DIABETES MEDICAL MANAGEMENT PLAN

*MUST be completed and signed by **both** the physician and the parent/guardian*

* * * * * * * * * * * * * * * * * * * *

Date of Plan ____ Effective Date ____

This plan should be completed by the student's personal health care team and the parent/guardian. This form will be reviewed with relevant staff and copies will 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 ______________________________________

Entering Grade ____________________________________ Division____

Physical Condition (check one) _____ Diabetes type 1 _____ Diabetes type 2

* * * * * * * * * * * * * * * * * * * *

Contact Information
Using a * indicate the primary contact person

Parent/Guardian 1 ____

Address ____

Home phone ________________________ Work phone _________________________ Cell phone ______________________

Parent/Guardian 2 ____

Address ____

Home phone ________________________ Work phone _________________________ Cell phone ______________________

Student's Physician/Health Care Provider ____

Address ____

Phone ____ Emergency phone ____________________________________

Other Emergency Contact ____ Relationship __________________________

Home phone ________________________ Work phone _________________________ Cell phone ______________________

Notify parent/guardian or emergency contact in the following situations: ____

____

____

____

Blood Glucose Monitoring
Target range for blood glucose (check one) _____ 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 his/her own blood glucose checks? _____ yes _____ no

Exceptions ____

Type of blood glucose meter student uses ____

Insulin
Usual Lunchtime Dose

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

Use of other insulin at lunch (circle type of insulin used) intermediate/NPH/lente ____________ units or Basal/Lantus/Ultralente ____________ units

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 his/her 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 Pumps

Type of pump: ____

Basal rates: ______ 12 am to __________ ________ to ________

Type of insulin in pump ____

Type of infusion set ____

Insulin/carbohydrate ration __________________________ Correction factor __________________________

Student Pump Abilities/Skills
Does the student need assistance to:

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

For Students Taking Oral Diabetes Medications

Type of Medication __________________________ Timing __________________________

Other Medication __________________________ Timing __________________________

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	____________	____________

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 group ____

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 parent/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

________ Blood glucose meter, blood glucose test strips, batteries for meter
________ Lancet device, lancets, gloves, etc.
________ Urine ketone strips
________ Insulin vials and syringes
________ Glucagon emergency kit
________ Insulin pump and supplies
________ Insulin pen, pen needles, insulin cartridges
________ Fast-acting source of glucose
________ Carbohydrate containing snack

Signatures
This Diabetes Medical Management Plan has been approved by:

____ ______________________________________
Physician/Health Care Provider Date

I give permission to the school nurse, trained diabetes personnel and other designate staff members of Laurel 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

____ ______________________________________
Parent/Guardian Date

Scan & email completed forms to:
summer@laurelschool.org
OR
Fax completed forms to:
216-464-8996
Attention: Summer at Laurel

For additional assistance, please call 216-455-3065