MADISON CONSOLIDATED SCHOOLS

Diabetes Medical Management Plan

Date of Plan: _____

Effective Dates: _____

The student's personal health care team and parents/guardian should complete this plan. 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.

Student's Name: _____

Date of Birth: _____ Date of Diabetes Diagnosis: _____

Grade: _____Homeroom Teacher: _____

Physical Condition: _____ Diabetes type 1 or _____ Diabetes type 2 _____
(*Please check*)

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: _____

Other Emergency Contacts:

Name: _____

Relationship:

_____

Telephone: Home _____ Work _____ Cell _____

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

_____

_____

_____

Blood Glucose Monitoring

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

Usual times to check blood glucose _____

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: _____

_____

Type of blood glucose meter student uses: _____

Insulin

Usual Lunchtime Dose

Base dose of **Humalog/Novolog /Regular insulin** at lunch (circle type of rapid-/short-acting insulin used) is _____ units or does flexible dosing using _____ units/ _____ grams carbohydrate.

Other: _____

Use of other insulin at lunch: (circle type of insulin used): **intermediate/NPH/lente** _____ units or **basal/Lantus/Ultralente** _____ units.

Other: _____

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 Is Student independent? □Yes □ No Or needs Supervision? □Yes □ No

Can student determine correct amount of insulin? □ Yes □ No

Is Student independent? □Yes □ No Or needs Supervision? □Yes □ No

Can student draw correct dose of insulin? □Yes □ No

Is Student independent? □Yes □ No Or needs Supervision? □Yes □ No

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: _____

Student Pump Abilities/Skills:	**Needs Assistance**	**Needs Supervision**
Count carbohydrates	□Yes □ No	□Yes □ No
Bolus correct amount for carbohydrates consumed	□Yes □ No	□Yes □ No
Calculate and administer corrective bolus	□ Yes □ No	□Yes □ No
Calculate and set basal profiles	□ Yes □ No	□Yes □ No
Calculate and set temporary basal rate	□ Yes □ No	□Yes □ No
Disconnect pump	□ Yes □ No	□Yes □ No
Reconnect pump at infusion set	□ Yes □ No	□Yes □ No
Prepare reservoir and tubing	□ Yes □ No	□Yes □ No
Insert infusion set	□ Yes □ No	□Yes □ No
Troubleshoot alarms and malfunctions	□ Yes □ No	□Yes □ No

For Students Taking Oral Diabetes Medications

Type of medication: _____ Timing: _____

Other medications: _____ Timing: _____

Meals and Snacks Eaten at School (*Snacks must be provided by parent)*

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

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.

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 (*Parents must provide supplies)***.**

_____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

Signatures: Physician

This Diabetes Medical Management Plan has been approved by:

Physician/Health Care Provider Printed name and Address:

_____

_____

_____

_____ _____

Student's Physician/Health Care Provider Signature Date

Madison Consolidated Schools acknowledges that the above medical orders may change throughout the school year. When changes are required, written communication must occur between the health care provider and the school nurse. Please provide the necessary information below.

Please list the name of a Contact Person *within your office* that has prescriptive authority or who is authorized by the health care provider to prescribe medication and/or make medication changes.

Person's Name: _____ Title: _____

Phone Number: _____ Fax: _____

E-mail Address: _____

Signatures: Parent/guardian

I give permission to the school nurse, trained diabetes personnel, and other designated staff members of Madison Consolidated Schools to perform and carry out the diabetes care tasks as outlined by (name of student)_____'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 Signature Date

_____ _____

Student's Parent/Guardian Signature Date