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 □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 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,