Correction factor: ___________________________

Special instructions, if any: ____

____

FOR STUDENTS WITH INSULIN PUMPS

Brand/Model 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	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

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

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

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

Glucagon is to be given if the student is unconscious, having a seizure (convulsion), or unable to swallow.
Route __**IM**_____ Dosage_______ Site: arm thigh other.

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: ____
For blood glucose greater than _______ mg/dl. **AND** at least ______ hours since last insulin dose give correction dose of insulin as noted on page 2.

DISASTER PLANNING

Special considerations, if any, to prepare for an unplanned disaster or emergency (72 hours).
Requires emergency supply kit from parent / guardian
____
____
____

OTHER CONSIDERATIONS FOR THE PLAN

____
____
____

PARENTAL PROVIDED SUPPLIES TO BE KEPT AT SCHOOL

Blood glucose meter and test strips
Batteries for meter
Lancet device and lancets
Urine ketone strips
Insulin vials and syringes
Insulin pump
Batteries for pump
Infusion set and supplies
Insulin pen, pen needles, insulin cartridges
Fast-acting source of glucose
Carbohydrate containing snack
Glucagon emergency kit
3 days supply of food and drink (disaster preparedness)
3 days supply of insulin and syringes (disaster preparedness)

Signatures and Authorizations

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 in ________________________'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. I hereby request school personnel to administer the ordered medications and treatments as prescribed in this Office of Catholic Schools Diocese of Arlington Diabetes Medical Management Plan. I agree to release, indemnify and hold harmless the designated school personnel or agents from lawsuits, claim expense, demand or action etc. against them for administering these injections /treatments provided the designated school personnel comply with the LHCP or orders as set forth above. I am aware that these injections / treatments may be administered by a specifically trained non- health professional. I have read the procedure outlined on this form and assume responsibility as required.

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. (2010). *Helping the Student with Diabetes Succeed: A Guide for School Personnel*. NIH Publication No. 03-5217,